

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/24/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/21/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUMMERSTONE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>485 VETERANS WAY</b> <b>KERNERSVILLE, NC 27284</b>		
(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 000	<p>INITIAL COMMENTS</p> <p>The survey team entered the facility on 1-7-20 to conduct a recertification and complaint investigation survey and exited on 1-11-20. Additional information were obtained on 1-21-20. Therefore, the exit date was changed to 1-20-20. Event ID# 0Q5611.</p> <p>3 of the 20 complaint allegations were substantiated resulting in deficiencies.</p> <p>Immediate Jeopardy was identified at CFR 483.25 at tag F697 at a scope and severity (J) for 2 residents and</p> <p>Immediate Jeopardy was identified at CFR 483.45 at tag F755 at a scope and severity (J) for one resident.</p> <p>The tag F697 constituted Substandard Quality of Care</p> <p>Resident #1 Immediate Jeopardy began on 12-13-19 and was removed on 1-10-20.</p> <p>Resident #2 Immediate Jeopardy began on 1-1-20 and was removed on 1-10-20.</p>	F 000			
F 658 SS=D	<p>A partial extended survey was conducted.</p> <p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced</p>	F 658		1/21/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

01/30/2020

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 658	<p>Continued From page 1</p> <p>by: Based on record review, resident interview, family interview, physician interview and the dispensing pharmacy interview, the facility failed to follow hospital discharge orders by not providing 1 of 2 residents (Resident #1) medication during her admission to the facility.</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 12-13-19 at approximately 6:45pm with multiple diagnoses that included posterior spinal fusion of L3-pelvis, chronic pain syndrome, cellulitis of the abdominal wall and history of pulmonary embolism.</p> <p>Resident #1's hospital discharge summary dated 12-13-19 revealed an order for the following medications; Bumex 1mg (milligram) 2 times a day for fluid retention last received on 12-13-19 at 3:32pm in the hospital prior to discharge to the facility, Coreg 3.125mg 2 times a day for high blood pressure last received on 12-13-19 at 10:42am in the hospital, Flonase 50 mcg (micrograms) 1 spray each nostril 2 times a day for allergies last received on 12-13-19 at 10:39am in the hospital, Advair 100-50mcg 1 puff every 12 hours for shortness of breath last received on 12-13-19 at 10:39am in the hospital and Prilosec 20mg daily for acid reflux.</p> <p>An interview with the admitting nurse, Nurse #1, occurred on 1-8-20 at 1:10pm. Nurse #1 said "the resident came into the building right before the end of my shift at 7:00pm." Nurse #1 stated she did not order any medications for Resident #1 from the pharmacy because she "did not have her (the resident) discharge paperwork from the</p>	F 658	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 658 Services Provided Meet Professional Standards</p> <p>Corrective Action: Resident #1 Resident discharged 12/14/2019</p> <p>Identification of other residents who may be involved with this practice: All current residents have the potential to be affected by the alleged practice. On 1/10/2020 a chart audit was initiated for all current residents. The audit was completed by the Assistant director of nursing, Unit Support nurses and Director of Nursing to ensure that all residents had their medications per physician order available. The audit also ensured that residents received medications as ordered and signed for on the Medication Administration Record. The audit also ensured that pain medications were administered as ordered. The Assistant Director of Nursing and Unit support nurses, checked all medication carts and compared to the physician orders, and ensured that all medications were available and medications administered</p>		

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F 658	Continued From page 2 hospital."  Resident #1 was interviewed by telephone on 1-7-20 at 11:01am. Resident #1 stated she arrived at the facility on the evening of 12-13-19 and upon arrival a staff member escorted her to her room and took her hospital discharge paperwork but did not remember the name or title of the staff member. She also stated she did not receive any of her scheduled medications on 12-13-19 or 12-14-19 and the last dose of her medications that she received were at the hospital prior to discharge on the evening of 12-13-19. Resident #1 stated she left the facility the next day (12-14-19) with a family member and went home.  Nurse #2 was interviewed on 1-8-20 at 1:25pm. Nurse #2 worked from 7:00pm to 11:00pm on the evening of 12-13-19. She said she did not receive a resident report from Nurse #1 prior to starting her shift at 7:00pm. Nurse #2 also indicated she received 2 of the resident's pain medications (Percocet and Robaxin) on 12-13-19 but did not administer the resident any medication and was not aware Resident #1's scheduled medications were not ordered from the pharmacy since she did not receive a report from the previous shift.  An interview with Nurse #3 occurred on 1-8-20 at 11:44am. Nurse #3 worked 11:00pm to 7:00am the night of 12-13-19 and remembered Resident #1. Nurse #3 stated she did not receive a report on Resident #1 before beginning her shift. The nurse said she did not administer any medication to Resident #1 during her shift and was not aware Resident #1's scheduled medications had not been ordered through the pharmacy since she did not receive a report on Resident #1 from the prior	F 658	per order. All current residents have medications available and medications administered per order. All audits were completed on 1/10/2020. Systemic Changes: All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses and Nursing assistants {which includes any Nursing assistants who are medication aides}) will be educated on the following by the Director of Nursing. Education began on 1/10/2020. Education was completed on 1/10/2020 in reference to how to order and reorder medication and following discharge orders. Education included: The facility must ensure that the services provided or arranged by the facility as outlined by the comprehensive care plan meet professional standards of quality. All scheduled medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved as not administered. PRN medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing or Unit		

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F 658	<p>Continued From page 3 shift.</p> <p>Resident #1's Medication Administration Record (MAR) was reviewed for 12-13-19 and revealed no documentation that Resident #1 received any of her scheduled medication.</p> <p>The MAR dated 12-14-19 at 9:00am revealed documentation that Resident #1 received her scheduled medication.</p> <p>During an interview with the pharmacy manager on 1-7-20 at 1:25pm, the pharmacy manager revealed Resident #1's medications were not delivered to the facility until after 3:00pm on 12-14-19.</p> <p>The pharmacy packing slip dated 12-14-19 revealed Resident #1's scheduled medications did not leave the pharmacy until 3:00pm on 12-14-19 and was signed into the facility by Nurse #2 on 12-15-19.</p> <p>Nurse #1 was interviewed a second time on 1-8-20 at 1:15pm. Nurse #1 worked on 12-14-19 from 7:00am to 7:00pm and indicated she did not administer any medications to Resident #1 stating the medications were not available from the pharmacy. She also said, "I must have forgotten to go back and put the medication was not available 12-14-19 at 9:00am."</p> <p>The Medical Director was interviewed on 1-9-20 at 3:30pm. The Medical Director said when a resident was admitted to the facility, staff would contact him or the physician assistant with the resident's information and medications that had been ordered. He also stated, admissions that happened later in the day would sometimes</p>	F 658	<p>Support Nurses and will include reviewing the Point of Care dashboard; Administered PRN medication in the last 24 hours for each assignment every day to ensure that PRN medications have been administered as ordered. What to do when a drug is not available? " If the medication is an OTC (over the counter drug), check the medication OTC stock supply located at each Medication room (Located at each nursing station). If you are unable to locate it there, proceed to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OTC is available there. If the medication is still unavailable, contact the DON or Nurse Manager for further guidance. " If the medication is a prescription drug, you would first check the Medispense system located at the Rehab hall nurses station medication room (100/200hall). If the medication is not in the Medispense system, then immediately notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed more than one hour, notify the physician for any additional orders or directions. Medications must be given in the form ordered by the Physician unless the MD gives an order to dose differently. If at any time you have questions regarding the medication administration process, please contact the DON or Nurse Manager. " Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for current residents (reordering).</p>		

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F 658	Continued From page 4 cause a delay in administering the admitted resident's medication but "it is the facility's goal to administer medications as ordered by the physician."  A nursing note dated 12-14-19 at 7:10pm documented Resident #1 being alert, oriented and able to make her needs known and Resident #1 stating she had not been assessed in 26 hours or received any of her medications.	F 658	1) Medication orders are written on a medication order form and transmitted to the pharmacy. The written entry includes: Date ordered, Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number. Resident's name. Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order. 2) Repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows: a) Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need. b) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy. 3) New medications, except for emergency or stat medications, are ordered as follows: a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours.		

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F 658	Continued From page 5	F 658	<p>b) Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery.</p> <p>4) Stat and emergency medications are ordered as follows:</p> <p>a) During regular pharmacy hours, the emergency or stat order is phoned or faxed to the pharmacy. Such medications are delivered and administered within (2) hours. If available, the initial dose is obtained from the emergency kit, when necessary.</p> <p>5) When phoning or faxing a medication order to the pharmacy, the following information is given:</p> <p>a) Resident's name. b) Prescription number if a refill. c) Complete order if a new medication order or direction changes to a previous order. d) Name of prescriber if a new order. e) Indication for use. f) Name of person calling in order.</p> <p>6) New Admission Orders:</p> <p>a) When calling/faxing medication orders for a newly admitted resident, the pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment. b) The medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, etc. of current medications.</p> <p>This in service was completed by</p>		

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F 658	Continued From page 6	F 658	<p>1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained</p> <p>Monitoring: The Director of Nursing and/or Assistant Director of Nursing, Unit Manager will review weekly starting on 1/24/2020, and during quality of life meeting. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved as not administered. The audit will also ensure that discharge orders are followed for new admissions or readmissions. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program</p>		

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F 658	Continued From page 7	F 658	reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager, Wound Nurse. Date of Compliance: 1/21/2020		
F 697 SS=J	<p>Pain Management CFR(s): 483.25(k)</p> <p>§483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, interviews with resident, family, staff, nurse practitioner, Orthopedic nurse practitioner and physician, the facility failed to manage residents' pain by not administering pain medication as ordered by the physician for 2 of 2 residents (Resident #1 and Resident #2) reviewed for pain management. This resulted in Resident #1 "crying and screaming" into her pillow due to the pain being "terrible" and ultimately leaving the facility the next day against medical advice. Resident #2 experienced pain at a scale of 10+ (0 being no pain and 10 being the worst pain) and ultimately was sent to the emergency room for pain management.</p> <p>Immediate Jeopardy began on 12-13-19 when Resident #1, who was newly admitted to the facility with hospital discharge orders for multiple pain medications, did not receive her pain</p>	F 697	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 697 Pain Management Corrective Action: Resident #1 Resident discharged 12/14/2019 Resident #2 Medications available and administered as ordered. Identification of other residents who may</p>	1/21/20	



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F 697	<p>Continued From page 8</p> <p>medications resulting in the resident experiencing excruciating pain and leaving the facility the next day. Resident #2's Immediate Jeopardy began on 1-1-20 when Resident #2 did not receive his pain medication because the facility ran out the medication resulting in the resident experiencing excruciating pain and the resident was transferred to the hospital emergency room to control his pain. Immediate Jeopardy was removed on 1-10-20 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put in place are effective.</p> <p>Findings included:</p> <p>1. Resident #1 was admitted to the facility on 12-13-19 at approximately 6:45pm with multiple diagnoses that included posterior spinal fusion of L3-pelvis, chronic pain syndrome, cellulitis of the abdominal wall and history of pulmonary embolism.</p> <p>Resident #1's hospital discharge summary dated 12-13-19 revealed an order for the following pain medications; Robaxin 500mg (milligrams) 3 times a day for muscle spasms, Percocet 10-325mg every 4 hours as needed for pain, Belbuca Film 150mcg (micrograms) every 12 hours for pain, Diclofenac gel 2 grams applied to the skin every 12 hours as needed for pain and Lyrica 50mg twice a day for pain.</p> <p>Resident #1 left the facility against medical advice on 12-14-19 at approximately 7:00pm. There was</p>	F 697	<p>be involved with this practice: All current residents have the potential to be affected by the alleged practice. Pain assessments ordered for all current residents on 1/10/2020 to be completed every shift daily by nurse. Pain assessments to be documented in the electronic medication administration record (EMAR). A complete audit of all current residents was completed on 1/10/2020 by the Nurse Consultant, Assistant Director of Nursing and Unit support nurses to ensure that all residents had a pain assessment completed. All pain assessments have been completed on all current residents on 1/10/2020. The audit also ensured that pain medications are administered as ordered. Physician was notified for any resident who complained of a new onset of pain or reported severe pain that was not treated with current interventions. Any new orders for pain medications were obtained, orders faxed to pharmacy so as to obtain medication from back up pharmacy. Medications administered as ordered. All audits were completed on 1/10/2020.</p> <p>Systemic Changes: All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses and Nursing assistants) will be educated on the following by the Director of Nursing. Education began on 1/10/2020. Education was completed on 1/10/2020 in reference to Pain management and assessment, Medication errors to include how to order and reorder medication.</p> <p>Education included: The facility must ensure that pain</p>		

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F 697	<p>Continued From page 9</p> <p>not a care plan, or a Minimum Data Set completed.</p> <p>Resident #1's facility's admission nursing assessment signed by Nurse #1 dated 12-13-19 revealed Resident #1 was alert, oriented and had a pain level of zero.</p> <p>An interview with the admitting nurse, Nurse #1, occurred on 1-8-20 at 1:10pm. Nurse #1 said she had "briefly" entered Resident #1's room on 12-13-19 "around" 6:50pm to introduce herself and initiated the nursing assessment in the resident's electronic medical record but did not complete a full nursing assessment or ask about Resident #1's pain level. The Nurse stated, "she didn't look like she was in pain." Nurse #1 stated, "the resident came into the building right before the end of my shift at 7:00pm." The nurse also indicated she was not comfortable completing an admission assessment on Resident #1 because she "did not have her (the resident) discharge paperwork from the hospital." Nurse #1 indicated she did not report Resident #1's admission to the on-coming nurse at 7:00pm.</p> <p>Resident #1 was interviewed by telephone on 1-7-20 at 11:01am. Resident #1 stated she arrived at the facility on the evening of 12-13-19 and upon arrival a staff member escorted her to her room and took her hospital discharge paperwork but she did not remember the name or title of the staff member. She also indicated a nursing assistant entered her room and obtained vital signs, but she did not see a nurse. Resident #1 said she requested to see a nurse for some pain medication "several" times on the evening of 12-13-19 and was not provided with either of her requests. The resident also expressed she felt</p>	F 697	<p>management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Pain assessment will be completed on each resident every shift by the nurse daily. Pain assessments will be completed for each new admissions or readmissions upon admission. Pain medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each hall assignment every day to ensure that all medications have been administered as ordered and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved as not administered. Changes in a patient condition occur for many different reasons. New onset of pain or complaints of pain or worsening pain unrelieved by interventions should be addressed by nurse for all resident in the facility. What to do if a resident has a new onset of pain or complains of pain or worsening pain unrelieved by interventions.</p> <p>" If you are not a nurse, then notify the nurse immediately of the pain changes you have noticed. Even small pain changes can be very important since they may indicate bigger problems to come.</p> <p>" Nurses should assess the patient for pain upon notification. Assessment needs</p>		

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F 697	<p>Continued From page 10</p> <p>"neglected" and described her pain as continuously "excruciating" and stated, "I remember crying and screaming into my pillow because the pain was so terrible" throughout the night of 12-13-19 and into the next day 12-14-19 for approximately 11 hours. Resident #1 stated she left the facility the next day (12-14-19) with a family member and went home.</p> <p>During an interview with nursing assistant (NA) #1 on 1-8-20 at 1:47pm, the NA was assigned to Resident #1 on the evening of 12-13-19 and remembered the resident using her call light two times during the shift (7:00pm-7:00am) and requesting pain medication for her back. NA #1 indicated she informed Nurse #2 and Nurse #3 of the resident's request for pain medication and Nurse #3 stated the pain medication was not available from the pharmacy. The NA revealed Resident #1 was not grimacing, grunting or crying at the time she requested pain medication. NA #1 said she had not provided any activities of daily living care to Resident #1.</p> <p>Nurse #2 was interviewed on 1-8-20 at 1:25pm. Nurse #2 worked from 7:00pm to 11:00pm on the evening of 12-13-19 but did not do an admission nursing assessment on Resident #1. Nurse #2 stated, "(Nurse #1) admitted (Resident #1) so she would have completed the assessment." She also said she did not receive a resident report from Nurse #1 prior to starting her shift at 7:00pm. Nurse #2 revealed she "briefly" spoke to Resident #1 after the pharmacy called inquiring if the resident was allergic to Percocet. Nurse #2 stated, "I went in and asked about her allergies but that's it." She also indicated she received 2 of the resident's pain medications (Percocet and Robaxin) on 12-13-19 but did not remember if</p>	F 697	<p>will vary depending on the patient <input type="checkbox"/>s complaint or signs/symptoms</p> <p>" The patient <input type="checkbox"/>s chart should also be reviewed in order to determine if a patient had a condition that may explain the signs and symptoms they are experiencing.</p> <p>" If interventions are available by using the standing orders, patient current orders, or items identified in the plan of care then they should be implemented as appropriate. This may include Tylenol for fever, prn pain medication etc. Administer pain medications as ordered by physician.</p> <p>" Pain Interventions should be implemented promptly when pain change is identified. Administer pain medications as ordered by physicians.</p> <p>" Pain Assessment results and interventions must be documented in the medical record.</p> <p>" Immediate Notification of physician is required when there is a new onset of pain or the pain is severe and current interventions are not effective. Documentation of this notification should be completed, and new orders obtained and documented. Administer pain medications per physician orders.</p> <p>" Phone numbers for physicians are located at the nursing stations. If a physician does not respond to an emergency or If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does</p>		

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F 697	<p>Continued From page 11</p> <p>Resident #1 complained of pain and stated she did not administer the resident any medication.</p> <p>An interview with Nurse #3 occurred on 1-8-20 at 11:44am. Nurse #3 worked 11:00pm to 7:00am the night of 12-13-19 and remembered Resident #1. She revealed she did not complete an admission assessment on Resident #1 because "the admitting nurse should have completed the assessment." Nurse #3 stated she did not receive a report on Resident #1 before beginning her shift. She stated "(Nurse #2) didn't know much because she did not get a report from (Nurse #1)." Nurse #3 indicated she did not have any interaction with Resident #1 and did not remember the resident requesting any pain medication, so she did not look to see if Resident #1 had any pain medication available. The nurse said she did not administer any medication to Resident #1 during her shift.</p> <p>NA #2 was interviewed on 1-9-20 at 4:10pm. NA #2 stated she worked on 12-14-19 from 7:00am to 3:00pm and was assigned to care for Resident #1. NA #2 remembered Resident #1 activating her call light a "few times" complaining of pain on 12-14-19. The NA said when Resident #1 would move the resident would make a grimacing face and grunt. NA #2 indicated she informed Nurse #1 "several times" on 12-14-19 of the resident's pain and the nurse told Resident #1 that staff was waiting for the physician to order her pain medication. The NA said she had not provided any activities of daily living care to Resident #1 because the resident did not request any care.</p> <p>The facility's narcotic count sheet dated 12-13-19 revealed one Percocet 10-325mg tablet was removed from the medication cart by Nurse #1 on</p>	F 697	<p>not call back within 30 minutes then the nurse is to contact the Director of Nursing immediately for further instructions.</p> <p>" Notify the responsible party and document this in the nursing notes.</p> <p>" If the physician orders for the resident to be transferred to an acute care hospital for evaluation, orders will be followed and implemented. If resident refuses to be transferred to the acute care hospital or if resident representative refuses for the resident to be transferred to the acute care hospital, Physician will be notified of the refusal. Document notification of physician on such situations, and follow and document physician orders and/or directives. Notify resident representative of resident's refusal and also of physician notification and of any new orders or directives.</p> <p>Pain assessments are documented in the electronic health record. This includes nursing user defined assessments; vital signs tab, and the electronic medication records. Verbal or visual pain scales can be used to assist patients who are able to verbalize pain. Nonverbal scales are used when patients are not able to verbalize pain intensity.</p> <p>Verbal Pain Scale (Ask the resident: "On a scale of 0 to 10, with 0 being no pain, 1-3 being mild pain, 4-6 being moderate pain, and 7-10 being severe pain, with 10 being the worst pain you can imagine, what number would you say best describes your pain right now?")</p> <p>Visual Pain Scale (Say to the resident: "There are six faces</p>		

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F 697	<p>Continued From page 12 12-14-19 at 11:00am for Resident #1.</p> <p>Resident #1's Medication Administration Record (MAR) for December 2019 revealed there was no documentation that medications were administered to Resident #1 on 12-13-19 or 12-14-19.</p> <p>Nurse #1 was interviewed a second time on 1-8-20 at 1:15pm. Nurse #1 worked on 12-14-19 from 7:00am to 7:00pm and remembered Resident #1 complaining of pain. She said she informed the resident that her medications were not available from the pharmacy. Nurse #1 indicated she did not administer any medications to Resident #1.</p> <p>During an interview with the pharmacy manager on 1-7-20 at 1:25pm, the pharmacy manager revealed Percocet 10-325mg tablet and Robaxin 500mg tablet were delivered to the facility at 9:45pm on 12-13-19 by the facility's back up pharmacy. He also said the rest of Resident #1's medications were not delivered to the facility until after 3:00pm on 12-14-19.</p> <p>During an Interview with the Quality Assurance Regional Nurse Consultant on 1/9/20 at 3:32 PM she stated it was not required, nor the facility's protocol to have nursing staff perform pain assessments every shift. She also stated, If a medication required a pain assessment prior to administration and a follow-up after administration of a pain medication, the physician's orders would specify that the nursing staff would need to complete a pain assessment.</p> <p>During an interview with the Physician Assistant (PA) on 1-9-20 at 5:40pm, the PA said she</p>	F 697	<p>below. The first face is a smiling, happy face, representing no pain. The last face is a sad, crying facing, representing severe pain. The four middle faces are somewhere in between. Point to or draw a mark beside the face that best describes your pain right now.")</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1-2</td> <td style="text-align: center;">3-4</td> <td style="text-align: center;">5-6</td> <td style="text-align: center;">7-8</td> <td style="text-align: center;">9-10</td> </tr> </table> <p>Non Verbal Pain Scale Use the descriptions listed below to obtain a pain intensity scale for the patient.</p> <p>What to do when a drug is not available? " If the medication is an OTC (over the counter drug), check the medication OTC stock supply located at each Medication room (Located at each nursing station). If you are unable to locate it there, proceed to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OTC is available there. If the medication is still unavailable, contact the DON or Nurse Manager for further guidance. " If the medication is a prescription drug, you would first check the Medispense system located at the Rehab hall nurses station medication room (100/200hall). If the medication is not in the Medispense system, then immediately notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed more than one hour, notify the physician for any additional orders or directions.</p>	0	1-2	3-4	5-6	7-8	9-10	
0	1-2	3-4	5-6	7-8	9-10					

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F 697	<p>Continued From page 13</p> <p>provided care to Resident #1 in the hospital post-surgery. She stated Resident #1 had a spinal fusion of her L3-pelvis area and would have been in excruciating pain and that the resident would not have been discharged without prescriptions for pain medication. The PA revealed Resident #1's mobility would have been hindered and recovery prolonged by not receiving pain medication.</p> <p>The Medical Director was interviewed on 1-9-20 at 3:30pm. The Medical Director said when a resident was admitted to the facility, staff would contact him or the physician assistant with the resident's information and medications that had been ordered. He also stated, admissions that happened later in the day would sometimes cause a delay in administering the admitted resident's medication but "it is the facility's goal to administer medications as ordered by the physician."</p> <p>Resident #1's family member was interviewed by telephone on 1-10-20 at 3:10pm. The family member said upon Resident #1's admission to the facility, the resident was able to walk with assistance with moderate to severe back pain. The family member stated she received a call from Resident #1 on 12-13-19 and 12-14-19 crying and stating she did not receive any of her medications. The family member revealed she called the facility to inquire about Resident #1's medications and was informed by Nurse #1 that the facility was still waiting for the physician to order the resident's medication. The family member said she drove to the facility and took Resident #1 home against medical advice. The family member stated Resident #1 was in "severe" pain and could "barley walk" out of the</p>	F 697	<p>Medications must be given in the form ordered by the Physician unless the MD gives an order to dose differently. If at any time you have questions regarding the medication administration process, please contact the DON or Nurse Manager.</p> <p>" Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for current residents (reordering).</p> <p>1) Medication orders are written on a medication order form and transmitted to the pharmacy. The written entry includes: Date ordered, Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number. Resident's name. Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order.</p> <p>2) Repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows:</p> <p>a) Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need.</p> <p>b) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors.</p> <p>c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy.</p>		

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F 697	<p>Continued From page 14</p> <p>facility but said she was able to give Resident #1 pain medication that the resident already had at home, which decreased the residents pain enough that the resident could sleep.</p> <p>A nursing note dated 12-14-19 at 7:10pm documented Resident #1 being alert, oriented and able to make her needs known and Resident #1 stating she had not been assessed in 26 hours or received any of her medications. Documentation revealed Resident #1 was ambulating down the facility hallway pushing a wheelchair with the resident's daughter present and leaving the facility in a private vehicle on 12-14-19 at 7:00pm.</p> <p>An interview was conducted with the orthopedic spinal physician assistant (OSPA) by telephone on 1-9-20 at 5:40pm. The (OSPA) revealed the resident would have been in excruciating pain without receiving her pain medication as ordered because of the type of surgery she received. The OSPA also said the resident's mobility would have been hindered due to the increased pain and resulted in prolonging recovery.</p> <p>2. Resident #2 was admitted to the facility on 12-3-18 with multiple diagnoses that included Parkinson's, chronic obstructive pulmonary disease, dysphagia and chronic kidney disease.</p> <p>Resident #2's care plan dated 11-15-19 revealed a goal that he would verbalize adequate relief of pain or the ability to cope with incomplete relief. The interventions associated with that goal were in part; anticipate need for pain relief, evaluate the effectiveness of pain interventions, notify the physician if interventions are unsuccessful and observe for and report to the nurse any signs and</p>	F 697	<p>3) New medications, except for emergency or stat medications, are ordered as follows:</p> <p>a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours.</p> <p>b) Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery.</p> <p>4) Stat and emergency medications are ordered as follows:</p> <p>a) During regular pharmacy hours, the emergency or stat order is phoned or faxed to the pharmacy. Such medications are delivered and administered within (2) hours. If available, the initial dose is obtained from the emergency kit, when necessary.</p> <p>5) When phoning or faxing a medication order to the pharmacy, the following information is given:</p> <p>a) Resident's name.</p> <p>b) Prescription number if a refill.</p> <p>c) Complete order if a new medication order or direction changes to a previous order.</p> <p>d) Name of prescriber if a new order.</p> <p>e) Indication for use.</p> <p>f) Name of person calling in order.</p> <p>6) New Admission Orders:</p> <p>a) When calling/faxing medication orders for a newly admitted resident, the</p>		

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F 697	<p>Continued From page 15 symptoms of non-verbal pain.</p> <p>The annual Minimum Data Set (MDS) dated 12-2-19 revealed Resident #2 was minimally cognitively impaired and coded as almost constantly in pain with decrease sleep and activities due to a pain level of 10 on a scale of 0 (no pain) to 10 (the worst pain). The MDS also revealed Resident #2 received opioid (pain medication) 7 out of 7 days.</p> <p>The physician orders revealed the following pain medications for Resident #2; Robaxin 500mg (milligrams) 1 tablet twice a day for muscle spasms, Baclofen 10mg 1 tablet 3 times a day for muscle spasms, Gabapentin 800mg 1 tablet 3 times a day for pain, Oxycodone 15mg 1 tablet 4 times a day for pain, Norco 5-325mg 1 tablet 4 times a day for pain until Oxycodone 15mg is available.</p> <p>During an interview with Resident #2 on 1-8-20 at 8:45am, the resident revealed he had constant pain in his back due to "my spine is falling apart because the discs are bad" but his regularly scheduled pain medication, Oxycodone 15mg, worked well controlling his pain. Resident #2 stated "about a week ago" the facility ran out of his pain medication in the morning and that it was not until "the middle of the night" the facility administered a different pain medication, Norco 5-325mg. The resident said he informed the nurse that Norco was not working and that he had "excruciating" pain. The resident described his pain at a level of 10+ "all day" and stated, "I couldn't even get out of bed." Resident #2 said he had to go to the emergency room to receive pain relief.</p>	F 697	<p>pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment.</p> <p>b) The medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, etc. of current medications.</p> <p>This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained</p> <p>Monitoring: The Director of Nursing and/or Assistant Director of Nursing, Unit Manager will review weekly starting on 1/24/2020, and during quality of life meeting. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and pain assessments are completed on each resident every shift by the nurse and pain medications administered as ordered, and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved</p>		



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F 697	<p>Continued From page 16</p> <p>Nursing assistant (NA) #6 was interviewed on 1-9-20 at 3:30pm. The NA stated Resident #2 "often" complained of pain and that she would inform the nurse. She also stated when Resident #2 was having pain she had to assist him more with his activities of daily living because "he could not move around as well."</p> <p>Resident #2's Medication Administration Record (MAR) for January 2020 revealed an order for Oxycodone 15mg 1 tablet 4 times a day at 9:00am, 12:00pm, 5:00pm and 9:00pm. On 1-1-20, Oxycodone was documented as administered to the resident at 9 am. On 1-1-20, Oxycodone was documented as unavailable for administration to the resident at 12pm, 5pm, and 9pm.</p> <p>Medication Aide (MA) #1 was interviewed on 1-9-20 at 11:23am. MA #1 stated she worked with Resident #2 on 1-1-20 and the resident ran out of his Oxycodone after she administered the 9:00am dose on 1-1-20. She stated she informed nurse #4 the resident was out of his medication. She also said the medication card had a refill request on it but as a Medication Aide she was not allowed to reorder the medication.</p> <p>During an interview with Nurse #4 on 1-9-20 at 8:50am, the nurse stated she was not made aware by MA #1 that Resident #2 had run out of his Oxycodone on 1-1-20 because "I was not giving medications, the MA #1 was giving medications at that time." She also said when Resident #2 complained of severe pain on 1-2-20 around 9:00pm, she realized he did not have his scheduled medication, so she called the physician to obtain orders for pain medication that was available through the facility's inventory</p>	F 697	<p>as not administered. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager, Wound Nurse.</p> <p>Date of Compliance: 1/21/2020</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/21/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>SUMMERSTONE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>485 VETERANS WAY</b> <b>KERNERSVILLE, NC 27284</b>		
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F 697	<p>Continued From page 17</p> <p>management system (Norco 5-325mg 1 tablet 4 times a day until Oxycodone 15mg is available) which she stated she administered at 10:00pm on 1-1-20. Nurse #4 said the resident informed her the pain medication was not controlling his pain and the resident requested to go to the emergency room. The nurse stated the resident was sent to the emergency room on 1-2-20 around 4:00am for severe pain.</p> <p>The facility's narcotic count sheet revealed Resident #2 received Norco 5-325mg 1 tab at 10:00pm on 1-1-20.</p> <p>A review of Resident #2's MAR for the medication Norco 5-325mg tablet revealed the medication had not been documented as administered on 1-1-20.</p> <p>Nurse #4's documentation dated 1-2-20 at 2:45am revealed Resident #2 was complaining of severe back pain and the pain was not relieved by the pain medication that had been administered. Documentation also revealed Resident #2 requested to go to the emergency room.</p> <p>Nurse #4's documentation on 1-2-20 at 3:05am revealed communication with the nurse practitioner and orders to send Resident #2 to the emergency room.</p> <p>The emergency department documentation dated 1-2-20 at 5:34am revealed Resident #2 was treated for chronic low back pain with Toradol (pain medication) 50mg intramuscular (injection) and Roxicodone (pain medication) 5mg by mouth. Documentation also revealed Resident #2's pain</p>	F 697			

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F 697	<p>Continued From page 18</p> <p>had improved, and the resident was transferred back to the facility.</p> <p>The pharmacy manager was interviewed by telephone on 1-9-20 at 10:48am. The pharmacy manager stated they received an order for Oxycodone 5mg to dispense 3 tablets on 1-2-20 and an order for Oxycodone 15mg 1 tablet for 4 doses on 1-2-20. The pharmacist stated the orders were filled on 1-2-20 and delivered to the facility around 4:00pm on 1-2-20.</p> <p>An interview with the Nurse Practitioner (NP) occurred on 1-9-20 at 12:30pm. The NP said she would not expect Resident #2 to suffer withdrawal symptoms from missing a few doses of his Oxycodone but would expect the resident to have increased pain and more difficulty with mobility. She also stated she would not expect a resident to run out of their medication "staff just has to call us, and we can fax a script over to the pharmacy."</p> <p>The Director of Nursing and the Corporate Nurse Consultant were notified of the Immediate Jeopardy on 1-10-20 at 12:10pm. On 1-10-20 at 11:05pm the facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>"Resident # 1 was admitted to the facility on 12/13/19 at approximately 6:45 PM after hospital stay status post revision of L3-pelvis revision/lumbar fusion. Resident diagnoses included cellulitis of abdominal wall, Staphylococcus aureus bacteremia, Warfarin anticoagulation and acute pulmonary embolism. Nursing Admission Assessment completed on</p>	F 697			

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F 697	<p>Continued From page 19</p> <p>12/13/2019 and indicated no pain was noted. On 12/13/2019 and 12/14/2019 resident did not receive medication as ordered. Resident discharged against medical advice on 12/14/2019. Nurse #1 on 12/13/2019 did not call pharmacy and request for back up pharmacy for medications to be delivered upon admission. On 12/13/2019 Nurse #3 did not remember any report of pain from the resident and did not give the resident any pain medication during the 11pm to 7am shift. On 12/14/2019 Nurse #2 did not call pharmacy and request for back up pharmacy for medications to be delivered.</p> <p>Root cause for the incident with Resident #1 is Nurse #1 did not administer pain medication due to lack of knowledge. Root cause for the incident with Resident #1 is Nurse #2 did not administer pain medication due to lack of knowledge. Root cause for the incident with Resident #1 is Nurse #3 did not administer pain medication due to lack of knowledge</p> <p>Resident #2.</p> <p>Resident #2 had an order for pain medication because of his diagnosis of spinal spondylosis. On 1/1/2020 resident was assessed for pain during day shift and asked if he had pain according to a 1-10 scale. Resident responded pain level was 0 per electronic medication administration record. On 1/1/2020 Resident did not receive Oxycodone 15mg at 12:00 noon, 5:00 pm and at 9:00 pm. On 1/1/2020 10:30 pm resident received pain medication Norco 5/325mg per physician orders as Oxycodone was on hold until medication received from pharmacy per orders. On 1/1/2020 at 11:30pm Nurse Practitioner was notified of resident complaining of severe back pain and requesting to go to the hospital and that resident indicated that medication given to him earlier did not do</p>	F 697			

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F 697	Continued From page 20 anything for him. At 11:50pm resident refused Tylenol and continued to state he wants to go to the hospital. Nurse practitioner notified at 12:03am on 1/2/2020 of the above, and ordered a one-time dose of Robaxin 500mg and to wait 4 hours before giving another Norco 5/325mg. On 1/2/2020 at 12:10am resident received pain medication Robaxin 500mg. On 1/2/2020 at 2:30am resident refused pain medication Norco 5/325mg when nurse offered medication per physician orders. Resident refused and stated he wanted to go to the hospital. Nurse Practitioner was notified, and resident was transferred to the hospital on 1/2/2020 at 2:45am. 1/3/2019 resident did not receive Oxycodone 15mg at 12:00 noon. Root cause for the incident with Resident #2 is Nurse #1 did not administer pain medication due to lack of knowledge. Pain assessments ordered for all current residents on 1/10/2020 to be completed every shift daily by nurse. Pain assessments to be documented in the electronic medication administration record (EMAR). A complete audit of all current residents was completed on 1/10/2020 by the Nurse Consultant, Assistant Director of Nursing and Unit support nurses to ensure that all residents had a pain assessment completed. All pain assessments have been completed on all current residents on 1/10/2020. The audit also ensured that pain medications are administered as ordered. Physician was notified for any resident who complained of a new onset of pain or reported severe pain that was not treated with current interventions. Any new orders for pain medications were obtained, orders faxed to pharmacy so as to obtain medication from back up pharmacy. Medications administered as ordered. All audits were completed on 1/10/2020. Specify the action the entity will take to alter the	F 697			

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F 697	<p>Continued From page 21</p> <p>process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses and Nursing assistants) will be educated on the following by the Director of Nursing. Education began on 1/10/2020. Education was completed on 1/10/2020 in reference to Pain management and assessment, Medication errors to include how to order and reorder medication.</p> <p>Education included:</p> <p>Pain assessment will be completed on each resident every shift by the nurse daily. Pain assessments will be completed for each new admissions or readmissions upon admission. Pain medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each hall assignment every day to ensure that all medications have been administered as ordered and also by reviewing the "Not Administered" Med passes in last 24 hours on the dashboard checking the # of documentation saved as "not administered". Changes in a patient condition occur for many different reasons. New onset of pain or complaints of pain or worsening pain unrelieved by interventions should be addressed by nurse for all resident in the facility.</p> <p>What to do if a resident has a new onset of pain or complains of pain or worsening pain unrelieved by interventions.</p> <p>" If you are not a nurse, then notify the nurse immediately of the pain changes you have noticed. Even small pain changes can be very</p>	F 697			

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F 697	Continued From page 22 important since they may indicate bigger problems to come. " Nurses should assess the patient for pain upon notification. Assessment needs will vary depending on the patient 's complaint or signs/symptoms " The patient's chart should also be reviewed in order to determine if a patient had a condition that may explain the signs and symptoms they are experiencing. " If interventions are available by using the standing orders, patient current orders, or items identified in the plan of care then they should be implemented as appropriate. This may include Tylenol for fever, prn pain medication etc. Administer pain medications as ordered by physician. " Pain Interventions should be implemented promptly when pain change is identified. Administer pain medications as ordered by physicians. " Pain Assessment results and interventions must be documented in the medical record. " Immediate Notification of physician is required when there is a new onset of pain or the pain is severe and current interventions are not effective. Documentation of this notification should be completed, and new orders obtained and documented. Administer pain medications per physician orders. " Phone numbers for physicians are located at the nursing stations. If a physician does not respond to an emergency or If you are unable to reach the attending physician or the physician on call, call the facility medical director within 30 minutes of contacting the primary physician. If the attending physician or medical director does not provide an appropriate response or does not call back within 30 minutes, then the nurse is to	F 697			

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F 697	<p>Continued From page 23</p> <p>contact the Director of Nursing immediately for further instructions.</p> <p>" Notify the responsible party and document this in the nursing notes.</p> <p>" If the physician orders for the resident to be transferred to an acute care hospital for evaluation, orders will be followed and implemented. If resident refuses to be transferred to the acute care hospital or if resident representative refuses for the resident to be transferred to the acute care hospital, Physician will be notified of the refusal. Document notification of physician on such situations and follow and document physician orders and/or directives. Notify resident representative of resident's refusal and of physician notification and of any new orders or directives.</p> <p>Pain assessments are documented in the electronic health record. This includes nursing user defined assessments; vital signs tab, and the electronic medication records. Verbal or visual pain scales can be used to assist patients who are able to verbalize pain. Nonverbal scales are used when patients are not able to verbalize pain intensity.</p> <p>What to do when a drug is not available?</p> <p>" If the medication is an OTC (over the counter drug), check the medication OTC stock supply located at each Medication room (Located at each nursing station). If you are unable to locate it there, proceed to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OTC is available there. If the medication is still unavailable, contact the DON or Nurse Manager for further guidance.</p> <p>" If the medication is a prescription drug, you would first check the Medispense system located at the Rehab hall nurses station medication room</p>	F 697			



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F 697	Continued From page 24 (100/200 hall). If the medication is not in the Medispense system, then immediately notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed more than one hour, notify the physician for any additional orders or directions. Medications must be given in the form ordered by the Physician unless the MD gives an order to dose differently. If at any time you have questions regarding the medication administration process, please contact the DON or Nurse Manager. " Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for current residents (reordering). 1) Medication orders are written on a medication order form and transmitted to the pharmacy. The written entry includes: Date ordered, Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number. Resident's name. Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order. 2) Repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows: a) Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need. b) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy.	F 697			

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F 697	Continued From page 25 3) New medications, except for emergency or "stat" medications, are ordered as follows: a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours. b) Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery. 4) "Stat" and emergency medications are ordered as follows: a) During regular pharmacy hours, the emergency or "stat" order is phoned or faxed to the pharmacy. Such medications are delivered and administered within (2) hours. If available, the initial dose is obtained from the emergency kit, when necessary. 5) When phoning or faxing a medication order to the pharmacy, the following information is given: a) Resident's name. b) Prescription number if a refill. c) Complete order if a new medication order or direction changes to a previous order. d) Name of prescriber if a new order. e) Indication for use. f) Name of person calling in order. 6) New Admission Orders: a) When calling/faxing medication orders for a newly admitted resident, the pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment. b) The medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, etc. of current medications.	F 697			

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F 697	Continued From page 26 This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees. Immediate Jeopardy Removal Date: 1/10/2020.  The credible allegation for Immediate Jeopardy removal was validated on 1-11-20 at 10:00am which removed the Immediate Jeopardy on 1-10-20 as evidenced by staff interviews, in-service record reviews and observations. The in-service included information on ordering and re-ordering medications, pain assessments, pain management, type of pain and the different pain scales, what to do when a medication is not available, types of medication errors and the facility's policy and procedures on medication administration.	F 697			
F 755 SS=J	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)  §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		1/21/20	

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F 755	<p>Continued From page 27</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, pharmacy interview, resident interview and nurse practitioner interview the facility failed to implement effective procedures to assure pain medication was available to meet the needs of the residents. This was evident in 1 of 2 residents (Resident #2) reviewed for pain management. This resulted in Resident #2 complaining of being in excruciating pain and ultimately having to be sent to the emergency room for pain management.</p> <p>Immediate Jeopardy began on 1-1-20 when Resident #2 did not receive his pain medication because the facility ran out of the medication on 1-1-20 resulting in the resident experiencing excruciating pain and the resident being transferred to the emergency room for pain management. Immediate Jeopardy was removed on 1-10-20 when the facility provided and</p>	F 755	<p>The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all Federal and State Regulations the facility has taken or will take the actions set forth in this Plan of Correction. The Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>F 755 Pharmacy Srvcs/Procedures/Pharmacist/Records Corrective Action: Resident #2 Medications available and administered as ordered. Identification of other residents who may be involved with this practice: All current residents have the potential to</p>		

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F 755	<p>Continued From page 28</p> <p>implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "D" (no harm with the potential for more than minimal harm that is not Immediate Jeopardy) to ensure monitoring systems put in place are effective.</p> <p>Findings included:</p> <p>The facility's policy and procedure (not dated) for ordering and receiving medications from the pharmacy was reviewed and revealed in part the following: "repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows; reorder medication 3 to 4 days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as schedule 2 controlled substances), order at least 7 days in advance of need." "The refill order is called in, faxed or otherwise transmitted to the pharmacy."</p> <p>Resident #2 was admitted to the facility on 12-3-18 with multiple diagnoses that included Parkinson's disease, chronic obstructive pulmonary disease, and chronic kidney disease.</p> <p>The annual Minimum Data Set (MDS) dated 12-2-19 revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 13 and coded as almost constantly in pain with decrease sleep and activities due to a pain level of 10 (0 no pain, 10 worst pain). The MDS also revealed Resident #2 received opioid (pain medication) during 7 out of 7 days of the look behind period.</p> <p>The physician orders revealed the following pain</p>	F 755	<p>be affected by the alleged practice. On 1/10/2020 a chart audit was initiated for all current residents. The audit was completed by the Assistant director of nursing, Unit Support nurses and Director of Nursing to ensure that all residents had their medications per physician order available. The audit also ensured that residents received medications as ordered and signed for on the Medication Administration Record. The audit also ensured that pain medications were administered as ordered. The Assistant Director of Nursing and Unit support nurses, checked all medication carts and compared to the physician orders, and ensured that all medications were available and medications administered per order. All current residents have medications available and medications administered per order. All audits were completed on 1/10/2020</p> <p>Systemic Changes: All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses and Nursing assistants {which includes any Nursing assistants who are medication aides}) will be educated on the following by the Director of Nursing. Education began on 1/10/2020. Education was completed on 1/10/2020 in reference to how to order and reorder medication.</p> <p>Education included: The facility must provide routine and emergency drugs and biologicals to its residents or obtain them per physician orders. The facility may permit unlicensed personnel to administer drugs if State law</p>		

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F 755	<p>Continued From page 29</p> <p>medications for Resident #2; Robaxin 500mg (milligrams) 1 tablet twice a day for muscle spasms, Baclofen 10mg 1 tablet 3 times a day for muscle spasms, Gabapentin 800mg 1 tablet 3 times a day for pain, Oxycodone 15mg 1 tablet 4 times a day for pain, Norco 5-325mg 1 tablet 4 times a day for pain until Oxycodone 15mg is available.</p> <p>During an interview with Resident #2 on 1-8-20 at 8:45am, the resident stated he had constant pain in his back due to "my spine is falling apart because the discs are bad" but his regularly scheduled pain medication, Oxycodone 15mg (milligrams), worked well controlling his pain. Resident #2 stated "about a week ago" the facility had run out of his pain medication (Oxycodone 15mg) in the morning and that it was not until "the middle of the night" the facility administered a different pain medication that, the resident stated, did not control his pain. The resident described his pain at a level of 10+ "all day." Resident #2 stated he had to be transferred to the emergency room to receive pain relief.</p> <p>Resident #2's Medication Administration Record (MAR) for January 2020 revealed an order for Oxycodone 15mg 1 tablet 4 times a day at 9:00am, 12:00pm, 5:00pm and 9:00pm. On 1-1-20, Oxycodone was documented as administered to the resident at 9 am. On 1-1-20, Oxycodone was documented as not available for administration to the resident at 12pm, 5pm, and 9pm.</p> <p>The facility's narcotic count sheet revealed Resident #2 received Norco 5-325mg 1 tab at 10:00pm on 1-1-20.</p>	F 755	<p>permits, but only under the general supervision of a licensed nurse. The facility must provide, pharmaceutical services ( including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Pain medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved as not administered.</p> <p>PRN pain medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing or Unit Support Nurses and will include reviewing the Point of Care</p>		

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F 755	<p>Continued From page 30</p> <p>Review of the MAR for 1-1-20 revealed the Norco was not documented as administered at 10:00pm.</p> <p>Nurse #4's documentation dated 1-2-20 at 2:45am revealed Resident #2 was complaining of severe back pain and the pain was not relieved by the pain medication that had been administered. Documentation also revealed Resident #2 requested to go to the emergency room.</p> <p>Nurse #4's documentation on 1-2-20 at 3:05am revealed communication with the nurse practitioner and orders to send Resident #2 to the emergency room.</p> <p>The emergency department documentation dated 1-2-20 at 5:34am revealed Resident #2 was treated for chronic low back pain with Toradol (pain medication) 50mg intramuscular (injection) and Roxicodone (pain medication) 5mg by mouth. Documentation also revealed Resident #2's pain had improved, and the resident was transferred back to the facility on 1-2-20 at 9:39am.</p> <p>Medication Aide (MA) #1 was interviewed on 1-9-20 at 11:23am. MA #1 worked with Resident #2 on 1-1-20 and stated the resident ran out of his Oxycodone after she administered the 9:00am dose on 1-1-20. She stated she informed Nurse #4 the resident was out of his medication. She also said the medication card had a refill request on it but as a MA she was not allowed to reorder the medication and that was why she informed the nurse.</p> <p>During an interview with Nurse #4 on 1-9-20 at 8:50am, Nurse #4 stated she was not made</p>	F 755	<p>dashboard; Administered PRN medication in the last 24 hours for each assignment every day to ensure that PRN medications have been administered as ordered.</p> <p>What to do if a resident has a new onset of pain or complains of pain or worsening pain unrelieved by interventions.</p> <p>" If interventions are available by using the standing orders, patient current orders, or items identified in the plan of care then they should be implemented as appropriate. This may include Tylenol for fever, prn pain medication etc. Administer pain medications as ordered by physician.</p> <p>What to do when a drug is not available?</p> <p>" If the medication is an OTC (over the counter drug), check the medication OTC stock supply located at each Medication room (Located at each nursing station). If you are unable to locate it there, proceed to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OTC is available there. If the medication is still unavailable, contact the DON or Nurse Manager for further guidance.</p> <p>" If the medication is a prescription drug, you would first check the Medispense system located at the Rehab hall nurses station medication room (100/200hall). If the medication is not in the Medispense system, then immediately notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed more than one hour, notify the physician for any additional orders or directions.</p>		

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F 755	<p>Continued From page 31</p> <p>aware Resident #2 was out of his Oxycodone on 1-1-20 until the 9:00pm dose was to be administered. She stated she called the physician to obtain an order for a pain medication that was available in the facility's inventory management system and informed MA #2 of the new order. Nurse #4 stated Resident #2 complained about 2 hours after the new pain medication was given that the pain medication was not working and requested to go to the emergency room. She stated Resident #2 was sent to the emergency room around 4:00am on 1-2-20. The nurse stated medications were reordered through the resident's electronic medical record but if there was a MA on the medication cart, then the MA would have to inform the nurse that the medication needed to be reordered.</p> <p>During an interview with Nurse #5 on 1-10-20 at 12:11pm, she said if the resident ran out of their medication the nurse would first call the pharmacy to see if there were refills and if not, then the nurse could call the physician and have them fax over the script to the pharmacy and the pharmacy would have the back up pharmacy deliver the medication.</p> <p>The pharmacy manager was interviewed on 1-9-20 at 10:48am. The pharmacy manager stated they received an order for Oxycodone 5mg to dispense 3 tablets on 1-2-20 and an order for Oxycodone 15mg 1 tablet for 4 doses on 1-2-20. The pharmacist stated the orders were filled on 1-2-20 and delivered to the facility around 4:00pm on 1-2-20.</p> <p>A review of Resident #2's MAR for 1-2-20 revealed Oxycodone was documented as administered to the resident at 5:00pm on 1-2-20.</p>	F 755	<p>Medications must be given in the form ordered by the Physician unless the MD gives an order to dose differently. If at any time you have questions regarding the medication administration process, please contact the DON or Nurse Manager.</p> <p>" Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for current residents (reordering).</p> <p>1) Medication orders are written on a medication order form and transmitted to the pharmacy. The written entry includes: Date ordered, Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number. Resident's name. Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order.</p> <p>2) Repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows:</p> <p>a) Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need.</p> <p>b) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors.</p> <p>c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy.</p>		



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F 755	<p>Continued From page 32</p> <p>An interview with the Nurse Practitioner (NP) occurred on 1-9-20 at 12:30pm. The NP said she would not expect a resident to run out of their medication "staff just has to call us, and we can fax a script over to the pharmacy."</p> <p>The Director of Nursing (DON) was interviewed on 1-10-20 at 10:06am. The DON stated the nurse on duty 1-1-20 should have reordered Resident #2's Oxycodone. She also said she had conducted an in-service in December 2019 on ordering/reordering medications due to a similar incident in December and would be re-educating the staff on the proper process per the facility's policy and procedures.</p> <p>During a telephone interview with the Director of Nursing (DON) on 1-21-20 at 2:50pm, the DON stated medications were delivered and dispensed on "bingo cards" and when there were 8 doses of a resident's medication left, the vertical line of the last 8 doses would be in a different color alerting the nurse to remove the re-order sticker from the card, place it on a re-order sheet and fax the re-order sheet to the pharmacy. She also stated the process for re-ordering narcotic medication was the same.</p> <p>The Director of Nursing and the Corporate Nurse Consultant were notified of the Immediate Jeopardy on 1-10-20 at 4:50pm. On 1-10-20 at 10:59pm the facility provided the following credible allegation of Immediate Jeopardy removal:</p> <p>Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance</p>	F 755	<p>3) New medications, except for emergency or stat medications, are ordered as follows:</p> <p>a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours.</p> <p>b) Timely delivery of new orders is required so that medication administration is not delayed.</p> <p>The emergency kit is used when the resident needs a medication prior to pharmacy delivery.</p> <p>4) Stat and emergency medications are ordered as follows:</p> <p>a) During regular pharmacy hours, the emergency or stat order is phoned or faxed to the pharmacy. Such medications are delivered and administered within (2) hours. If available, the initial dose is obtained from the emergency kit, when necessary.</p> <p>5) When phoning or faxing a medication order to the pharmacy, the following information is given:</p> <p>a) Resident's name.</p> <p>b) Prescription number if a refill.</p> <p>c) Complete order if a new medication order or direction changes to a previous order.</p> <p>d) Name of prescriber if a new order.</p> <p>e) Indication for use.</p> <p>f) Name of person calling in order.</p> <p>6) New Admission Orders:</p> <p>a) When calling/faxing medication orders for a newly admitted resident, the</p>		

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F 755	<p>Continued From page 33</p> <p>Resident #2 had an order for pain medication because of his diagnosis of spinal spondylosis. On 1/1/2020 resident was assessed for pain during day shift and asked if he had pain according to a 1-10 scale. Resident responded pain level was 0 per electronic medication administration record. On 1/1/2020 Resident did not receive Oxycodone 15mg at 12:00 noon, 5:00 pm and at 9:00 pm. On 1/1/2020 10:30 pm resident received pain medication Norco 5/325mg per physician orders as Oxycodone was on hold until medication received from pharmacy per orders. On 1/1/2020 at 11:30pm Nurse Practitioner was notified of resident complaining of severe back pain and requesting to go to the hospital and that resident indicated that medication given to him earlier did not do anything for him. At 11:50pm resident refused Tylenol and continued to state he wants to go to the hospital. Nurse practitioner notified at 12:03am on 1/2/2020 of the above and ordered a one-time dose of Robaxin 500mg and to wait 4 hours before giving another Norco 5/325mg. On 1/2/2020 at 12:10am resident received pain medication Robaxin 500mg. On 1/2/2020 at 2:30am resident refused pain medication Norco 5/325mg when nurse offered medication per physician orders. Resident refused and stated he wanted to go to the hospital. Nurse Practitioner was notified, and resident was transferred to the hospital on 1/2/2020 at 2:45am. 1/3/2019 resident did not receive Oxycodone 15mg at 12:00 noon.</p> <p>Root because for the incident with Resident #2 is Nurse #1 did not administer pain medication due to lack of knowledge of how to order and reorder narcotic medication timely, as the pain medication was not reordered in time.</p>	F 755	<p>pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment.</p> <p>b) The medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, etc. of current medications.</p> <p>This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained</p> <p>Monitoring: The Director of Nursing and/or Assistant Director of Nursing, Unit Manager will review weekly starting on 1/24/2020, and during quality of life meeting. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and also by reviewing the Not Administered Med passes in last 24 hours on the dashboard checking the # of documentations saved as not administered. The audit will also ensure to check all medication carts and compare to the physician orders, and ensure that all</p>		

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F 755	<p>Continued From page 34</p> <p>On 1/10/2020 a chart audit was initiated for all current residents. The audit was completed by the Assistant director of nursing, Unit Support nurses and Director of Nursing to ensure that all residents had their medications per physician order available. The audit also ensured that residents received medications as ordered and signed for on the Medication Administration Record. The audit also ensured that pain medications were administered as ordered. The Assistant Director of Nursing and Unit support nurses, checked all medication carts and compared to the physician orders, and ensured that all medications were available and medications administered per order. All current residents have medications available and medications administered per order. All audits were completed on 1/10/2020.</p> <p>Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.</p> <p>All Full Time and Part Time and as needed (PRN) Nursing Staff (Nurses and Nursing assistants {which includes any Nursing assistants who are medication aides}) will be educated on the following by the Director of Nursing. Education began on 1/10/2020.</p> <p>Education was completed on 1/10/2020 in reference to how to order and reorder medication.</p> <p>Education included:</p> <p>Pain medications will be administered as ordered by physician. The monitoring will be done by the</p>	F 755	<p>medications are available. This will be done on weekly basis for 4 weeks then monthly for 3 months. Reports will be presented to the weekly QA Committee by the Director of Nursing and/or Mini Data Set (MDS) Coordinators to ensure corrective action initiated as appropriate. Any immediate concerns will be brought to the Director of Nursing or Administrator for appropriate action. Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. Weekly QA Committee meeting is attended by Administrator, Director of Nursing, MDS Coordinator, Unit Manager, Support Nurse, Therapy, HIM(Health Information Management), Dietary Manager, Wound Nurse.</p> <p>Date of Compliance: 1/21/2020</p>		

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F 755	<p>Continued From page 35</p> <p>Director of Nursing or Assistant Director of Nursing Or Unit Support Nurses and will include reviewing the Point of care dashboard; Med Passes in the last 24 hours for each assignment every day to ensure that all medications have been administered as ordered and also by reviewing the "Not Administered" Med passes in last 24 hours on the dashboard checking the # of documentation saved as "not administered".</p> <p>PRN pain medications will be administered as ordered by physician. The monitoring will be done by the Director of Nursing or Assistant Director of Nursing or Unit Support Nurses and will include reviewing the Point of Care dashboard; Administered PRN medication in the last 24 hours for each assignment every day to ensure that PRN medications have been administered as ordered.</p> <p>What to do if a resident has a new onset of pain or complains of pain or worsening pain unrelieved by interventions. If interventions are available by using the standing orders, patient current orders, or items identified in the plan of care then they should be implemented as appropriate. This may include Tylenol for fever, prn pain medication etc. Administer pain medications as ordered by physician.</p> <p>What to do when a drug is not available? If the medication is an OTC (over the counter drug), check the medication OTC stock supply located at each Medication room (Located at each nursing station). If you are unable to locate it there, proceed to the Central Supply Room. If you are unable to locate it there, proceed to the other medication carts to see if the OTC is</p>	F 755			

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F 755	<p>Continued From page 36</p> <p>available there. If the medication is still unavailable, contact the DON or Nurse Manager for further guidance.</p> <p>If the medication is a prescription drug, you would first check the Medispense system located at the Rehab hall nurses station medication room (100/200 hall). If the medication is not in the Medispense system, then immediately notify pharmacy so it can be obtained from back up. If the prescription medication ordered will be delayed more than one hour, notify the physician for any additional orders or directions. Medications must be given in the form ordered by the Physician unless the MD gives an order to dose differently. If at any time you have questions regarding the medication administration process, please contact the DON or Nurse Manager.</p> <p>Ordering Medications from the Provider Pharmacy for new admission, readmissions, new orders, and for current residents (reordering).</p> <p>1) Medication orders are written on a medication order form and transmitted to the pharmacy. The written entry includes: Date ordered, Whether the order is new or a repeat order (refill). If the order is a repeat order (refill), include the prescription number. Resident's name. Medication name and strength, when indicated. Directions for use, if a new order, or direction changes to a previous order.</p> <p>2) Repeat medications (refills) are ordered by peeling the top label from the unit dose card and placing it in the appropriate area and ordered as follows:</p>	F 755			

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NAME OF PROVIDER OR SUPPLIER  <b>SUMMERSTONE HEALTH AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>485 VETERANS WAY</b> <b>KERNERSVILLE, NC 27284</b>		
(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 755	<p>Continued From page 37</p> <p>a) Reorder medication (three to four) days in advance of need to assure an adequate supply is on hand. When reordering medication that requires special processing (such as Schedule II controlled substances, Department of Veterans Affairs prescriptions), order at least (seven days) in advance of need.</p> <p>b) The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors.</p> <p>c) The refill order is called in, faxed, or otherwise transmitted to the pharmacy.</p> <p>3) New medications, except for emergency or "stat" medications, are ordered as follows:</p> <p>a) If needed before the next regular delivery, phone the medication order to the pharmacy immediately upon receipt. Inform pharmacy of the need for prompt delivery and request delivery within (4) hours.</p> <p>b) Timely delivery of new orders is required so that medication administration is not delayed. The emergency kit is used when the resident needs a medication prior to pharmacy delivery.</p> <p>4) "Stat" and emergency medications are ordered as follows:</p> <p>a) During regular pharmacy hours, the emergency or "stat" order is phoned or faxed to the pharmacy. Such medications are delivered and administered within (2) hours. If available, the initial dose is obtained from the emergency kit, when necessary.</p>	F 755		

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NAME OF PROVIDER OR SUPPLIER  <b>SUMMERSTONE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>485 VETERANS WAY</b> <b>KERNERSVILLE, NC 27284</b>		
(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 755	<p>Continued From page 38</p> <p>5) When phoning or faxing a medication order to the pharmacy, the following information is given:</p> <ul style="list-style-type: none"> <li>a) Resident's name.</li> <li>b) Prescription number if a refill.</li> <li>c) Complete order if a new medication order or direction changes to a previous order.</li> <li>d) Name of prescriber if a new order.</li> <li>e) Indication for use.</li> <li>f) Name of person calling in order.</li> </ul> <p>6) New Admission Orders:</p> <ul style="list-style-type: none"> <li>a) When calling/faxing medication orders for a newly admitted resident, the pharmacy is also given all ancillary orders, allergies, and diagnoses to facilitate generation of a patient profile and computer summary sheet, and permit initial medication use assessment.</li> <li>b) The medication order form is also used to notify the provider pharmacy of changes in dosage, directions for use, etc. of current medications.</li> </ul> <p>This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees.</p> <p>Education was completed on 1/10/2020 in reference to how to order and reorder medications.</p> <p>This in service was completed by 1/10/2020. Any nursing staff (full time, part time, and PRN) who did not receive in-service training will not be</p>	F 755			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  <b>SUMMERSTONE HEALTH AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>485 VETERANS WAY</b> <b>KERNERSVILLE, NC 27284</b>		
(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 755	Continued From page 39 allowed to work until training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees.  Immediate Jeopardy Removal Date: 1/10/2020.  The credible allegation for Immediate Jeopardy removal was validated on 1-11-20 at 10:00am which removed the Immediate Jeopardy on 1-10-20 as evidenced by staff interviews, in-service record reviews and observations. The in-service included information on ordering and re-ordering medications, what to do when a medication is not available, types of medication errors and the facility's policy and procedures on medication administration.	F 755			