STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345105

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____________________________
B. WING ____________________________

(X3) DATE SURVEY COMPLETED
C 01/14/2016

(NOTIFY OF CHANGES
(INJURY/DECLINE/ROOM, ETC)

F 157
SS=D

483.10(b)(11) NOTIFY OF CHANGES
A facility must immediately inform the resident;
consult with the resident's physician; and if
known, notify the resident's legal representative
or an interested family member when there is an
accident involving the resident which results in
injury and has the potential for requiring physician
intervention; a significant change in the resident's
physical, mental, or psychosocial status (i.e., a
deterioration in health, mental, or psychosocial
status in either life threatening conditions or
clinical complications); a need to alter treatment
significantly (i.e., a need to discontinue an
existing form of treatment due to adverse
consequences, or to commence a new form of
treatment); or a decision to transfer or discharge
the resident from the facility as specified in
§483.12(a).

The facility must also promptly notify the resident
and, if known, the resident's legal representative
or interested family member when there is a
change in room or roommate assignment as
specified in §483.15(e)(2); or a change in
resident rights under Federal or State law or
regulations as specified in paragraph (b)(1) of
this section.

The facility must record and periodically update
the address and phone number of the resident's
legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:

Based on record review and staff interviews, the
facility failed to notify the physician about five
doses of antibiotic that were not administered to 1

This plan of correction constitutes a
written allegation of substantial compliance with Federal and Medicaid

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Electronically Signed
01/29/2016

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.
**SUMMARY STATEMENT OF DEFICIENCIES**

- **F 157** Continued From page 1 of 1 sampled resident, resulting in hospitalization (Resident #31).

  Findings included:
  - Resident #31 was admitted to the facility on 8/9/15 with diagnoses including diabetes mellitus, depression and asthma. Review of the recent Minimum Data Set dated 12/26/15 revealed that the resident was moderately cognitively impaired.
  - Medical records of the hospital’s discharge notes review revealed that resident #31 received his last dose of ampicillin 2000 milligram (mg) intravenously (IV) in the hospital on 11/25/15 at 6:00 AM.
  - Record review of physician orders, dated 11/25/15, revealed an order for ampicillin (an antibiotic) 2000 mg IV every six hours for the treatment of an infection.
  - Review of the Medication Administration Record (MAR) for 11/25/15 and 11/26/15 revealed that ampicillin was not administered.
  - Record review of the nurses’ notes, dated 11/25/15 at 3:00 PM, revealed that the resident readmitted to the facility from the hospital with discharge orders, including ampicillin 2000 mg IV every six hours, which were faxed to the Nurse Practitioner (NP) for verification.
  - Record review of the nurses’ notes, dated 11/25/15 at 10:00 PM, revealed that the NP confirmed the orders and MAR was sent to the pharmacy.
  - Record review of the nurses’ notes, dated 11/26/15 at 9:00 PM indicated that the Assistant of Director of Nursing was notified that there was no ampicillin available.
  - Record review of the situation background assessment recommendation (SBAR), dated 11/26/15, revealed an order at 9:00 PM to send Resident #31 to the hospital since the facility was unable to give ampicillin 2000 mg every six hours

**Immediate Corrective Actions**

- 1. Medical Director was notified on 11/26/15.

**METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED**

- 1. Licensed Nurse Supervisor completed a daily MAR review of antibiotic administration to ensure any missing antibiotic administration was communicated to Medical Director.

**SYSTEMIC CHANGES**

- 1. Licensed Nurse Manager or Clinical Competency Coordinator provided education of nursing staff on policy regarding Medical Director notification of missing dosage
  - 2. Director of Health Services or Licensed Nurse Manager will in-service all new nurses during general orientation on policy regarding MD notification of missing dosage
as ordered.

On 1/13/16 at 3:20 PM, during an interview, nurse supervisor stated that on 11/25/15 he faxed the order for ampicillin to the pharmacy more than once but did not receive this antibiotic during his shift. The nurse passed this information to the next shift, but did not notify physician.

On 1/13/16 at 3:30 PM, during an interview, the Administrator indicated that her expectation was if the ordered medication was not available, the staff had to notify MD and responsible party.

3. The Director of Health Services or Licensed Nurse Manager will review the Medication Administration Registration of missing antibiotics including physician notification of same daily for seven days, weekly for one month and monthly thereafter

MONITORING
Director of Health Services will bring analysis of tracking and trending of Medical Director notification to monthly QAPI for review and revision as needed.
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.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to administer five doses of an antibiotic to 1 of 3 residents, resulting in hospitalization (Resident #31).

Findings included:
Resident #31 was admitted to the facility on 8/9/15, with diagnoses including diabetes mellitus, depression and asthma. Review of the recent Minimum Data Set, dated 12/26/15, revealed that the resident was moderately cognitively impaired.
Record review of physician orders, dated 11/25/15, revealed an order for ampicillin (an antibiotic) 2000 milligram (mg) intravenously (IV) every six hours for the treatment of an infection. Medical records of the hospital’s discharge notes review revealed that resident #31 received his last dose of ampicillin 2000 mg IV in the hospital on 11/25/15 at 6:00 AM. Review of the Medication Administration Record (MAR) for 11/25/15 and 11/26/15 revealed that ampicillin was not administered. Record review of the nurses’ notes dated 11/25/15 at 3:00 PM revealed that the orders were faxed to the Nurse Practitioner (NP) for verification. Record review of the nurses’ notes dated 11/25/15 at 10:00 PM revealed that the NP

This plan of correction constitutes a written allegation of substantial compliance with Federal and Medicaid requirements. Preparation and/or execution of this correction do not constitute admission or agreement by the provider of the truth of items alleged or conclusions set forth for the alleged deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law in order to remove the immediate jeopardy. It also demonstrates our good faith and desire to continue to improve the quality of care and services to our residents.

Immediate Corrective Actions
1. Resident 1 was transferred to hospital for antibiotic administration on 11/26/15.

METHODS TO IDENTIFY ANY OTHER RESIDENTS WHO MIGHT BE AFFECTED
1. Licensed Nurse Supervisor completed a daily MAR review of antibiotic administration 12/1/2015.
F 425 Continued From page 4 confirmed the orders and MAR was sent to the pharmacy.
Record review of the nurses’ notes dated 11/26/15 at 9 PM indicated that the Assistant of Director of Nursing was notified that there was no ampicillin available.
Record review of the situation background assessment recommendation (SBAR) report dated 11/26/15 revealed an order at 9:00 PM to send Resident #31 to the hospital since the facility was unable to give ampicillin 2000 mg every six hours as ordered.
During an interview on 1/11/16 at 2:55 PM, Nurse #7 stated that he called the pharmacy on 11/26/15 at 3:00 PM to inquire about the status of the ampicillin. The pharmacy staff promised to call the facility when the antibiotic was ready.
During an interview on 1/13/16 at 3:20 PM, the Nurse Supervisor stated that on 11/25/15 he faxed the order for ampicillin to the pharmacy more than once, but did not receive this antibiotic during his shift.
During an interview on 1/13/16 at 3:30 PM, the administrator stated that resident #31 missed five doses of ampicillin between 11/25/15 and 11/26/15.

F 425 SYSTEMIC CHANGES
1. Director of Health Service or Licensed Nurse Manager provided education of licensed nursing staff on policy regarding missing antibiotic delivery for new orders.
2. Director of Health Service or Licensed Nurse Manager provided education of all new nurses on policy regarding new orders and procedure if new orders do not arrive from pharmacy.

MONITORING
Director of Health Services will bring analysis of tracking and trending of antibiotic availability and administration as ordered to monthly QAPI for review and revision as needed.