STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 07/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident, primary care physician (PCP) and staff interview, the facility failed to assess and measure weekly non-pressure wounds on 1 of 3 sampled residents (Resident #2) reviewed for an alteration in skin integrity. Resident #2 was re-admitted to the facility on 4/23/16 with diagnoses of peripheral vascular disease (PVD), congestive heart failure (CHF), hypertension and anemia. The 4/18/16 Quarterly Minimum Data Set (MDS) indicated Resident #2 was cognitively intact. Extensive assistance was required for activities of daily living. The resident had no pressure ulcers, but was assessed as being at risk. There were no other ulcers, wounds or skin problems identified. The Nursing Admission Information Sheet, dated 4/23/16 indicated had no skin breakdown, rashes or edema present. On 7/12/16 at 3:27 PM, the nurse documented the nursing assistant (NA) made her aware of blisters on the resident's toes. She documented toes 2-5 on the right foot had fluid filled blisters. The nurse described Resident 32 ' s toes as swollen and dark. The Primary Care Physician	F 309	Nursing reassessed Resident #2 on 07/26/2016 and updated medical record to show findings. On 7/26/2016, the Physician was made aware of appearance of blisters. Physician for Resident #2 visited the facility the evening of 7/26/16 to insure no medical decline had occurred. Resident was started on an antibiotic as well as a Sterapred dose pack on 7/25/16 for pemphigus. A full house skin sweep to be completed by 8/18/2016 to insure there are no undocumented skin integrity issues for the center. Documentation of these rounds/sweep will be documented in Electronic Medical Record. Skin integrity issues will be documented in the Wound Sense platform. Education completed with Licensed Nursing of the facility by 8/18/2016 regarding proper documentation of skin integrity issues and compliance with facility Policy and procedure. Education will be provided by the Director of Nursing	8/18/16

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

Electronically Signed | 08/18/2016

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F 309	Continued From page 1 (PCP) was notified and ordered Bactroban (an antibiotic ointment) to be applied to the resident ' s toes and ordered her feet be elevated. Notes for 7/14/16 and 7/15/16 on the night shift indicated the treatment to the blisters on the right toes continued. While the nurse documented the toes had improved. There was no further description. On 7/15/16 at 6:30 PM, Resident #2 received new orders for an antibiotic and to continue applying Bactroban to the right foot On 7/21/16 at 8:01 AM, 7/24/16 at 5:08 AM and 7/25/16 at 10:03 AM, nurse ' s notes indicated the treatment to Resident #2 ' s blisters on her toes continued. There was no documentation of a description. On 7/25/16 at 1:49 PM, the resident was observed in bed with her feet elevated and uncovered. Observations of her right foot indicated black areas on all toes. Review of Resident #2 ' s electronic medical record failed to reveal weekly documentation related to a description, measurements or notes about the progression of healing for the wounds on Resident #2 ' s foot. The Wound Care Nurse (WCN) was interviewed on 7/26/15 on 12:15 PM. The nurse stated as the facility ' s WCN, she was expected to document information about all wounds in the electronic medical record weekly to chart the progression of wounds. The WCN stated she categorized Resident #2 ' s blisters as non-pressure areas. The nurse stated while the blisters started as fluid filled, they were now dark and dried. The WCN added it would be important to weekly assess any drainage, the condition of the surrounding skin, if the wounds had odor or not and for pedal pulses. The WCN acknowledged she had not assessed and	F 309	(DON), Staff Development Coordinator, or wound nurse moving forward to insure Licensed Nursing are adhering to expected policy and procedure. This is to be completed by 8/18/2016. This education is to include new hires upon orientation as well as annually through skills review. Weekly rounds to be made by the Director of Nursing (DON) or Assistant Director of Nursing (ADON) with the wound nurse to review in house skin issues. Audits to be completed by the DON to insure compliance of skin integrity documentation. These audits will be for five days per week for two weeks, then weekly for two weeks, then monthly for two months. These audits will cover no less than 10 % of the population of the facility. Data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Services.	

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F 309	Continued From page 2 documented the appearance, measurements or healing progression of Resident #2 ' s non-pressure wounds on weekly basis. She added she was fairly new and was still learning the facility ' s electronic wound care program. The Director of Nursing (DON) was interviewed on 7/26/16 at 2:55 PM. The DON stated the expectation was for pressure and non-pressure wounds to be measured and described weekly. She added Resident #2 should have weekly documentation regarding the blisters and dried areas on her toes An observation was made on 7/26/16 at 3:00 PM. Resident #2 ' s feet were elevated. Each toe on her right foot had either blackened areas and/or fluid filled blisters. There were several open areas that were observed with a red wound bed. The DON assessed the resident ' s pedal pulse and added while not a strong pulse, the pulse was present. Resident #2 stated this was the first time something of this nature had occurred.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and review of medical records, the facility failed to assist with the resident ' s transfer from a personal vehicle to a wheelchair on return to the facility, for 1 of 3 sampled residents	F 312	Resident #1 had their care card and plan of care reviewed to validate accuracy on 7/15/16. Nurse #1 was educated on expectations of assisting with transfers for resident that is requesting assistance.	8/18/16

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F 312	Continued From page 3 (Resident #1) reviewed for accidents. Findings included: Resident #1 was readmitted to the facility on 7/19/16 with diagnoses that included a stroke. Her quarterly Minimum Data Set (MDS), dated 6/10/16, indicated the resident was moderately cognitively impaired. The MDS also coded Resident #1 as requiring extensive assistance with transfers and limited assistance with walking. She was identified as requiring human assistance to maintain her balance when moving from a sitting to standing position, moving from surface to surface and when turning around. The MDS also indicated the resident had a functional limitation in one lower extremity. Nurse ' s notes for 7/5/16 indicated the resident had fallen and had been sent to the hospital for evaluation. On 7/6/16, the nurse documented Resident #1 returned to the facility via the Responsible Party (RP). The nurse noted a laceration to the resident ' s face. During a telephone interview with the RP on 7/25/16 at 2:45 PM, it was revealed Resident #1 had fallen on 7/5/16 and had been sent to the hospital for evaluation. She returned to the facility after midnight on 7/5/16. The RP stated she went to Station I and saw 2 staff members who then followed her back to the car. The RP added she had to send them back into the facility to get a wheelchair in order to transport Resident #1 into the building. The RP stated she requested assistance with transferring Resident #1 from the vehicle to the wheelchair and the staff refused, telling her since Resident was in a private car, it was " on her " to transfer the resident. The RP stated she later spoke with Assistant Director of Nursing (ADON) #1 who told the reason staff had refused to help was because	F 312	This education was provided by the Administrator on 7/15/2016. Transport log for appointments will be reviewed by the Interdisciplinary Team during Clinical Whiteboard meeting weekly to review appropriate transfer assistance is provided. Care cards will be updated as needed if changes in level of assistance is needed. Education will be provided by the Director of Nursing (DON) or Staff Development Coordinator (SDC) moving forward to insure nursing assistants and Licensed Nurses are adhering to expected policy and procedure. This in house education to be completed by 8/18/2016. This education is to include new hires upon orientation as well as annually through skills review. Weekly observational rounds to be made by the DON or ADON to insure the center is providing appropriate ADL assistance for residents. These audits will be for five days per week for two weeks, then weekly for two weeks, then monthly for two months. Data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director,	

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F 312	Continued From page 4 she, the RP, had refused to transport the Resident back to the facility via ambulance. The RP added she had not refused the ambulance; hospital staff had told her Resident #1 was safe to transport by car. On 7/26/16 at 9:39 AM, Nurse #3 was interviewed. The nurse stated she worked the 11:00 PM to 7:00 AM shift and was working the night Resident #1 returned from the hospital. The nurse stated the facility ' s policy for transfer indicated if a family member put a resident in the car, then the family was responsible for taking them out of the car. Nurse #3 added if she was unsure what to do she would call the Director of Nursing (DON) or the ADON and in fact this type of event happened to her about 2 weeks ago. The nurse revealed Resident #1 had been sent to the hospital for evaluation and had been sent from the hospital in the RP ' s vehicle. Nurse #3 added the vehicle was a big truck and she and the Nursing Assistant (NA- name unknown) were unsure what they should do. She added they had called ADON #2 and explained Resident #1 had returned to the facility in the RP ' s truck. The nurse stated the ADON told her she could not help with the transfer from the truck to the wheelchair, but could push the wheelchair into the facility once the transfer had been completed. Nurse #3 acknowledged she and the NA had not assisted with the transfer and the resident, with the assistance of her RP had stepped down from the truck and into the wheelchair. The wheelchair was right there and the resident stepped down, pivoted and sat down. The nurse stated while she was not totally sure why the resident had been at the hospital, she thought it was for a fall and had been transported by emergency medical services. The nurse stated if the resident had lost her balance and fallen, since	F 312	Chaplain, and Environmental Services.	

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F 312	Continued From page 5	F 312		

she and the NA were there, they would have been responsible.
ADON #2 was interviewed on 7/26/16 at 2:01 PM. The ADON stated if family members transported residents to or from appointments, staff would assist with transfers to and from the vehicle. The ADON stated she was not sure if the facility had a policy on transferring residents from a personal vehicle and if she did not think it was safe, she would not help with the transfer. The ADON described Resident #1 as requiring one person assistance for transfer with the amount of assistance required depending upon the type of day the resident had. The nurse stated she remembered someone calling her and telling her the RP had transferred the resident back from the hospital. The person, identified as Nurse #3, had told her the NA had not felt comfortable with the transfer from the personal vehicle to the wheelchair. ADON #2 stated she had instructed Nurse #3 to get another staff member to help with Resident #1 ' s transfer from the vehicle. She added she had talked to Nurse #3 the next morning who told her everything had worked out fine. ADON #2 added she had no idea why Nurse #3 had not followed her instructions and assisted with Resident #1 ' s transfer. She added she saw that as a problem since Resident #1 could have sustained another fall.
On 7/26/16 at 2:27 PM the DON was interviewed. The DON stated the facility policy was to assist residents out of personal vehicles. She stated she was aware of an incident that happened 2-3 weeks ago with Resident #1. The DON stated Nurse #3 asked her a couple of days after the incident what the facility liability was if the resident had fallen while staff transferred the resident from a private vehicle. The DON stated she told Nurse #3 that the facility staff needed to assist with

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F 312	Continued From page 6 transfers, no matter what. The DON added her understanding of the situation included the RP asking for a wheelchair, the staff brought a wheelchair out and assisted with the transfer. She added she, the RP, the Administrator and the ADON had a meeting. The DON stated that ' s when she found out how upset the RP was because staff would not help her with the transfer and told her it was a facility liability to bring Resident #1 back to the facility in a private vehicle.	F 312		
F 329 SS=G	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		8/18/16

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F 329	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observations, interviews with the resident, Responsible Party (RP), primary care physician (PCP) and staff, and record review the facility failed to clarify a medication allergy for 1 of 3 sampled residents (Resident #1) reviewed for medication interaction which resulted in the resident being hospitalized. Findings included: Resident #1 was admitted to the facility on 9/5/14 and readmitted to the facility on 7/19/16 with diagnoses that included Stevens-Johnson syndrome (A rare, serious disorder of the skin and mucous membranes that is usually a reaction to a medication or an infection) and wounds. A laboratory report, dated 2/11/16, had a hand written note, signed by the PCP, indicating Resident #1 had an allergy to medications containing Sulfa. While the PCP had signed the lab work, the handwriting for the sulfa allergy was different than the PCP ' s signature. Review of a 2/21/16 hospital discharge summary did not list sulfa as an allergy for Resident #1. Review of dictated physician progress note for March, April and June 2016 listed " No Known Allergy; Sulfa (SULFONAMIDE ANTIBIOTICS) " . The quarterly Minimum Data Set (MDS) for Resident #1, dated 6/10/16, indicated she was moderately cognitively impaired. The MDS also coded Resident #1 as requiring extensive assistance with transfers, bed mobility, toilet use and personal hygiene. Resident #1 was identified at risk for pressure ulcers, but at the time of assessment had no pressure ulcers, rashes or open lesions. The resident was coded as having skin tears.	F 329	Sulfa medication was discontinued on 7/09/16 for resident #1. Resident #1 also received a onetime dose of Prednisone and was later started on a Medrol dose pack on 7/11/16. Allergy of sulfa drugs added to the medical record for Resident # 1 on 7/09/16 by a clinical nurse. A full in house review of the resident charts was completed by 08/18/2016 to insure there were no further discrepancies regarding drug allergies or side effects. Any variances were immediately reported to the physician providing care in the center and the medical record was updated to show new or changed allergies by Director of Nursing. Education will be provided by the Director of Nursing (DON) or Staff Development Coordinator (SDC) moving forward to insure the Licensed Nurses adheres to expected policy and procedure by 8/18/2016. This education is to include new hires upon orientation as well as annually through skills review. Review of new admissions, readmissions and appointment information to be discussed in Clinical white board meeting by the DON or Assistant Director of Nurses (ADON), SDC, or Nursing Supervisor to insure allergies are identified and recorded in the medical record for the resident. This review will be	

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F 329	Continued From page 8 Nurse ' s notes dated 6/30/16 at 9:11 PM, indicated Resident #1 had increased confusion. The PCP was called, laboratory tests were ordered including a urine for culture and sensitivity. Initially, the physician ordered Amoxicillin (an antibiotic) 875 milligrams (mgs) twice daily to treat Resident #1 ' s urinary tract infection. Lab results with a status of " final report " was called to the MD on 7/6/16. The urine culture revealed greater than 100,000 colony forming units per milliliter of urine of Staphylococcus Haemolyticus (type of bacterial organism) that was susceptible to Bactrim DS (another type of antibiotic that contains sulfa). The physician ordered the Amoxicillin discontinued and ordered Bactrim DS to be given twice daily for 10 days. On 7/6/16 at 12:55 AM, nurse ' s notes indicated Resident #1 had fallen, been sent to the hospital for evaluation and had returned to the facility. There was no indication of red skin, whelps or blotches noted. Review of the July 2016 Medication Administration Record indicated Resident #1 received 3 doses of Bactrim DS. On 7/9/16 at 7:26 AM, the nurse documented Resident #1 had red areas on her legs and arms. The PCP was made aware and orders were received to discontinue the Bactrim and start Macrodantin (another type of antibiotic). One dose of Prednisone (a steroid medication) was given along with orders to monitor the resident. At 8:29 PM, the nurse ' s notes indicated the red areas to Resident #1 ' s legs were fading. Nurse ' s notes written on 7/11/16 indicated Resident #1 had scattered red patches over her body that were inflamed and were scratched until one area on her lower right posterior thigh opened. The nurse documented the PCP was	F 329	documented on the daily sheet and will be monitored for five days per week for two weeks, then weekly for two weeks, then monthly for two months. Data will be summarized and presented to the facility QAPI meeting monthly by the DON or SDC. Issues or trends identified will be addressed by the QAPI committee as they arise and the plan will be revised to ensure continued compliance. The QAPI committee consists of the Administrator, DON, SDC, MDS Coordinator, Admissions Coordinator, Medical Director, Director of Social Services, Quality of Life Director, Chaplain, and Environmental Services.	

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called. Orders were received for Medrol (a type of steroid medication) be given in addition to Benadryl (an anti-histamine medication).
On 7/13/16 at 7:59 PM, nurse ' s notes documented Resident #1 was noted to have an open area to her back where she had broken out from an allergic reaction. The nurse documented she would make the PCP aware.
Review of nurse ' s notes dated 7/14/16 at 8:23 AM, indicated a message had been left for the PCP related to the open areas Resident #1 had on her back and redness in her oral cavity. The nurse documented she had made the on-coming nurse aware.
The hospital history and physical, dated 7/14/16, indicated Resident #1 had taken several different antibiotics for a urinary tract infection, developed an erythematous (red) rash on her torso and extremities over the past few days and had been given steroids without complete resolution of the symptoms. The physician documented the resident had no fever, chills, nausea, vomiting or abdominal pain. The plan of action to resolve the resident ' s skin condition was receiving intravenous steroids.
A hospital wound consult note, dated 7/15/16, indicated Resident #1 had multiple open sores involving her back, lower extremities and left breast and chest that has arisen spontaneously within the past several days during which time she received several different antibiotics for an infection. Sulfa was listed as an allergy with an onset date of 7/14/16. Under Impression, the hospital physician documented diffuse open sores of the chest back and lower extremities equivalent to second degree burns that had the appearance of Stevens-Johnson syndrome.
The hospital discharge summary dated 7/18/16 indicated Resident #1 had a diagnosis of

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Stevens- Johnson syndrome from recent Bactrim use.
The Nursing Admission Information sheet, dated 7/19/16 revealed the resident was alert and oriented to person, place, time and situation. Documentation indicated the resident had scattered bruises and blisters all over her body.
Resident #1 and a family member were interviewed on 7/25/16 at 2:07 PM. The resident stated she had been in the hospital the previous weekend with a reaction to Bactrim. The resident and the family member stated they had been unaware of the Bactrim allergy, adding she had taken the medication previously with no reaction.
The Responsible Party was interviewed by telephone on 7/25/16 at 2:45 PM. She stated she was unaware Resident #1 had an allergy to any medications. She stated on Tuesday, July 12, 2016, she visited Resident #1 and saw red spots on her skin. On return, 2 days later, Thursday, July 14, 2016, Resident #1 had blisters, some that had popped, covering her back, shoulders, legs and in her mouth.
Nurse #1 was interviewed on 7/26/16 at 10:34 AM. She confirmed she had written the 7/14/16 at 7:40 PM note. The nurse stated if a resident had an allergy, it was listed on the resident ' s medical chart and was found in the computer system. She added when a physician ' s order was received, nurses were to check for allergies and notify the PCP if a problem was identified.
Nurse #1 stated she was familiar with Resident #1 and knew the resident had received Bactrim for an infection. The nurse stated at first, when the resident ' s skin started turning red, was hard to tell if Resident #1 was having a medication reaction because she had a habit of picking and scratching her skin. Nurse #1 described Resident #1 ' s skin as pale with a darker colored

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	345336	A. BUILDING _____ B. WING _____	C 07/26/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

(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
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tongue, describing her tongue as deep, dark red infused with pink and purplish colors. Nurse #1 stated the resident ' s tongue did not swell and she was never in any respiratory distress. At that point, staff or the PCP suggested a hospital evaluation because everyone thought giving the resident Medrol would resolve the symptoms. The nurse added after receiving the Medrol, Resident #1 had no more discoloration of her tongue. Nurse #1 stated after Resident #1 had received the Medrol, she had been off work for a few days. On returning to work, she had been told by the night nurse that Resident #1 had developed blisters and open areas during the 7/13/16 night shift. The night nurse informed Nurse #1 she was waiting for the PCP to return her call. Nurse #1 stated after receiving report from the night nurse, she paged the PCP between 7:00 AM and 8:00 AM with the PCP returning her call before 9:00 AM. Orders were received for aloe vera gel and she had been instructed to treat the resident as if she had a sun burn. The nurse added when she saw Resident #1 she found the areas on her skin to be red, but not hot to touch. She added Resident #1 ' s skin was tender and she hollered out during care. Nurse #1 added when the resident received the Bactrim ordered on 7/5/16, the chart did not contain the Bactrim allergy and she was unaware Bactrim had been listed on the lab or in the physician ' s notes as an allergy.
The Assistant Director of Nursing (ADON) #1 was interviewed on 7/26/16 at 11:20 AM. The ADON stated she had reviewed the laboratory results for February 2016, but denied she was the one that had written sulfa allergy on the lab. She verified the PCP had signed the lab results, but was unable to identify the handwriting of the person who had written sulfa allergy on the lab report.

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The ADON stated she saw the resident around 5:15 PM when she was transferred to the hospital. She stated while the resident was uncomfortable, she was in bed watching television and in no acute distress. The ADON verified she was the nurse that had written the 7/6/16 Bactrim order, but was unaware the physician ' s progress notes had both no known allergy and allergy to Sulfa written. Told by the nurses the resident had an allergic reaction and asked what med. The ADON during morning report, on Monday, July 11, 2016, she had informed staff thought Resident #1 was having a medication reaction. She added when she had assessed Resident #1 she had observed flat red spots on Resident #1 ' s arms, legs and back. She added on Tuesday, the spots had started to blister. The ADON stated she checked the MAR to make sure the Bactrim had been discontinued. The ADON stated she had assessed Resident #1 on the day she went to the hospital at approximately 5:15 PM and found the resident in bed watching television. The ADON stated if she had been aware Resident #1 had a Bactrim allergy she would not have written the 7/6/16 order for Bactrim.

On 7/26/16 at 12:08 PM, Nurse #2 was interviewed. The nurse stated she entered Bactrim into the computer system and added it to Resident #1 ' s chart as an allergy after the facility realized she had an allergy to the Bactrim.

Prior to Resident #1 having the current reaction to Bactrim, the nurse stated she was unaware of the resident ' s Bactrim allergy. Nurse #2 stated after the allergic reaction she had reviewed Resident #1 ' s chart and had found no information regarding a Bactrim allergy. She was unaware of the February 2016 lab result or the physician ' s progress notes that indicated a potential sulfa

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allergy. Nurse #2 was unable to identify the handwriting of the person that had written sulfa allergy on the lab report.
A telephone interview was held with Resident #1 ' s PCP on 7/26/16 at 1:49 PM. The PCP stated Resident #1 recently had an episode of Stevens-Johnson syndrome caused by taking Bactrim. The PCP stated previously Resident #1 had discontinued Bactrim herself because of a gastrointestinal intolerance, but it was not a true allergy. The PCP added Resident #1 had previously taken Bactrim prescribed by him with no side effects or allergic reaction. The PCP stated he had not written the sulfa allergy notation on the February 2016 lab and had no idea who had placed the notation on the lab. The PCP gave no explanation why progress notes, dictated by him, contained conflicting information regarding no known allergies followed by sulfa allergy. He added allergic reactions were unpredictable and could result in violent reactions, which Resident #1 experienced this time. The PCP stated with the Stevens-Johnson syndrome there could be a delayed onset, such as Resident #1 experienced. The PCP added when he had last assessed her Resident #1, she had a mild rash; adding the facility kept him well informed of the changes Resident #1 experienced. The PCP stated the facility had acted appropriately with the information they had.
On 7/26/16 at 2:27 PM, the Director of Nursing (DON) was interviewed. The DON stated if a resident had an allergy to a medication, staff were expected to notify the PCP. She reviewed the MD progress notes and stated the notes were confusing with the PCP documenting no allergies and then writing Sulfa. The DON added she and the PCP had spoken after Resident #1 ' s reaction and he had told her the resident ' s

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F 329	Continued From page 14 record had not indicated she had an allergy to sulfa medications. She stated she was unaware how Sulfa got written as an allergy on the lab slip and was unable to identify the hand writing. With documentation on the lab report and the PCP progress notes, the DON stated she would have expected the nurses to notify the PCP and clarify the allergy information for Resident #1. The DON stated the reaction experienced by Resident #1, while blamed on the Bactrim, could have been any of the antibiotics she received during that week or a combination of several medications.	F 329		