STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345252	A. BUILDING _____ B. WING _____	C 08/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARSAW HEALTH & REHABILITATION CENTER	214 LANEFIELD ROAD WARSAW, NC 28398

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F 157 SS=G	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and review of medical records, the facility failed to notify the primary care physician (PCP) of a	F 157	Submission of this response and Plan of Correction is not a legal admission that a deficiency was correctly cited. It is not to	9/19/16

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

Electronically Signed | 09/19/2016

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F 157	Continued From page 1 change in a resident ' s bowel function for 1 of 3 sampled residents (Resident #1) who was reviewed. Failing to notify the resident ' s physician resulted in a lack of treatment and hospitalization for sepsis. Findings included: Resident #1 was admitted to the facility on 12/18/15 with diagnoses that included dementia. The 6/15/16 Quarterly Minimum Data Set (MDS) indicated Resident #1 had both short and long term memory impairment and severely impaired cognitive skills for daily decision making. The resident was identified as requiring extensive assistance with bed mobility, transfer, walking in his room, locomotion, dressing, eating toilet use and was coded as totally dependent for personal hygiene. The MDS coded the resident as always incontinent of bowel and bladder. Review of the August 2016 monthly orders included Miralax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams to be given daily. Review of the August Medication Administration Record revealed the resident received Miralax daily from 8/17/16 to 8/23/16 as scheduled. Review of Resident #1 ' s bowel movement (BM) record from August 1-15 indicated the resident had from 2-4 BM ' s per day. From August 16-23, 2016, Resident #1 ' s BM record indicated from 3-6 BMs per day with 6 BMs recorded on 8/21/16 and 6/22/16. There was no documentation of BMs on 8/23/16 for the 7:00 AM to 3:00 PM shift. The form only indicated Resident #1 was in the hospital. On 8/23/16 at 2:45 PM, the nurse documented the resident had increased respirations, agitation with an oxygen saturation (oxygen saturation is the measurement of the amount of oxygen in the	F 157	be construed as an admission of interest against the facility, the Administrator, Director of Nursing or any employee, agent or other individuals who draft or maybe discussed in this response or the Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged nor the correction of any conclusions set forth in this allegation by the survey agency. For the deficiencies cited during this survey, this facility has developed and implemented a facility-wide system to assure correction and continued compliance with the regulations. This facility will provide a complete copy of the deficiency list to the QAA Committee for review and appropriate actions. We would like you to accept this PoC as our credible allegation of compliance. Per facility policy, we will immediately inform a resident's physician and legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychosocial status or a need to alter treatment significantly. A. Resident #1 is discharged from the facility as of 8/23/2016 B. On going audits will be done to update contact information C. A review of all residents' records will be overseen by the MDS staff , senior nursing staff, to identify other residents	

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F 157	Continued From page 2 blood stream) of 87% (Any measurement of less than 90% is considered low). Oxygen was applied at 2 liters per minute. Vital signs were respirations 52. The PCP was notified and orders obtained to send Resident #1 to the hospital for evaluation. The resident's primary care physician (PCP) was interviewed via telephone on 8/30/16 at 3:00 PM. He stated he was disturbed about Resident #1 ' s recent hospitalization, adding the resident was admitted to the hospital with Clostridium difficile (C. diff - an intestinal infection causing increased bowel movements). The PCP stated he had received information from a hospitalist that Resident #1 had C.diff and was acutely ill. He stated he had not received any notification the resident had loose stools and in going through the records and speaking with staff, he only knew about the one episode of loose stools that had happened during the morning of 8/23/16. Nursing Assistant (NA) #3 was interviewed on 8/30/16 at 3:31 PM. She confirmed she had cared for Resident #1 on Monday, 8/22/16 on the 3:00 PM to 11:00 PM shift. The NA reported Resident #1 had a loose, but not watery BM prior to the end of her shift. She stated she had not reported the loose BM to the nurse. During a telephone interview with NA #4 on 8/30/16 at 3:59 PM. The NA stated she had been assigned to Resident #1 on the 11:00 PM to 7:00 AM shift on 8/22/16. The NA reported the resident had 3 loose stools with the first being small and the last 2 being large. NA #4 added she reported the loose stools to Nurse #4. A telephone interview was held with Nurse #4 on 8/30/16 at 4:07 PM. The nurse stated she had cared for Resident #1 on the 11:00 PM to 7:00 AM shift on 8/22/16. Nurse #4 denied receiving any reports of diarrhea from the previous shift.	F 157	having the potential to be affected by the same issue. To ensure that the occurrence do not happen again , the MDS staff/senior nursing will review the 24 hour report daily, and verify proper notification in condition have been made to the appropriate family member and attending physician. Additionally, facility staff will have regular team meetings where resident records are reviewed for accuracy and appropriate. notification. Discrepancies in notification will be corrected immediately by members of this team. Additionally, facility staff will have regular team meetings where resident records are reviewed for accuracy and appropriate notification. Discrepancies in notification will be corrected immediately by members of this team. A. Using the 24 hour report and the team meeting check list as audit tools, the nurses will conduct random audits of 10% of residents noted to have a change in condition or change in medication to insure compliance. Results of the audits will be reported to the facility administrator for monitoring and oversight. The administrator will report the findings of the audits to the Quarterly QA Committee. The monitoring process will continue for at least 12 months to assure the staff is aware of the proper procedures so that this issue does	

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F 157	Continued From page 3 She stated she had given Resident #1 Imodium (a medication to stop diarrhea) on 8/19/16. The nurse stated she knew the resident had one BM on her shift, but stated she could not remember if other episodes of diarrhea had been reported. NA #5 was interviewed by phone on 8/31/16 at 8:42 AM. She acknowledged she had worked with Resident #1 during the 11:00 PM to 7:00 AM shift on 8/22/16. The NA stated during the shift the resident had 3 large, loose BM's. NA #5 added she had not reported this to Nurse #4 since Nurse #4 had assisted with incontinent care and knew the resident was having large, loose stools. The PCP was interviewed again on 8/31/16 at 9:57 AM. The information gathered during interview and review of the BM record was reviewed with the PCP. He stated only one loose BM had been reported to him during the 7:00 AM to 3:00 PM shift on 8/23/16. The PCP stated he was unaware of the multiple loose BMs and had been unaware Resident #1 had 3-6 BMs recorded daily for the week prior to his 8/23/16 hospitalization. The PCP added it was not normal for any resident, including Resident #1 to have 3-6 BMs per day. He stated in retrospect, with the new information, he believed the multiple stools was part of the resident's illness. He stated while foul smelling stools was an indication of C. difficile, it was possible to have C. diff without a temperature and malodorous stool. The MD stated had he been notified of the multiple BMs and multiple episodes of diarrhea, he would have ordered lab work to rule out C. diff. and possibly altered the resident ' s outcome. Nurse #1 was interviewed on 8/31/16 at 10:10 AM. She stated she had not worked with Resident #1 from August 17th through the 22nd and had only worked with Resident #1 on the	F 157	not recur.	

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23rd. The nurse reviewed the BM record and stated the PCP should have been notified of the 3-6 BMs per day for the week prior to his hospitalization. She stated none of the diarrhea episodes had been reported to her, so therefore she had not had the information to notify the PCP.

On 8/31/16 at 10:20 AM, Nurse #5 was interviewed. The nurse acknowledged she had worked Resident #1 several times from 8/17/16 through 8/22/16. The nurse stated the NAs informed her of how many BMs the residents had. Nurse #5 stated she had not received information regarding the large number of BMs Resident #1 had and had not received information about any episodes of diarrhea. She stated she had not reported any changes to the PCP because she had been unaware of changes.

The Director of Nursing and Administrator were interviewed on 8/31/16 at 10:31 AM. The DON stated if Resident #1 had episodes of diarrhea or multiple BMs per day she expected staff to notify the PCP for guidance. The DON reviewed the BM record for Resident #1 and stated her expectation would have been for staff to call the PCP. The Administrator stated she would have expected the NAs to report to the nurse the numbers and types of BMS the resident was experiencing so the nurse could have called the PCP. The DON and the Administrator agreed the nurses had a responsibility to check the BM record and inform the PCP of irregularities.

During a telephone interview with NA #6 on 8/31/16 at 11:12 AM, she reported she had received information during morning report on 8/23/16 that Resident #1 had multiple episodes of diarrhea during the previous shift. The NA stated she reported the information she had received to Nurse #1.

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F 309 SS=G	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 staff and physician interviews and review of medical records, the facility failed to assess, monitor and manage the resident's overall gastrointestinal condition with respect to medications and bowel movements for 1 of 3 sampled residents (Resident #1). On 8/23/16, Resident #1 was admitted to the hospital with a diagnosis of sepsis. Findings included: Resident #1 was admitted to the facility on 12/18/15 with diagnoses that included heart attack, aspiration pneumonia, and dementia without behaviors, hypertension and chronic kidney disease. The 6/15/16 Quarterly Minimum Data Set (MDS) indicated Resident #1 had both short and long term memory impairment and severely impaired cognitive skills for daily decision making. He was rarely able to make his needs known. The MDS indicated Resident #1 exhibited physical behaviors 1 to 3 days during the assessment period. The resident was identified as requiring extensive assistance with bed mobility, transfer, walking in his room, locomotion, dressing, eating toilet use and was coded as totally dependent for personal hygiene. The MDS coded the resident	F 309	Per facility policy the facility will provide each resident 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. A. Resident #1 was discharged from the facility on 8/23/2016 B. All clinical staff will be in- serviced related to : 1. 24 hour report 2. ADL flow sheet inclusive of bowel/ bladder function. 3. Notification of Physician and Family/ Responsible Party C. An audit will be completed by senior nursing staff to insure all other facility residents: 1. Are receiving appropriate medications / no unnecessary medications 2. ADL flow sheets indicate No increased bowel activity. D. Using the 24 hour report and the team	9/19/16

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F 309	Continued From page 6 as always incontinent of bowel and bladder. Review of the August 2016 monthly orders included Ferrous Sulfate (an iron supplement that can cause constipation) 325 milligrams daily and Miralax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams daily for constipation. Review of the physician's orders indicated Resident #1 had received both the iron and the Miralax for the past 6 months. Review of the Medication Administration Record for August 2016 indicated Resident #1 received Miralax daily until his discharge to the hospital on 8/23/16. Review of the August 2016 bowel record, completed by the nursing assistants (NAs) indicated from August 1 through August 15, 2016, Resident #1's usual bowel routine was 2 to 4 times per day. Review of the bowel record for August 16, 2016 to August 23, 2016, indicated Resident #1 averaged from 3 to 6 bowel movements (BM) per day. There was no documentation that indicated if the BM was formed or loose. The 8/22/16 weekly nursing note indicated Resident #1 was lying in bed with his eyes closed, but was easily aroused. Respirations were even and unlabored with an oxygen saturation of 96% on room air. No pain or discomfort was reported. Bowel sounds were documented as active. Vital signs on 8/22/16 during the 3:00 PM to 11:00 PM shift were recorded as BP of 110/58, pulse of 64, respirations 20 and temperature of 97.6 degrees. During the 11:00 PM to 7:00 AM shift, Resident #1's vital signs were recorded as a temperature of 98.8 degrees, pulse of 78, respirations of 20 and BP of 128/72. On 8/23/16 at 2:45 PM, Nurse #1 documented Resident #1 had increased respirations, agitation	F 309	meeting check list as audit tools, the nurses will conduct random audits of 10% of residents noted to have a change in condition or change in medication to insure compliance. E. Utilizing the 24 hour report and the team meeting check list senior staff will monitor results of the audits will be reported to the facility administrator for monitoring and oversight. The administrator will report the findings of the audit to the Quarterly QA Committee. The monitoring process will continue for at least 12 months to assure the staff is aware of the procedures so that this issue does not recur.	

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with an oxygen saturation of 87% (oxygen saturation measures the amount of oxygen in the blood stream. Normal is considered any value greater than 90%). Oxygen was applied at 2 liters per minute. Vital signs were recorded as a temperature of 96.8 degrees, pulse of 97, BP of 142/80 and a respiratory rate of 52 (the normal range for respirations is considered to be 16 to 20 breaths per minute). The primary care physician (PCP) was notified and an order was obtained to send the resident to the hospital.
Hospital Emergency Department (ED) notes, dated 8/23/16, indicated the resident's admitting diagnosis was sepsis (a life threatening condition that arises when the body's response to infection injuries its own tissues and organs) due to an unknown organism. Under History of Present Illness, the physician had documented the resident presented complaining of reported multiple episodes of diarrhea since the previous day. The physician noted while the resident was unable to speak, information had been received by the emergency crew. Resident #1's white blood cell count was 62,000 (normal range is 4,500-10,000 white blood cells per milliliter. Elevated white blood cells is an indication of infection). Vancomycin and Zosyn (antibiotics) were started. The physician noted the resident had no urinary output and was also in acute renal failure and indicated Resident #1's prognosis was extremely grim.
The Hospital History and Physical (H & P), dated 8/23/16, indicated under Assessment/Plan that Resident #1 had a presumptive diagnosis of severe clostridium difficile (C.dificile- a gastrological infection that causes multiple loose stools). Also listed as diagnoses were sepsis due to the C. difficile and increased sodium level with dehydration secondary to fluid loss secondary to

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the C.dificile.
Nurse #1 was interviewed on 8/30/16 at 2:20 PM. She acknowledged she had cared for Resident #1 on 8/23/16 and was the nurse that was responsible for calling the PCP and sending the resident to the hospital. On 8/23/16, Nurse #1 stated she first observed the resident between 7:00 AM and 9:00 AM. At that time, she noticed nothing unusual and Resident #1 was in no distress. The nurse added the only thing out of the ordinary was the resident was not agitated and took his morning medicine on the first try. She stated while he had good days and bad days, typically it took several tries to get him to take his medication; therefore, she decided to keep her eye on him. The nurse added around 2:00 PM, Resident #1 was sitting at the nurse's station. He looked lethargic and was napping in his chair. Nurse #1 stated she requested the nursing assistant (NA) take Resident #1 ' s vital signs and then she checked them again to make sure the values were correct. She added Resident #1 was breathing rapidly and his respirations were 52 breaths per minute. Initially, Nurse #1 said she thought Resident #1 was having a panic attack since he had no temperature or any other signs of illness. Nurse #1 stated she had been surprised to hear Resident #1 was diagnosed with sepsis and was in the intensive care unit (ICU). The nurse stated the morning of 8/23/16 Resident #1 had a large BM, which was not unusual. She gave his Miralax as was ordered. The nurse was unaware the resident had received Imodium for diarrhea.
NA #1 was interviewed on 8/30/16 at 2:48 PM. The NA stated she had cared for Resident #1 on 8/22/16, the day prior to his hospitalization. She stated on that day, he was his normal self and had actually slept until 11:30 AM. The NA added

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that Resident #1 had no elevated temperature or any symptoms that would make anyone think he was sick. The NA stated she was unaware Resident #1 had any BMs during her scheduled shift.
On 8/30/16 at 2:54 PM, the treatment nurse was interviewed. She stated prior to completing a treatment for Resident #1 on 8/23/16, she had to get the NA to clean him up due to a large, loose BM. The Treatment Nurse stated there was no unusual odor associated with the BM.
Resident #1's primary care physician (PCP) was interviewed via telephone on 8/30/16 at 3:00 PM. The PCP stated he found out from a hospitalist the admitting diagnosis for Resident #1 was Clostridium difficile and that Resident #1 was acutely ill. He stated typically, the facility reported any change in a resident ' s condition immediately. The PCP added since the resident's hospitalization, he had reviewed the record and spoken to staff and found evidence of one large, loose BM that occurred on the morning of 8/23/16 and could not understand what had happened and why it had happened so quickly.
On 8/30/16 at 3:15 PM, Nurse #2 was interviewed. She stated she had cared for Resident #1 on 8/22/16, prior to his hospitalization. She stated the resident was his normal self with no temperature, diarrhea or any other symptom that indicated he was acutely ill.
Nurse #3 was interviewed on 8/30/16 at 3:19 PM. The nurse stated Resident #1 was discharged to the hospital on 8/23/16 close to change of shift. She added while Nurse #1 took care of PCP notification, she assisted getting Resident #1 ready for transport. Nurse #3 described Resident #1 as having rapid respirations. Oxygen was started. When the resident was returned to bed, the nurse stated the resident ' s respirations had

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decreased to 24 breaths per minute. She added when Resident #1 was placed in bed, he had had a large loose BM. She added stool kept pouring out even as the resident was changed. Nurse #3 stated the smell of the BM was horrible and quite different than the smell the night before. Even when a clean brief was placed on Resident #1, the BM continued. The night before, 8/22/16, Nurse #3 stated she had worked on the 3:00 PM to 11:00 PM shift. She stated one loose stool around 10:30 PM had been reported. When she went to assess the resident, she had not noted a strong odor. The nurse stated she gave the resident Imodium (a medication given to correct loose BMs) and had given the next shift information about Resident #1's diarrhea. Review of the Medication Administration Record indicated Imodium had been given by Nurse #3 at 10:45 PM.

NA #3 was interviewed on 8/30/16 at 3:31 PM. The NA stated she had cared for Resident #1 on Monday, 8/22/16 on the 3:00 PM to 11:00 PM shift. The resident ate good, napped and was his usual self. The NA stated Resident #1 had one BM that was loose, but not watery with no odor on her shift. She added he ate 100% of his supper. The NA stated she documented the BMs in the activities of daily living (ADL) book kept at the nurse's station. The book was kept there so both NAs and nurses could review the information as needed.

On 8/30/16 at 3:59 PM, a telephone interview was held with NA #4. She stated Resident #1 seemed ok when she worked with him on the 11:00 PM to 7:00 AM shift beginning on 8/22/16. The NA reported the resident had 3 loose stools with the first being small and the last 2 being large. She denied any odor. The NA stated she reported the loose stools to Nurse #4.

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A telephone interview was held with Nurse #4 on 8/30/16 at 4:07 PM. She stated she had worked with Resident #1 during the 11:00 PM to 7:00 AM shift on 8/22/16. The nurse stated when she arrived for work around 11:00 PM, Resident #1 seemed ok. She had not received any report of fevers, diarrhea or the use of Imodium during the previous shift. She stated she had actually given the resident Imodium on the previous Friday, August 19th when she worked due to a report of loose stools from the NA (name unknown). She added on 8/23/16 between 6:00 AM and 7:00 AM she had assisted the NA (unsure of which NA) with incontinent care. At that time, the nurse reported Resident #1 had a large semi-formed stool. The nurse stated she was unable to remember if she had received other reports during her shift about the resident having diarrhea.

NA #5 was interviewed by phone on 8/31/16 at 8:42 AM. She acknowledged she had helped care for Resident #1 during the 11:00 PM to 7:00 AM shift on 8/22/16. The NA stated during the shift the resident had 3 large, loose BM's. She stated she had not reported this to the nurse, because the nurse had helped her provide incontinent care. The NA stated there was no unusual odor associated with the resident's 3 large loose BM's. She stated the BMs were documented in the ADL book kept at the nurse's station.

Resident #1's PCP was again interviewed via telephone on 8/31/16 at 9:57 AM. The result of the interviews and review of the BM record was shared with the MD. The PCP stated none of the multiple BM's from August 16-23, 2016 had been reported to him; adding it was not good for any resident to have that many BM's on a daily basis. The PCP stated it was not normal for Resident #1

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to have 3-6 BM's per day. The PCP stated if any resident had that many BM's he expected for the resident to be checked for impaction and to be notified of the results. He stated in retrospect, with the new information, he believed the multiple stools was part of the resident's illness that resulted in hospitalization. He stated while foul smelling stools was an indication of Clostridium difficile (C.diff), it was possible to have C. diff without a temperature and malodorous stool.
The MD stated had he been notified of the multiple BMs he would have ordered lab work to rule out C.diff. The MD stated 2 other residents on the resident's hall had C. diff, but they had received antibiotics which increased their risk. He added Resident #1 had received no antibiotic and to the best of his knowledge had no risk factors. The MD stated knowing about the multiple stools would have made a difference in his course of action with treatment and possibly the resident's outcome of being hospitalized in serious condition.
Nurse #1 was interviewed on 8/31/16 at 10:10 AM. She stated she had not worked with the resident during from 8/17th until she cared for him on 8/23/16. The nurse reviewed the BM list and stated none of the multiple BMs had been reported to her. She added had she known, she would not have given the Miralax.
Nurse #5 was interviewed on 8/31/16 at 10:20 AM. The nurse acknowledged she had worked with Resident #1 multiple days from 8/17/16 through 8/22/16. She stated she had not been advised of the large number of BMs Resident #1 had on a daily basis.
The Director of Nursing (DON) and the Administrator were interviewed on 8/31/16 at 10:31 AM. The DON stated if a resident was having multiple stools or episodes of diarrhea the

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F 309	Continued From page 13 staff would be expected to call the PCP and ask for guidance. The Administrator stated she would have expected the information about Resident #1's diarrhea and multiple BMs per day to be shared nurse to nurse during report and she would have expected the NA to report to the nurse the number of BMs so the nurse could have called the PCP. Both the DON and the Administrator stated the nurse caring for Resident #1 had responsibility to check the BM record prior to the administration of a scheduled laxative. The DON added if Resident #1's PCP had all the information, he probably would have chosen a different treatment plan. NA #6 was interviewed by telephone on 8/31/16 at 11:12 AM. She acknowledged she had cared for Resident #1 on the 7:00 AM to 3:00 PM shift on 8/23/16. The NA stated she had received in report from another NA (unknown) that Resident #1 had diarrhea during the previous shift. The NA stated she reported the diarrhea to Nurse #1. The NA stated on the 7 to 3 shift, the resident had one large, loose stool around 9:30 to 10:00 AM with no odor.	F 309		
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	F 329		9/19/16

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F 329	Continued From page 14 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff and physician interviews and review of medical records, the facility failed to hold a laxative for 1 of 3 sampled residents (Resident #1) who was reviewed for medications. Failing to hold the laxative when the resident had multiple bowel movements (BMs) per day resulted in the resident ' s hospitalization. Findings included: Resident #1 was admitted to the facility on 12/18/15 with diagnoses that included heart attack, aspiration pneumonia, and dementia without behaviors, hypertension and chronic kidney disease. The 6/15/16 Quarterly Minimum Data Set (MDS) indicated Resident #1 had both short and long term memory impairment and severely impaired cognitive skills for daily decision making. The resident was identified as requiring extensive assistance with bed mobility, transfer, walking in his room, locomotion, dressing, eating toilet use and was coded as totally dependent for personal hygiene. The MDS coded the resident as always	F 329	Per facility policy the facility will insure all residents are free from unnecessary drugs. A. Resident #1 was discharged 8/23/2016 B. A review will be completed by the senior nursing staff of all current resident medications and compared to the current diagnose to ensure appropriateness of medication regimen. C. An audit will be performed monthly by the pharmacy consultant on all facility residents to insure appropriate medication usage. A report will be sent to the facility administrator , the D.O.N and A.D.O.N who will notify the physician of any required changes. On a monthly basis the facility interdisciplinary team will monitor 10% of	

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F 329	Continued From page 15 incontinent of bowel and bladder. The care plan, last reviewed on 6/22/16, identified Resident #1 as totally incontinent. The review indicated the resident was offered incontinent care every 2 hours. Review of the August 2016 monthly orders included Miralax (a laxative solution that increases the amount of water in the intestinal tract to stimulate bowel movements) 17 grams to be given daily as a scheduled medication. Review of the August 2016 Bowel Movement (BM) record indicated Resident #1 had an average of 2-4 BMs per day from 8/1-15/2016 and an average of 4-6 BMs per day from August 16-23rd when he was hospitalized. Review of the August Medication Administration Record revealed the resident received Miralax daily from 8/17/16 to 8/23/16. The Emergency Department (ED) notes, dated 8/23/16, indicated Resident #1 had been taken to the ED with reports of multiple episodes of diarrhea that had started the previous day. He was admitted with a diagnosis of sepsis of unknown organism. The ED physician documented the resident ' s prognosis was grim. The resident was admitted to the hospital. Lab results indicated a white blood cell count (elevated white blood cell counts are indicative of infection) was recorded as 62,000 (normal white blood cell count is 4,500 to 10,000 cells per microliter of blood). A telephone interview was held with Nursing Assistant (NA) #4 on 8/30/16 at 3:59 PM. The NA stated she had cared for Resident #1 on the 11:00 PM to 7:00 AM shift starting on 8/22/16. NA #4 reported Resident #1 had 3 loose stools with the first BM described as a small BM and the last 2 BMs described as large. The NA stated she reported Resident #1 ' s loose stools to	F 329	the resident samples to insure ongoing compliance. Results will be reviewed quarterly with the QA Committee.	

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Nurse #4.
On 8/30/16 at 4:07 PM, a telephone interview was held with Nurse #4. The nurse stated when she arrived for work on her 11:00 PM to 7:00 AM shift beginning 8/22/16, she had not received a report or any information that Resident #1 had diarrhea. She stated she had actually given the resident Imodium (an anti-diarrheal medication) on the previous Friday, August 19th when she worked due to a report of loose stools from the NA (name unknown). The nurse stated the NAs had not reported any episodes of loose stools to her.
NA #5 was interviewed by phone on 8/31/16 at 8:42 AM. She acknowledged she had worked with the resident during the 11:00 PM to 7:00 AM shift on 8/22/16. The NA stated during the shift the resident had 3 large, loose BM's. She stated she had not reported this to the nurse, because the nurse knew since she had helped her provide incontinent care to Resident #1.
During a telephone interview with Resident #1 ' s primary care physician (PCP) on 8/31/16 at 9:57 AM, the results of the BM record for 8/16/16 through 8/23/2016 and interviews with staff were reviewed. The PCP stated it was not normal for residents, including Resident #1 to have 3-6 BMs per day. He stated if any resident had that many BMs, he would expect nurses to check the resident for impaction and to be notified of the results. The PCP stated if he had known Resident #1 had that many BMs, he would have ordered lab work to rule out other illnesses.
Nurse #1 was interviewed on 8/31/16 at 10:10 AM. The nurse stated she had not worked with the resident from August 17th through the 22nd and had only cared for him on 8/22/16. The nurse reviewed the BM record from 8/16-8/22/2016 and stated Resident #1 ' s Miralax should not have been given due to the large

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number of BMs per day. She stated if she had known about the number of BMs he was having, she would not have given him the Miralax on 8/23/16.
On 8/31/16 at 10:20 AM, Nurse #5 was interviewed. The nurse acknowledged she had cared for Resident #1 several days during the preceding week, including 8/22/16 and confirmed she had given the resident Miralax on the days she had worked. She stated Miralax was used as a laxative and to help residents have BMs without trouble. Nurse #5 stated if a resident had consistent diarrhea or not having problems with having BMs she would not give the Miralax. Usually, the nurse added, NAs reported the number of BMs. The nurse reviewed the BM record for the week prior to Resident #1 ' s hospitalization and stated she was unaware Resident #1 had from 3-6 BMs per day.
The Director of Nursing (DON) and Administrator were interviewed on 8/31/16 at 10:31 AM. The DON stated Miralax was used as a laxative and should not be given if a resident had liquid stools or a large number of stools per day. The DON reviewed the BM record and the MAR for Resident #1 and stated her expectation would have been the staff to call the PCP prior to giving the Miralax. The DON and the Administrator agreed it was the responsibility of the nurses to check the BM record prior to giving laxatives.
The Administrator stated she would call the Miralax an unnecessary medication since the Resident #1 had diarrhea from 3-6 BMs per day from August 16th through August 23rd when he was hospitalized.