STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185333	A. Building B. Wing	07/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31274 Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system in place to notify the Physician and/or the Advanced Practice Registered Nurse (APRN) when medications were not available to treat diagnosed conditions for two (2) of twenty-three (23) sampled residents, Resident #40 and #51. Record review revealed Resident #40 had a Physician order to start Clindamycin (antibiotic) on 06/10/18 for treatment of Pneumonia. However, per interview, the Clindamycin was not available for administration and the resident did not receive all doses of the antibiotic between 06/10/18 - 06/13/18 and staff did not notify the provider. The resident was transferred to the hospital on 06/13/18 for difficulty breathing, an elevated heart rate, and a decrease in blood oxygenation. Resident #51 had a Physician order to receive Rifaximin (antibiotic) for the treatment of his/her fatty liver disease with a start date of 05/22/18. However, the resident did not receive fifteen (15) doses of the medication between 05/22/18 - 05/29/18 due to the unavailability of the medication. Staff failed to notify the provider and the resident had periods of confusion and an elevated ammonia level during the time when the medication was not administered, which according to interview, was a result of not receiving the antibiotic. The facility's failure to have an effective system in place to ensure the Physician was notified when residents did not receive ordered medication, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 06/25/18 and was determined to exist on 05/22/18. The facility was notified of the IJ on 06/25/18. The facility provided an acceptable Allegation of Compliance (AOC) on 06/27/18, which alleged removal of the IJ on 06/28/18. The State Survey Agency (SSA) verified the IJ was removed on 06/28/18, prior to exit on 07/01/18. The Scope and Severity was lowered to a D while the facility develops and implements a Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Medication Administration: General, revised 11/28/17, under the section Practice Standards, if there were medication discrepancies, including medication not available, notify physician/advanced practice provider and/or pharmacy as indicated. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Medication Shortages/Unavailable Medications, revised 01/01/13, revealed upon discovery that the facility had an inadequate supply of a medication to administer to a resident, and the medication was not available in the Emergency Medication Supply and was unavailable from the pharmacy or third party pharmacy and could not be supplied from the manufacturer, the facility should obtain alternate Physician/Prescriber orders, as necessary. 1. Review of Resident #40's clinical record revealed the facility readmitted the resident on 10/27/17, with diagnoses that included a history of Respiratory Failure and Pneumonitis Due to Inhalation of Food and Vomit. The resident was transferred to the hospital on 06/05/18 for low oxygenation, increase pulse, coughing up white thick sputum, and an altered level of consciousness. The resident was transferred back to the facility on [DATE] at 9:10 PM. Review of the Hospital Discharge Summary, date 06/09/18, revealed an order for Clindamycin (antibiotic) 150 milligram (mg) capsule, three (3) capsules (450 mg) (3) times a day for four (4) days. In addition, there was an order for Ipratropium-Albuterol (breathing treatment) 3 milliliters (ml) per nebulization three (3) times per day. Review of Resident #40's Medication Administration Record (MAR), dated June 2018, revealed Clindamycin 450 mg scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the medication on 06/10/18 at 8:00 AM, 12:00 PM, and 8:00 PM, 06/11/18 at 8:00 AM and 12:00 PM, 06/12/18 at 8:00 AM and 12:00 PM, and 06/13/18 at 8:00 AM. In addition, Ipratropium-Albuterol was scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the breathing treatments on 06/10/18 at 12:00 PM, 12/11/18 at 12:00 PM, and 06/12/18 at 12:00 PM. However, there was no documented evidence the Physician was notified of the missed doses. Interview with Licensed Practical Nurse (LPN) #3, on 06/22/18 at 11:05 AM, revealed she cared for Resident #40 on 06/10/18 and 06/12/18. LPN #3 stated she thought Resident #40's antibiotic was ordered on 06/09/18; however, the medication was not delivered on 06/10/18. She stated she did not notify the Center Nurse Executive (CNE), Physician, or APRN, even though the APRN was in the facility that day (06/10/18). She stated she was not sure why she did not inform the APRN because she usually made the APRN aware of any resident issues. LPN #3 revealed she did not call the pharmacy to follow up when she realized she did not have the medication for the resident and when she came back to work on 06/12/18, Resident #40's antibiotic was still not available. She stated she thought she contacted the pharmacy that day, but did not inform the CNE the antibiotic had not been delivered. Interview with LPN #4, on 06/22/18 at 3:25 PM, revealed she observed Resident #40 on 06/13/18 around 7:30 AM - 7:45 AM and he/she seemed to have difficulty breathing, was coughing, and sounded like he/she had mucous in his/her throat. LPN #4 stated the APRN arrived shortly, assessed Resident #40, and ordered the resident transferred to the hospital for further evaluation. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the APRN, on 06/22/18 at 12:01 PM, revealed in her professional opinion, Resident #40 missed doses of the antibiotic and breathing treatments from 06/10/18 - 06/13/18, would have negatively impacted the resident's condition and necessitated his/her transfer back to the hospital for further treatment. She stated she did not learn Resident #40 had not received all of the Clindamycin doses until the morning of 06/13/18, even though she had been in to see the resident on 06/12/18 related to vomiting the resident had the day before. The APRN stated, on 06/13/18 staff reported the resident was short of air, had congestion and an Oxygen saturation of 88%, and she gave the order to transfer the resident to the hospital. She revealed as the CNE was preparing the paperwork for the resident's transfer to the hospital, the CNE told her Resident #40 had not received all doses of his/her Clindamycin because it had not been delivered to the facility. She further stated nurses had not been notifying her or the Medical Director that medications were not available, and therefore not administered per the orders. According to the APRN, it was difficult to the treat residents' condition if the provider was not aware of medications the resident did or did not receive. 2. Review of the clinical record for Resident #51 revealed the facility admitted the resident on 05/22/18, with a diagnosis of Nonalcoholic Steatohepatitis (NASH-fatty liver). Review of Physician Orders for Resident #51, dated 05/22/18, revealed staff was to administer Rifaximin 550 mg every twelve (12) hours for the diagnosis of NASH. Review of the MAR, for Resident #51, dated May 2018, revealed Rifaximin 550 mg was to be administered every twelve (12) hours. Documentation revealed fifteen (15) doses of the medication were not administered. On 05/22/18, the dose at 9:00 PM was left blank. The doses on 05/23/18, 05/24/18, 05/25/18, and 05/26/18 at 9:00 AM and 9:00 PM had staff initials circled. The 05/27/18 9:00 AM dose had staff initials circled, and the 9:00 PM dose was blank. The 05/28/18 and 05/29/18 scheduled doses at 9:00 AM and 9:00 PM had staff initials circled. Interview, on 06/22/18 at 3:45 PM, with LPN #3 revealed when medication was not available for administration; staff initialed the MAR and circled their initials, which indicated the medication was not given. Review of Resident #51's ammonia level results, dated 05/29/18 at 1:00 AM, revealed the ammonia level was elevated at 118, with a normal range of 18 - 75. Interview, on 06/22/18 at 4:35 PM, with LPN #4 revealed her process was not notify the Physician of missed medication until three (3) doses of a resident's medication had been withheld or missed, and then she notified the provider. LPN #4 stated she might have told the provider about missed medications if she saw the provider in the building. LPN #4 further stated in relation to Resident #51, if the Rifaximin was not administered per the Physician order, his/her ammonia level could go up, and it would not be beneficial for the resident to miss his/her ordered medications. Interview, on 06/22/18 at 12:01 PM, with the APRN revealed she received a call from the facility about a week after Resident #51's admission, and staff reported the resident had an increase in behaviors and confusion. She stated it was at about that time when she learned the resident had not been receiving the Rifaximin that was ordered on 05/22/18, when the resident was admitted . She further stated the resident's missed doses of the medication could have been a contributing factor to the resident's increased ammonia level. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview, on 06/22/18 at 1:45 PM, LPN #1/Unit Manager (UM), revealed before assuming the position of UM, two (2) weeks ago, she worked as a floor nurse at the facility and would notice medications were unavailable for resident administration. In her two (2) months of employment at the facility, she stated she witnessed nurses notifying the pharmacy when medications were not available, but they would not notify the provider. The UM stated when a medicine was not available for administration at the scheduled time, the nurse should try to obtain the medicine by notifying the pharmacy to send the medicine, and the prescriber in case he or she would want to give additional orders. The UM further stated the nurse should notify the CNE and the Center Executive Director (CED) so they would be aware of the delayed medication deliveries and further address the matter with the pharmacy staff. Interview, on 06/28/18 at 2:00 PM, with the Medical Director revealed her Medical Assistant somehow learned that medications were not being administered to residents as ordered because they were not available. The Medical Director stated she thought she and the APRN became aware of the issue about two (2) weeks ago. She stated when she learned of the issue with missed medications and the delayed pharmacy deliveries, she talked with the CED and told her the nurses must report that information to the prescriber, as well as the CNE, and follow other parts of the protocol for notifications. In addition, she stated she informed the CNE that the nurses needed to know how to make notifications to her via the call center, and how to report pertinent resident information. The Medical Director stated she had an answering service and nurses could phone the call center seven (7) days per week around the clock. Interview with the CNE, on 06/26/18 at 1:45 PM, revealed it was very concerning to her that residents had not received medications as ordered. She stated if the resident refused medications or the medication was not effective, that information should be documented and communicated to the physician so other interventions could be attempted. Interview, on 06/22/18 at 8:50 PM, with the CED revealed she delegated management of the nursing staff to the CNE who should ensure the nurses notified the prescribers, and the nursing and administrative leadership when there were issues with non-timely delivery of scheduled medications, and when medications could not be administered as ordered. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. 8. Additional education of licensed staff and two (2) CMTs was completed on 06/25/18. Education included procedure for sending medication orders to pharmacy; procedure for unavailable medications including refusals and notification of the pharmacy and physicians; when to notify the CNE and CED of unavailable medications; and the care plan process of revising and implementing the care plan with new orders. Posttests provided to validate understanding. 9. On 06/25/18, an adHoc QAPI meeting was conducted with the CED, the CNE, and the Medical Director to review additional education conducted. 10. Beginning 06/26/18, the Pharmacy Program Manager would contact the facility daily, including weekends, and speak with the CED, the CNE, or Registered Nurse (RN) Charge Nurse to confirm any medications needed would be sent to the facility stat (immediately). 11. On 06/26/18, the facility's EDK was re-stocked. 12. The CNE, CED, and/or Unit Manager will monitor MARs, conduct observations, and ensure daily communications occur with the Pharmacy Program Manager daily times two (2) weeks across all shifts; then three (3) times weekly for two (2) weeks; then weekly for two (2) months; then bi-weekly for two (2) months; and, then monthly for one (1) month to ensure medications were available as prescribed and the care plans were being followed. 13. The Regional [NAME] President of Operations and/or the Clinical Quality Specialist will review the QAPI minutes monthly for six (6) months and ongoing thereafter to ensure audits, education, and in-services are completed as needed. The SSA validated the facility implemented the following actions: 1. Record review of the MARs for Resident #51 revealed he/she had received all medications since 05/30/18 as ordered. 2. Record review revealed Resident #40 was no longer in the facility. 3. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had received and had an understanding of the education. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the sign-in sheet for the in-service education provided between 06/11/18 - 06/21/18 revealed all licensed staff and two (2) CMTs signed acknowledgement of the education. 4. Interview with the CNE, on 07/01/18 at 2:17 PM, revealed she completed medication audits for all resident MARs and documented twelve (12) residents had missed medications for June 2018. The Audit tool was reviewed against the MARs for the residents identified with missed medications. 5. Record review revealed assessments were completed for eleven (11) of the twelve (12) identified residents. The twelfth resident had been discharged home at the time of the discovery. 6. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed they began auditing for availability of medications and documentation of medications on 06/23/18. Record review revealed audits began on 06/23/18 and were signed by the CED or CNE daily. Random audits of the medication carts, conducted by the SSA on 06/30/18, revealed medications were available for randomly selected residents when compared to medications ordered by the Physician. 7. Review of the audit tools revealed missing medications were identified on 06/23/18 and medications were ordered from the pharmacy prior to medication dosages being missed. 8. Review of the sign-in sheet for the additional education related to care plans and following Physician orders revealed all licensed staff signed acknowledgement of education. Posttests reviewed for each of the licensed staff revealed a 100% pass rate. Review of the sign-in sheet for the additional education related to ordering medications for new admissions and re-admissions; re-ordering the EDK; and, the procedure for unavailable medications revealed all licensed staff and two (2) CMTs were educated. Posttests reviewed revealed a 100% pass rate. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had an understanding of the education provided. 9. Interview with the MDS Coordinator, on 06/30/18 at 9:26 AM, revealed she was present at a QAPI meeting and medication issues were discussed. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed they discussed medication issues in the QAPI meeting held on 06/25/18. Review of the sign-in sheet for the QAPI meeting on 06/25/18 revealed the MDS Coordinator, the CED, the CNE, and the Medical Director attended the meeting. 10. Interview with the CED, on 07/01/18 at 10:33 AM, revealed conversations with pharmacy were occurring daily. Review of the log documenting daily pharmacy phone calls revealed calls occurred daily as alleged. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	11. Observation of the EDK revealed the box had been refilled. Interview with the Unit Manager, on 06/30/18 at 11:10 AM, revealed if staff took medication out of the EDK, staff filled out a form and faxed it to the pharmacy. If the entire stock of the medication was used, pharmacy refilled the EDK the same day. 12. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed audits of the MARs and Physician orders would continue as outlined in the AOC. Review of the audits revealed the CNE or CED audited the MARs and Physician orders daily beginning 06/23/18. 13. Observations during the AOC validation revealed the Clinical Quality Specialist (CQS) was in the facility daily assisting with MAR/TAR audits and medication cart audits. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed the CQS or Regional [NAME] President would review QAPI minutes monthly. Review of the most recent QAPI sign-in sheet revealed the CQS attended the meeting.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on observation, interview, and facility policy review, it was determined the facility failed to maintain a clean, comfortable, homelike environment in six (6) of fifty-six (56) resident rooms, Resident Rooms 8, 19, 28, 25, 29, and 34. Resident rooms were missing light bulbs, had broken window blinds, emergency pull cords were knotted, and toilets missing or incomplete. In addition, the facility failed to maintain wheelchairs in good repair for five (5) of ten (10) sampled residents, Residents #1, #6, #19, #31, and #56. Observations revealed resident wheelchairs with torn vinyl, exposed foam padding, and missing pieces. The findings include: Review of the facility's policy, Preventive Maintenance Policies and Procedures, revised 06/01/07, revealed requests for routine maintenance on the physical plant, fixtures and equipment required a work order and response to work orders on a timely basis. Each service location had designated areas where requests were picked up. The maintenance supervisor or designee retrieved work orders on a predetermined schedule and prioritized the work orders. Once completed, the maintenance supervisor or designee recorded the action taken on the work order. 1. Observation of Resident room [ROOM NUMBER], on 06/19/18 at 8:32 AM, revealed a magazine-type page hung on the right side of the window blind, covering an open area in blind that had missing slats. One (1) closet door was missing a handle. The light over bed B was missing the light bulb. The door to the resident restroom had a hole in the door, and a scraped, rough area aligning with the hole in the door. In addition, the hole in the door was at the same height and size of the doorknob of the door on the adjacent wall, exiting the resident room. Interview with Resident #52, on 06/19/18 at 8:32 AM, revealed his/her light had been missing for several days. He/she stated he/she placed the page out of a magazine over the hole in the blinds so no one could see in the window. He/she stated the slats from the window blinds had been missing for several months. Observation of Resident room [ROOM NUMBER], on 06/19/18 at 10:18 AM and 06/21/18 at 08:40 AM, revealed the light bulb was missing from the light fixture over Bed A. Interview with Resident #12, on 06/19/18 at 8:40 AM, revealed the bulb over his/her bed had been missing for a while, more than a couple of weeks. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Maintenance (DOM), on 06/21/18 at 10:15 AM, revealed the staff input maintenance requests in the computer system and he checked the system for any work orders. The DOM stated he drove the bus to transport residents, and had for quite a while, therefore other facility responsibilities had been a low priority. He stated he did not have a routine preventive maintenance schedule for the facility and when something was reported to him, that was when he fixed the concern. He revealed he removed the light bulbs in the resident rooms when they burned out. Additionally, he stated the light bulbs were ordered, as he did not have any replacements in stock. He stated he was not aware of the broken blinds in Resident room [ROOM NUMBER], nor the hole in the bathroom door. He stated he had let many of his responsibilities go in an effort to transport residents to their appointments. Observation of the restroom in Resident room [ROOM NUMBER], on 06/19/18 at 1:03 PM, revealed the toilet tank lid was absent from the top of the tank. Interview with Resident #28, on 06/19/18 at 1:03 PM, stated the lid had been gone since January 2018. Observation of the restroom in Resident room [ROOM NUMBER], on 06/19/18 at 2:56 PM, revealed the toilet was missing in the bathroom and there was a large hole in the floor, where the toilet should have been, with two (2) sharp metal rods exposed on both sides of the hole. The bathroom door was unlocked and accessible to residents. Observation of Resident room [ROOM NUMBER], on 06/19/18 at 8:15 AM, revealed the emergency pull cord in the restroom was knotted up to where it was approximately 1 - 2 inches in length and unreachable to a resident if they would have fallen to the floor. Observation of Resident room [ROOM NUMBER], on 06/20/18 at 3:20 PM, revealed the cord attached to the emergency call light in the restroom was tied in knots and wrapped around a grab bar next to the toilet. The cord was not accessible to a resident if they should fall to the floor. Interview with the Center Nurse Executive (CNE), on 06/26/18 at 1:45 PM, revealed emergency pull cords in resident restrooms should remain untied and hang down to allow a resident to activate the emergency call system should they fall to the floor. She stated the emergency call system must be accessible to the residents so they could obtain rapid assistance in an emergency. Interview with the Center Executive Director (CED), on 06/22/18 at 9:38 AM, revealed the DOM had been driving the transportation bus and had been doing a lot of the transportation with the residents. Continued interview on 06/26/18 at 1:46 PM, revealed all resident pull cords should hang so it was available to a resident and a resident could reach the pull cord. The pull cord should not be tangled up, or unable to release. The resident must be able to pull the cord for assistance in the event a fall occurred, or if they needed assistance. 40244 2. The facility did not provide a policy specifically related to wheelchair repairs. (continued on next page)

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	185333	A. Building B. Wing	07/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of Resident #1, on 06/19/18 at 8:15 AM and 2:30 PM, revealed the resident sitting in her/his wheelchair with a strong odor of urine and exposed cushion and torn vinyl on both armrests. The resident stated he/she used a urinal and sometimes spilled the urine. The resident stated he/she asked the nurse for a new wheelchair. Observation of Resident #19, on 06/19/18 at 1:05 PM and 06/20/18 at 9:08 AM, revealed his/her wheelchair was missing an armrest on the left side. Resident #19 stated the armrest had been missing since he/she returned from a home visit and the facility had not replaced the armrest. Resident #19 stated he/she reported it to the nurse but could not recall the date. Observation of Resident #31, on 06/19/18 at 1:45 PM and 06/20/18 at 9:15 AM, revealed both wheelchair armrests had torn vinyl and exposed cushion. The resident stated the armrests were in that condition for so long he/she could not remember when it was not torn. Observation, on 06/20/18 at 3:20 PM, revealed both wheelchair armrests on the wheelchair for Resident #6 had torn, ripped vinyl, and exposed foam padding on the left armrest. Observation, on 06/26/18 at 1:30 PM, revealed the left armrest on Resident #156's wheelchair had torn and cracked vinyl covering. Interview with Certified Nurse Assistant (CNA) #1, on 06/21/18 at 8:25 AM, revealed CNAs were instructed to notify therapy when a wheelchair needed repair and therapy would handle it. The CNA stated there was no form used to notify therapy, staff just notified them verbally. She stated wheelchairs needing repair included those with cracks in the vinyl, missing vinyl, exposed cushion, and missing parts. She stated the wheelchairs looked bad, held odors, and if missing parts, might cause injuries. CNA #1 was unsure if any staff followed-up to ensure the wheelchairs were repaired after reported to therapy. Interview with CNA #7, on 06/21/18 at 10:06 AM, revealed CNAs took wheelchairs needing repair to therapy and therapy fixed them. She stated wheelchairs needed repair when soiled and were unable to be cleaned, if the seats or armrests were torn, or if the wheels did not work. CNA #7 stated she did not use a form to notify therapy, just gave therapy a verbal report. She stated missing parts on a wheelchair could cause injury to a resident and torn material may cause odor and infection. CNA #7 further stated no one followed-up to ensure the wheelchairs were fixed after reported to therapy. According to the CNA, she saw Resident #19 and #31's wheelchairs and although she could not recall the date, she recalled Resident #19's armrest was missing and Resident #31's armrest was torn. CNA #7 stated she would have reported it but she was very busy. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #1/Unit Manager (UM), on 06/21/18 at 11:16 AM, revealed CNAs and nurses reported wheelchair repairs to therapy and the Director of Maintenance (DOM). She stated therapy usually did the repairs because the DOM was out of the building a lot, driving the facility van. The UM stated wheelchairs needed repair when the seats were torn, parts were missing, had torn armrests, or if they had heavily soiled seats. She stated there was no form used to notify therapy or maintenance of repairs needed. The nurses and CNAs reported needed repairs to the CNE and the Administrator, and notified maintenance via the computer. She stated no one followed-up to ensure the repairs were addressed and no one audited wheelchairs to ensure issues were reported. She stated she noticed wheelchairs that needed repairs but had not reported them as she often worked on the units when staffing levels were short. The UM did not know if education was offered to staff on the process of reporting wheelchair maintenance requests. Interview with the Social Worker, on 06/21/18 at 1:20 PM, revealed she was not aware Resident #1 requested a new wheelchair. She stated she noticed wheelchairs with torn armrests but did not report them to maintenance and she was unsure why. Interview, on 06/21/18 at 8:55 AM, with the Occupational Therapist (OT) revealed therapy department staff assessed residents for use of a wheelchair. She stated extra replacement parts were available to replace damaged armrests, and she thought the DOM made most of those types of repairs. The OT stated it was important to replace armrests with torn, ripped vinyl in order to prevent breaks in a resident's skin and for overall comfort of the resident. Continued interview at 11:35 AM, revealed there was a storage room with wheelchair equipment to complete repairs. She stated there were times when therapy staff performed simple repairs because the DOM was out of the facility. The OT stated nurses and CNAs reported wheelchair repairs needed to therapy and therapy reported them to the CNE. Interview, on 06/21/18 at 10:55 AM, with the Director of Therapy revealed maintenance staff was responsible for replacement of damaged wheelchair armrests. He stated if he discovered a resident's wheelchair needed replacement parts, he completed a requisition within the computer system, which alerted the DOM of the requested wheelchair repair. Interview with the DOM, on 06/21/18 at 5:31 PM, revealed it was the responsibility of therapy to repair wheelchairs and to order parts for wheelchairs. He stated there were times when he replaced wheelchair arms, but it was the responsibility of therapy. He explained therapy had a closet with boxes of supplies for them to make repairs; however, if he was informed about the repairs then he completed them. He stated the CNE or CED usually notified him through the computer system, which sent a text message to his telephone. The Director stated he had not been able to work on wheelchairs in a while due to driving the facility's bus. He was unsure when he completed the last wheelchair repair or when the last education was given to staff to ensure they knew how to notify him of repairs. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the CNE, on 06/21/18 at 1:55 PM, revealed wheelchairs should be assessed and repaired according to facility policy. She stated nurses and CNAs were responsible for cleaning wheelchairs nightly and notifying the CNE or CED of needed repairs. The CNE stated there was not a written form for maintenance repairs of wheelchairs; however, requested repairs were placed in the computer system, which notified the DOM of repairs needed. The CNE further stated it was the responsibility of maintenance to ensure wheelchairs were repaired and the responsibility of therapy to order adaptive equipment for wheelchairs such as anti-tippers and special seat cushions. She stated it was the responsibility of the UM and night shift supervisor to ensure wheelchairs were cleaned nightly and repairs completed when reported. In addition, the CNE stated the DOM should respond to work orders in a timely manner and report action taken once work orders were completed. Interview with the CED, on 06/26/18 at 9:44 AM, revealed the facility had an ambassador program in place, which meant administrative staff made rounds periodically. The ambassadors should make rounds in their assigned area at least weekly and put in work orders as they identified items or areas in need of repair. The CED stated the ambassador team should observe residents' wheelchairs during their assigned rounds, and staff who cleaned wheelchairs during the night shift should report any wheelchairs in need of repair. The CED stated therapy staff would recommend types of parts to be added to wheelchairs according to their resident assessments, but the DOM should make the repairs such as adding new parts or applying new armrests.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31274 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure staff implemented care plans related to following physician orders for medication administration and treatments for nine (9) of twenty-three (23) residents, Resident #5, #9, #16, #23, #26, #38, #40, #42 and #51. Per record review and staff interview, Resident #40 was readmitted to the facility after an acute hospital stay on 06/09/18, with care plan interventions to administer respiratory treatments as ordered. Resident #40 did not receive all doses of breathing treatments, nor antibiotics, between 06/10/18 - 06/13/18. The resident was transferred to the hospital on the morning of 06/13/18 for difficulty breathing, an elevated heart rate, and a decrease in blood oxygenation. Resident #51 was admitted on [DATE] with care plan interventions to monitor conditions that could contribute to his/her mood/state, such as liver disease, and to monitor newly ordered medications for side effects, drug toxicity, or errors. The resident was ordered Rifaximin (antibiotic) for treatment of fatty liver disease and did not receive the medication from 05/22/18 - 05/29/18. The resident had documented periods of confusion and elevated serum ammonia levels during the time when the medication was not administered. In addition, staff did not follow the care plan for wound treatments for Resident #5, #16, and #26, and did not follow the care plan for medication administration for Resident #9, #23, #38, and #42. The facility's failure to have a system in place to ensure care plan interventions were implemented, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 06/25/18 and was determined to exist on 05/22/18. The facility was notified of the Immediate Jeopardy on 06/25/18. The facility provided an acceptable Allegation of Compliance (AOC) on 06/27/18, which alleged removal of the IJ on 06/28/18. The State Survey Agency (SSA) verified the IJ was removed on 06/28/18, prior to exit on 07/01/18. The Scope and Severity was lowered to a E while the facility develops and implements a Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Person-Centered Care Plan, revised 03/01/18, revealed the facility must develop and implement a baseline care plan within 48 hours for each resident that included the instructions needed to provide effective and person-centered care that met professional standards and quality of care. A comprehensive, individualized care plan must be developed within seven (7) days after completion of the comprehensive assessment for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, nutrition, and psychosocial needs that were identified in the comprehensive assessments. The care plan would be developed by the interdisciplinary team that include the Physician, the Registered Nurse with responsibility for the resident, a nurse aid responsible for the resident, food and nutrition services staff, and to the extent practicable the resident or the resident representative(s). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Further review of the policy revealed the purpose of the care plan was to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plans would be communicated to appropriate staff, the resident and family, and would be reviewed and revised by the interdisciplinary team after each assessment, and as needed to reflect the response to care and changing needs and goals. Interview, on 06/26/18 at 1:45 PM, with the CNE revealed the care plan was a guide to assist staff in the delivery of the best resident care and was a communication tool for staff across all disciplines. She stated if Physician ordered interventions included in the care plan were not done, then the care plan was not followed. She stated if a resident did not receive medications as ordered, and if the Medication Administration Record (MAR) and/or the Treatment Administration Record (TAR) showed no documented evidence medications or treatments were provided, then the care plan was not followed. 1. Review of Resident #40's clinical record revealed the facility readmitted the resident on 10/27/17, with diagnoses that included a history of Respiratory Failure, Pneumonitis Due to Inhalation of Food and Vomit, and Metabolic Encephalopathy. The resident was transferred to the hospital on 06/05/18 for low oxygenation, an increase pulse, coughing up white thick sputum, and an altered level of consciousness. The resident was transferred back to the facility on [DATE] at 9:10 PM. Review of the Hospital Discharge Summary, dated 06/09/18, revealed the resident was treated for Aspiration Pneumonia and an order for Clindamycin (antibiotic) 150 milligrams (mg), three (3) capsules (450 mg) three (3) times a day for four (4) days. In addition, an order for Ipratropium-Albuterol (breathing treatment) 3 milliliters (ml) per nebulization three (3) times per day. Review of Resident #40's Progress Notes, dated 06/10/18 at 2:30 AM, revealed the nurse faxed the medication list to the pharmacy and notified the pharmacy the resident was a new admission and to please STAT (immediately) deliver the medications. According to the documentation, the nurse called the pharmacy as well, there was no answer, and left a message to call the nurse for confirmation. The nurse called the pharmacy again at 8:40 AM on 06/10/18 and informed pharmacy staff the medications for Resident #40 had not been received. The nurse reiterated the order faxed stated the resident was a new admission and to please STAT the medications and the nurse was informed by pharmacy the medications would be sent as soon as possible. Review of Resident #40's Care Plan, dated 12/30/16, revealed the resident was at risk for complications of infection with an intervention for the administration of antibiotics, as ordered, but the intervention was dated 06/21/18, after the resident was readmitted to the facility from his/her hospitalization of 06/13/18 through 06/19/18. The facility did not provide any other care plan documents. Review of Resident #40's MAR, dated June 2018, revealed the Clindamycin was scheduled for administration at 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the Clindamycin on 06/10/18 at 8:00 AM, 12:00 PM, and 8:00 PM, 06/11/18 at 8:00 AM and 12:00 PM, 06/12/18 at 8:00 AM and 12:00 PM, and 06/13/18 at 8:00 AM. In addition, the Ipratropium-Albuterol was scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the medication on 06/10/18 at 12:00 PM, 12/11/18 at 12:00 PM, and 06/12/18 at 12:00 PM. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview, on 06/22/18 at 11:05 AM, with Licensed Practical Nurse (LPN) #3 revealed she cared for Resident #40 on 06/10/18 and 06/12/18. LPN #3 stated she was under the impression Resident #40's antibiotic had been ordered upon his/her readmission on 06/09/18; however, the medication was not delivered on 06/10/18. She stated she did not call the pharmacy to follow up when she realized she did not have the medication for the resident. LPN #3 stated she worked again on 06/12/18 and the resident's antibiotic was still not available for the scheduled doses. Interview, on 06/22/18 at 5:10 PM, with LPN #4 revealed care plans assisted staff in the delivery of resident care. She stated if a resident did not receive breathing treatments or medications, as ordered and as listed on the care plan, then the care plan was not followed. She stated if the care plan was not followed, the resident's condition could worsen. LPN #4 stated care plans should stay up to date to ensure nurses and other caregivers delivered correct care as driven by the Physician orders and ongoing assessments of the resident's status. Interview, on 06/28/18 at 12:47 PM, with the Minimum Data Set (MDS) Assistant revealed the care plan was a guide to ensure all staff caring for a resident knew the care the resident needed. She stated it was a communication tool for use across all disciplines. She stated she made sure the care area needs identified through routine MDS assessments were taken into consideration as the care plans were developed. She stated the care plan should address any care areas associated with infections, such as administration of antibiotics, and insulin administration for diagnosed Diabetes. She stated if a resident had an order for breathing treatments, then those interventions should be added to the care plan and the care should be provided. She stated if breathing treatments were not administered as care planned, then the care plan was not being followed and there would be the potential for the resident's condition to worsen, and could result in hospitalization or even death. 28733 2. Review of Resident #51's clinical record revealed the facility admitted the resident on 05/22/18, with multiple diagnoses, which included Nonalcoholic Steatohepatitis (NASH). Review of Resident #51's Physician Orders, dated 05/22/18, revealed Rifaximin 550 mg every twelve (12) hours for NASH diagnosis. Review of the Care Plan for Resident #51, created 05/28/18, revealed the resident exhibited or was at risk for distressed/fluctuating mood/anxiety symptoms with interventions to monitor for conditions that could contribute to his/her mood/state, such as liver disease and electrolyte imbalances. Staff was to monitor medications, especially those newly ordered, changed, or discontinued for any observed side effects, drug interactions, adverse drug reactions, drug toxicity, or errors, and monitor lab values and report abnormal results to the physician or mid-level practitioner. In addition, the resident was at risk for complications related to use of psychotropic medications, antidepressants, and antipsychotic medicines with interventions to monitor for side effects of the medications, and consult the physician and/or pharmacist, as needed. Review of Resident #51's MAR, dated May 2018, revealed fifteen (15) doses of Rifaximin were documented as not administered. The MAR revealed the 9:00 PM dose on 05/22/18 was blank. The doses scheduled on 05/23/18, 05/24/18, 05/25/18, and 05/26/18 at 9:00 AM and 9:00 PM had circled staff initials. The 9:00 AM dose on 05/27/18 had circled initials and the 9:00 PM dose was blank. The 05/28/18 and 05/29/18 scheduled doses at 9:00 AM and 9:00 PM had circled initials. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #3, on 06/22/18 at 3:45 PM revealed when medication was not available for administration; staff initialed the MAR and circled the initials, which indicated the medication was not given. Interview with the Pharmacist, on 06/28/18 at 11:51 AM, revealed the pharmacy received Resident #51's Rifaximin order on 05/22/18; however, the order was not filled because of a billing issue. He stated the order was delivered to the facility on [DATE]. Review of laboratory results for Resident #51, dated 05/24/18 at 12:50 AM, revealed the resident's ammonia level was elevated at 98, (normal range of 18-75). Review of the Progress Notes for Resident #51, dated 05/26/18, revealed the resident was alert to person (self) and place, but verbalized confusion from time to time while packing his/her clothes and wanting to go home. Review of the Progress Notes, dated 05/28/18, revealed he/she was alert and oriented to person (self), place, and approximate time of day. The resident showed signs of confusion and required redirection several times during the day. The resident took his/her dressing off of his/her foot and rolled away in his/her wheelchair from his/her intravenous (IV) pump/pole while the IV was infusing. Results of an ammonia level, dated 05/29/18 at 1:00 AM, revealed the resident's ammonia level was elevated at 118. Continued interview with LPN #3, on 06/22/18 at 3:45 PM, revealed she cared for Resident #51 during the time he/she did not receive the Rifaximin. She stated she did not do anything about Resident #51's missing Rifaximin such as call the pharmacy, Physician, or the CNE; however, she stated she should have notified all of them. She stated by not receiving the medication, the resident was not treated for his/her liver disease. Interview with LPN #1/UM, on 06/22/18 at 11:07 AM and 1:49 PM, revealed missing medications should be reported to the Physician, and pharmacy and have it delivered STAT. She stated as she reviewed the MAR for Resident #51 and there were fifteen (15) doses of Rifaximin not administered. The fifteen doses were circled not available and not administered. She stated the Rifaximin was given for Resident #51's liver disease and the lack of the medication could lead to high ammonia levels and increase the resident's confusion. Interview with the CNE, on 06/26/18 at 1:46 PM, revealed nurses should administer antibiotics as ordered, and if not done, the care plan was not followed. Interview, on 06/26/18 at 9:44 AM, with the Center Executive Director (CED) revealed from a systems perspective, there had been no identified issues with care not being provided as care planned. 3. Review of the clinical record for Resident #42 revealed the facility admitted the resident on 04/04/18, with diagnoses that included Acute Kidney Failure, Type 2 Diabetes, and Chronic Kidney Disease. Physician orders revealed staff was to administer Glargine insulin, 60 units every morning, and 50 units every bedtime. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #42's Care Plan revealed the resident was insulin dependent related to a diagnosis of Diabetes with an intervention to administer hypoglycemic medications as ordered. However, review of the MAR, dated May 2018, revealed on 05/09/18, 05/14/18, and 05/30/18, the date and time spaces for the Glargine 60 unit doses were blank, with no explanation why the insulin was not administered. In addition, on 05/12/18 and 05/13/18, the date and time spaces for Glargine 50 unit doses were blank, with no explanation why the insulin was not administered. Review of the MAR, dated June 2018, revealed Glargine 60 unit dose was not documented as given on 06/23/18, nor the Glargine 50 unit dose on 06/21/18. The date and time spaces for both of the scheduled doses were blank, with no explanation why the insulin was not administered. Interview, on 06/26/18 at 11:25 AM, with LPN#1/UM revealed the nurses should have documented the reasons why Resident #42 did not receive his/her insulin, and should have informed the provider of those missed doses. She stated it was very important to follow the resident's care plan for management of Diabetes and one interventions was to provide Diabetes medications as ordered. She stated the care plan was in place to guide staff with maintaining acceptable blood sugar levels. 35750 4. Review of Resident #23's clinical record revealed the facility admitted the resident on 04/27/18, with multiple diagnoses, which included Diabetes Mellitus Type 1. Review of Resident #23's Comprehensive Care Plan, initiated 04/28/18, revealed interventions for the resident's diagnosis of Diabetes that included administering hypoglycemic medications (insulin) as ordered. Review of Resident #23's MAR, for May 2018, revealed an order for Lantus SoloStar Solution Pen-Injector (insulin), 8 units every morning at 8:00 AM for Diabetes, start date 04/28/18. Documentation revealed the insulin was not administered on 05/07/18 and 05/14/18. Continue review revealed the insulin order was discontinued on 05/26/18 and a new order started for Basaglar KwikPen Solution Pen-Injector (insulin), 8 units in the morning at 8:00 AM. However, documentation on the MAR revealed the resident did not receive the Basaglar insulin on 05/26/18 and 05/27/18. Review of the June 2018 MAR revealed the resident did not receive insulin on 06/07/18. Interview, on 06/22/18 at 4:33 PM, with LPN #4 revealed if Resident #23's insulin dosages were not documented as done, then there would not be evidence the care plan was followed. LPN #4 stated the resident blood sugar could elevate if not administered the insulin, which could result in the resident to be unconscious. Interview with the CNE, on 06/26/18 at 2:29 PM, revealed nurses should administer medications per Physician order and if that did not occur, the care plan was not being implemented. The CNE stated nurses were responsible for the MAR/TAR and if the document showed missed medications and no documented evidence why the medications were missed, it meant the care plan was not followed. 38038 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. Review of the clinical record for Resident #38 revealed the facility admitted the resident on 05/11/18, with diagnoses of Chronic Obstructive Pulmonary Disease, Shortness of Breath, Bacterial Pneumonia, and Type 2 Diabetes Mellitus. Review of the Care Plan for Resident #38, dated 05/23/18, revealed the resident had a diagnosis of Chronic Obstructive Pulmonary Disease with an intervention to administer medications per physician orders. Review of Resident #38's MAR, for May 2018, revealed an order for Heparin Sodium 5000 Units every twelve (12) hours at 9:00 AM and 9:00 PM. Documentation revealed the medication were not administered on 05/12/18, 05/13/18 at 9:00 AM, 05/14/18 at 9:00 AM, 05/23/18 at 9:00 PM, and 05/30/18. In addition, there was an order for Umeclidinium Bromide Aerosol Powder 62.5 mg, one (1) puff at 9:00 AM daily. The medication was not administered on 05/12/18, 05/13/18, 05/14/18, 05/19/18, 05/20/18, 05/29/18, and 05/30/18. Further review of the MAR revealed Xopenex Concentrate Nebulization Solution 0.5 ML via nebulizer every six (6) hours at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM. Documentation revealed the medication was not administered on 05/12/18, 05/13/18 at 2:00 AM, 8:00 AM, and 2:00 PM, 05/14/18 at 8:00 AM, 05/16/18 at 2:00 AM, 05/21/18 at 2:00 PM, 05/25/18 at 2:00 AM, 05/26/18 at 2:00 AM, 05/28/18 at 2:00 AM, and 05/30/18 at 8:00 PM. Additional review revealed an order for Advair Diskus Aerosol Powder 250-50 microgram, one (1) puff two (2) times daily at 9:00 AM and 9:00 PM. The medication was not administered on 05/12/18 for either dose or at 9:00 AM on 05/13/18. Interview with the MDS Assistant, on 06/26/18 at 12:47 PM, revealed failure to administer medications as ordered, including breathing treatments, could result in adverse consequences for the resident. She further stated that all breathing treatments and inhalers should be listed on the care plan as an intervention and not administering the treatments/inhalers meant the care plan was not followed. Interview with the CNE, on 06/26/18 at 1:46 PM, revealed she expected all breathing treatments to be administered as ordered by the Physician and if not documented, it was not given. She stated if medications were not administered as ordered by the Physician, the care plan was not followed. 6. Review of the clinical record for Resident #9 revealed the facility admitted this resident on 03/13/18, with a diagnosis of Diabetes Mellitus. Review of the Care Plan for Resident #9, dated 04/06/18, revealed the resident had a diagnosis of Diabetes and was insulin dependent with an intervention to administer hypoglycemic medication as ordered. Review of the MAR, dated May 2018, for Resident #9 revealed an order for insulin, Detemir, 19 units twice daily at 8:00 AM and 8:00 PM for Diabetes. Documentation revealed the resident did not receive seven (7) doses of insulin, on 05/04/18 at 8:00 AM, 05/16/18 at 8:00 PM, 05/21/18 at 8:00 AM, 05/23/18 at 8:00 AM, 05/30/18 at 8:00 AM and 8:00 PM, and 05/31/18 at 8:00 PM. Review of the June 2018 MAR revealed the resident did not receive the insulin on 06/04/18 at 8:00 PM and 06/08/18 at 8:00 PM. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #1/UM, on 06/26/18 at 10:44 AM, revealed if insulin was not administered as ordered, the resident could experience hyperglycemia, decreased urine output, a sugar coma, and the overall health of the resident would be negatively impacted. She stated not administering insulin as ordered meant staff did not follow the care plan. Interview with the MDS Assistant, on 06/26/18 at 12:47 PM, revealed insulin should be administered as ordered and listed on the care plan as an intervention for Diabetes. She stated if staff did not document insulin administration, it indicated the medication was not given and the care plan was not followed. She stated if insulin was not given as ordered, the resident could return to the hospital. In addition to staff not following care plans for medication administration, care plans related to wound treatment were also not followed. 7. Review of Resident #5's clinical record revealed the facility admitted the resident on 06/07/17, with a diagnosis of Pressure Ulcer of Other Site Unspecified Stage. Review of Physician Orders for Resident #5, dated 05/07/18, revealed apply Bactroban and Santyl compound to the buttocks wound bed and cover with 1/8 strength Dakins gauze twice a day and Santyl Ointment to the left heel, cover with 1/8 strength Dakins moist gauze every night. Review of Resident #5's Care Plan, revised 03/23/18, revealed the resident had actual skin breakdown for a pressure ulcer to the coccyx and to the left outer aspect of the left heel with an intervention to provide wound treatment as ordered. Review of Resident #5's MAR, for May 2018, revealed no documentation the left heel wound care was performed on 05/08/18 and 05/20/18. Review of the TAR, dated May 2018, revealed the buttocks wound care was scheduled for 6:00 AM - 2:00 PM and 10:00 PM - 6:00 AM. There was no documentation wound care was performed on 05/08/18 and 05/21/18 for 10:00 PM - 6:00 AM, and on 05/11/18, 05/14/18, 05/17/18, and 05/24/18 for 6:00 AM - 2:00 PM. Review of Resident #5's TAR, dated June 2018, revealed no documentation wound care for the left heel was performed on 06/08/18, 06/15/18, 06/19/18, 06/20/18, and 06/21/18. There was no documentation the buttocks wound care was performed on 06/01/18, 06/08/18, 06/11/18, and 06/22/18 for 6:00 AM - 2:00 PM, and on 06/15/18 and 06/21/18 for 10:00 PM - 6:00 AM. 8. Review of the clinical record for Resident #16 revealed the facility readmitted this resident on 04/18/18, with multiple diagnoses, which included Pressure Ulcer. Review of the Admission MDS for Resident #16, dated 04/25/18, revealed the facility assessed the resident as interviewable with a Brief Interview for Mental Status score of thirteen (13) out of fifteen (15). Review of the Care Plan for Resident #16, dated 05/01/18, revealed the resident had actual skin breakdown with an intervention to provide wound treatment as ordered to the left heel. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the TAR for Resident #16, for June 2018, revealed an order for Negative Pressure Therapy (wound vacuum) to the left foot/heel, which included cleaning, applying skin prep, and covering the heel with a dressing. The dressing was to be changed every third day on day shift. Interview with Resident #16, on 06/20/18 at 8:41 AM, revealed the resident had a pressure ulcer on his/her left foot and negative pressure wound therapy (a wound vacuum) was being used for treatment of the wound. Resident #16 stated the dressing on the foot connected to the wound vacuum was supposed to be changed every three (3) days and it had not been changed in at least four (4) days. Observation of the Wound Vacuum dressing for Resident #16, on 06/20/18 at 10:35 AM, revealed there was no date or time on the dressing. Continued review of the TAR revealed the last dressing change was performed on 06/15/18 and the next dressing change due on 06/18/18. Documentation revealed the dressing change was not completed on 06/18/18. Interview with LPN #2, on 06/20/18 at 10:35 AM, revealed the bandage on Resident #16's wound vacuum should be dated and wound care should be documented on the TAR. She stated if wound care was not documented, it was not done. Interview with LPN #7, on 06/21/18 at 10:00 AM, revealed she was the nurse assigned to care for Resident #16 on 06/18/18 and she did not complete the wound care because she did not check the TAR and did not know she had orders for a wound vacuum dressing. She stated she should have checked the TAR for any treatments that might be due. 9. Review of Resident #26's clinical record revealed the facility admitted the resident on 10/15/17, with multiple diagnoses, which included Gastroparesis (stomach cannot empty food). Review of Resident #26's Care Plan, revised 04/25/18, revealed the resident had an enteral feeding tube (G-tube) with a goal that the resident would not develop any G-tube related complications. Review of Resident #26's TAR, for June 2018, revealed an order for Mupirocin Ointment 2%, apply topically to the G-tube site with the dressing changed every night. Documentation revealed the treatment was not completed on 06/07/18, 06/09/18, 06/16/18, and 06/17/18. Documentation revealed the treatment was completed on 06/18/18 and 06/19/18. Observation of Resident #26, on 06/20/18 at 9:15 AM, revealed LPN #1/UM administered medication via the resident's G-tube. The dressing around the G-tube site was dated 06/18/18; however, the TAR revealed the dressing was changed on 06/19/18. The dressing had brown and yellow stains and appeared old. The LPN changed the dressing and dated it 06/20/18. Interview with LPN #1/UM, on 06/20/18 at 9:15 AM, during the observation revealed Resident #26's dressing would have been dated 06/19/18 if the dressing were changed as documented. She stated the Mupirocin Ointment to the G-tube site and the dressing change prevented infection and allowed the wound to heal. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Telephone interview with LPN #8, on 06/20/18 at 2:57 PM, revealed she changed Resident #26's dressing to the G-tube site on 06/18/18 and 06/19/18 she was not sure why the dressing was labeled 06/18/18 instead of 06/19/18. LPN #8 stated all treatments were completed as ordered and initialed on the TAR. She knew it was important to change the dressing as ordered to prevent infection to the resident. Continued interview with LPN #7, on 06/21/18 at 10:00 AM, revealed not completing wound care as ordered could result in wounds worsening, or in the development of an infection. She stated not completing wound care meant the care plan was not followed. Continued interview with LPN #1/UM, on 06/21/18 at 12:07 PM, revealed it was important to complete wound care as ordered to ensure the wound was healing and to monitor the wound for changes. She further stated if the wound care was not performed as ordered, the wound could worsen or become infected which could lead to sepsis or re-hospitalization of the resident. She also stated not completing wound treatments as ordered meant staff did not follow the care plan. Interview with the MDS Assistant, on 06/26/18 at 12:46 PM, revealed the care plan communicated about resident needs and providing care for each resident and interventions on the care plan should be followed since they were ordered by the Physician. She stated if treatments were not provided, then the care plan was not followed and the residents did not receive the care that was ordered. Interview with the CNE, on 06/21/18 at 2:13 PM and 06/26/18 at 1:46 PM, revealed a wound vacuum was generally used on more severe wounds and she would be concerned about failure to change the dressing. She stated if the dressing was not changed as ordered, the wound could not be monitored for worsening or signs of infection. She further stated she would be concerned residents might develop an infection if dressings were not changed as ordered and might develop skin breakdown. She stated not providing wound care as ordered meant the facility had not provided the care and services needed and care plans were not followed. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. 8. Additional education of licensed staff and two (2) CMTs was completed on 06/25/18. Education included procedure for sending medication orders to pharmacy; procedure for unavailable medications including refusals and notification of the pharmacy and physicians; when to notify the CNE and CED of unavailable medications; and the care plan process of revising and implementing the care plan with new orders. Posttests provided to validate understanding. 9. On 06/25/18, an adHoc QAPI meeting was conducted with the CED, the CNE, and the Medical Director to review additional education conducted. 10. Beginning 06/26/18, the Pharmacy Program Manager would contact the facility daily, including weekends, and speak with the CED, the CNE, or Registered Nurse (RN) Charge Nurse to confirm any medications needed would be sent to the facility stat (immediately). 11. On 06/26/18, the facility's EDK was re-stocked. 12. The CNE, CED, and/or Unit Manager will monitor MARs, conduct observations, and ensure daily communications occur with the Pharmacy Program Manager daily times two (2) weeks across all shifts; then three (3) times weekly for two (2) weeks; then weekly for two (2) months; then bi-weekly for two (2) months; and, then monthly for one (1) month to ensure medications were available as prescribed and the care plans were being followed. 13. The Regional [NAME] President of Operations and/or the Clinical Quality Specialist will review the QAPI minutes monthly for six (6) months and ongoing thereafter to ensure audits, education, and in-services are completed as needed. The SSA validated the facility implemented the following actions: 1. Record review of the MARs for Resident #51 revealed he/she had received all medications since 05/30/18 as ordered. 2. Record review revealed Resident #40 was no longer in the facility. 3. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had received and had an understanding of the education. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the sign-in sheet for the in-service education provided between 06/11/18 - 06/21/18 revealed all licensed staff

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 31274 Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure five (5) of twenty-three (23) sampled residents received medications/treatment in accordance with Physician orders for Resident #9, #23, #26, #38, and #42. The findings include: Review of the facility's Medication Errors Policy, last reviewed 03/01/16, revealed a medication error was identified as a discrepancy between what the Physician/mid-level provider ordered and what the resident received. Types of errors included medication omission. 1. Review of the clinical record for Resident #42 revealed the facility admitted the resident on 04/04/18, with multiple diagnoses, which included Type 2 Diabetes. Physician orders included Glargine insulin, 60 units every morning and 50 units every bedtime. However, review of Resident #42's MAR, for May 2018, revealed the resident did not receive the insulin as ordered. Documentation revealed on 05/09/18, 05/14/18, and 05/30/18, the date and time spaces for the Glargine 60 unit doses were blank with no explanation why the insulin was not administered. In addition, on 05/12/18 and 05/13/18, the date and time spaces for Glargine 50 unit doses were blank with no explanation why the insulin was not administered. Review of the MAR, for June 2018, revealed Glargine 60 unit dose was not documented as given on 06/23/18, nor the Glargine 50 unit dose on 06/21/18. The date and time spaces for both of the scheduled doses were blank with no explanation why the insulin was not administered. Interview with LPN #1/Unit Manager (UM), on 06/26/18 at 11:25 AM, revealed Resident #42's doses of insulin were not administered and there should have been documentation in the resident's clinical record why the insulin was not administered, and the prescriber should have been contacted and documentation of that as well. She stated it was necessary for the nurses to administer insulin to prevent an elevated blood sugar level which could have an adverse effect on the resident's health. She further stated if the insulin was not documented as administered, it was assumed Resident #42 did not receive the insulin. 28733 35750 2. Review of Resident #23's clinical record revealed the facility admitted the resident on 04/27/18, with multiple diagnoses, which included Diabetes Mellitus Type 1. Review of Resident #23's Comprehensive Care Plan, initiated 04/28/18, revealed interventions for the resident's diagnosis of Diabetes that included administering hypoglycemic medications (insulin) as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #23's MAR, for May 2018, revealed an order for Lantus SoloStar Solution Pen-Injector (insulin), 8 units every morning at 8:00 AM for Diabetes, start date 04/28/18 and discontinued on 05/26/18. Continue reviewed revealed an order for Basaglar KwikPen Solution Pen-Injector (insulin), 8 units in the morning at 8:00 AM, start date 05/26/18. Documentation on the MAR revealed the resident did not receive the Basaglar for two (2) days for treatment of his/her Diabetes, on 05/26/18 and 05/27/18. Review of Resident #23's Progress Notes, dated 05/26/18 to 05/28/18, revealed no documentation regarding the missed doses of insulin on 05/26/18 and 05/27/18, nor documentation the Physician was notified of the missed doses. Interview, on 06/22/18 at 12:05 PM, with LPN #2 revealed if a resident did not receive his/her medication, their condition could get worse. Interview, on 06/22/18 at 4:33 PM, with LPN #4 revealed if a resident did not receive his/her insulin, his/her blood sugar could be higher than normal and could cause the resident to become unconscious. Interview, on 06/26/18 at 11:23 AM, with LPN #1/UM revealed if insulin was not administered to Resident #23, the resident could have became hyperglycemic (high blood sugar), got disoriented, fell , or gone into a coma. Interview, on 06/26/18 at 2:29 PM, with the CNE revealed she expected nurses to administer medications per Physician order. 38038 3. Review of the clinical record for Resident #9 revealed the facility admitted the resident on 03/13/18, with multiple diagnoses, which included Diabetes Mellitus. Review of Resident #9's MAR, dated May 2018, revealed an order for insulin, Detemir, 19 units twice daily at 8:00 AM and 8:00 PM for Diabetes. Documentation revealed the resident did not receive seven (7) doses of insulin, on 05/04/18 at 8:00 AM, 05/16/18 at 8:00 PM, 05/21/18 at 8:00 AM, 05/23/18 at 8:00 AM, 05/30/18 at 8:00 AM and 8:00 PM, and 05/31/18 at 8:00 PM. Review of the June 2018 MAR revealed the resident did not receive the insulin on 06/04/18 at 8:00 PM and 06/08/18 at 8:00 PM. Review of the Care Plan for Resident #9, dated 04/06/18, revealed the resident had a diagnosis of Diabetes and was insulin dependent. Interview with LPN #1/UM, on 06/22/18 at 1:49 PM, and on 06/26/18 at 10:44 AM, revealed she was concerned if Resident #9 did not receive his/her insulin per Physician order as the resident could have experienced hyperglycemia, decreased urine output, a diabetic coma, and the overall health of the resident could have been negatively impacted. Interview with the MDS Assistant, on 06/26/18 at 12:47 PM, revealed insulin should be administered as ordered to provide the care the resident needed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	40244 4. Review of the clinical record for Resident #38 revealed the facility admitted the resident on 05/11/18, with diagnoses of Chronic Obstructive Pulmonary Disease, Shortness of Breath, Bacterial Pneumonia, and Type 2 Diabetes Mellitus. Review of Resident #38's MAR, dated May 2018, revealed an order for Umeclidinium Bromide Aerosol Powder 62.5 mg, one (1) puff at 9:00 AM daily. Seven (7) doses of the medication were not administered, on 05/12/18, 05/13/18, 05/14/18, 05/19/18, 05/20/18, 05/29/18, and 05/30/18. Further review of the MAR revealed Xopenex Concentrate Nebulization Solution 0.5 ML via nebulizer every six (6) hours at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM. Documentation revealed fourteen (14) doses of the medication were not administered, on 05/12/18 at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM, 05/13/18 at 2:00 AM, 8:00 AM, and 2:00 PM, 05/14/18 at 8:00 AM, 05/16/18 at 2:00 AM, 05/21/18 at 2:00 PM, 05/25/18 at 2:00 AM, 05/26/18 at 2:00 AM, 05/28/18 at 2:00 AM, and 05/30/18 at 8:00 PM. Additional review revealed an order for Advair Diskus Aerosol Powder 250-50 microgram, one (1) puff two (2) times daily at 9:00 AM and 9:00 PM. The medication was not administered on 05/12/18 for either dose or at 9:00 AM on 05/13/18. Interview, on 06/28/18 at 11:51 AM, with the Pharmacist via telephone revealed the pharmacy received Resident #38's medication orders on 05/11/18 at 10:22 PM. He stated the breathing treatment, and inhalers were not filled and sent to the facility immediately because there were issues with insurance coverage and the availability of the medications. He revealed he did not have documentation the facility had called to follow-up on the medication orders. Interview, on 06/26/18 at 10:44 AM, with LPN #1/UM revealed if staff did not give Resident #38 the breathing treatments and inhalers, it could result in the resident experiencing respiratory distress. Interview with the MDS Assistant, on 06/26/18 at 12:47 PM, revealed if staff did not administer the breathing treatments as ordered, it could result in adverse consequences for the resident. 5. Review of Resident #26's clinical record revealed the facility admitted the resident on 10/15/17, with multiple diagnoses, which included Gastroparesis (stomach cannot empty food). Review of Resident #26's TAR, for June 2018, revealed an order for Mupirocin Ointment 2%, apply topically to Gastrostomy (G-tube) site with the dressing changed every night. Documentation revealed the treatment was not completed on 06/07/18, 06/09/18, 06/16/18, and 06/17/18. Documentation revealed the treatment was completed on 06/18/18 and 06/19/18. Observation of Resident #26, on 06/20/18 at 9:15 AM, revealed LPN #1 administered medication via the resident's G-tube. The dressing around the G-tube site was dated 06/18/18; however, the TAR revealed the dressing was changed on 06/19/18. The dressing had brown and yellow stains and appeared old. The LPN changed the dressing and dated it 06/20/18. Interview with LPN #1/UM, on 06/20/18 at 9:15 AM, during the observation revealed Resident #26's dressing would have been dated 06/19/18 if the Physician order was followed. LPN #1 stated the Mupirocin Ointment to the G-tube site and the dressing changed prevented infection and allowed the wound to heal. She stated she received education in orientation on following Physician orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Telephone interview with LPN #8, on 06/20/18 at 2:57 PM, revealed she changed Resident #26's dressing to the G-tube site on 06/18/18 and 06/19/18 and was not sure why the dressing was labeled 06/18/18, instead of 06/19/18. LPN #8 stated all treatments were completed as ordered and initialed on the TAR. She knew it was important to change the dressing as ordered to prevent infection to the resident. LPN #8 was unable to recall the last time she received education on following Physician orders. Interview with the CNE, on 06/21/18 at 2:13 PM, revealed nurses received ongoing training on implementing treatments per the Physician order; however, they were verbal teachings and not documented. The CNE stated dressings not changed as ordered could place a resident at risk for infection and skin breakdown. Further interview with the CNE, on 06/26/18 at 1:46 PM, revealed if residents did not receive their ordered medications/treatments, their condition could worsen and they could die. She further stated the facility had not provided residents with care and services to meet their needs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 38038 Based on observation, interview, and record review, it was determined the facility failed to provide treatment for pressure ulcers per the physician's order for one (1) of twenty-three (23) sampled residents, Resident #16. The findings include: Review of the facility's policy, Skin Integrity Management, revised 11/28/16, revealed wound care treatments/techniques should be implemented as ordered. Review of the clinical record for Resident #16 revealed the facility readmitted this resident on 04/18/18, with multiple diagnoses, which included Pressure Ulcer. Review of the Admission Minimum Data Set for Resident #16, dated 04/25/18, revealed the facility assessed the resident as interviewable with a Brief Interview for Mental Status score of thirteen (13) out of fifteen (15). Review of the Care Plan for Resident #16, dated 05/01/18, revealed the resident had actual skin breakdown with an intervention to provide wound treatment as ordered to the left heel. Review of the Treatment Administration Record (TAR) for Resident #16, for June 2018, revealed an order, dated 06/15/18, for Negative Pressure Therapy (wound vacuum) to the left foot/heel, which included cleaning, applying skin prep, and covering the heel with a dressing. The dressing was to be changed every third day on day shift. Interview with Resident #16, on 06/20/18 at 8:41 AM, revealed the resident had a pressure ulcer on his/her left foot and negative pressure wound therapy (a wound vacuum) was being used for treatment of the wound. Resident #16 stated the dressing on the foot connected to the wound vacuum was supposed to be changed every three (3) days and it had not been changed in at least four (4) days. Observation of the Wound Vacuum dressing for Resident #16, on 06/20/18 at 10:35 AM, revealed there was no date or time on the dressing. Continued review of the TAR revealed the last dressing change was performed on 06/15/18 and the next dressing change due on 06/18/18. Documentation revealed the dressing change was not completed on 06/18/18. Interview with Licensed Practical Nurse (LPN) #2, on 06/20/18 at 10:35 AM, revealed staff should have dated the bandage on Resident #16's wound vacuum and documented the dressing change on the TAR. She stated if wound care was not documented it was not done. Interview with LPN #7, on 06/21/18 at 10:00 AM, revealed she cared for Resident #16 on 06/18/18 and did not complete wound care because she did not check the TAR and did not know there were orders for the wound vacuum dressing. She stated since the wound care was not completed as ordered by the Physician, it could lead to deterioration of the wound, or the development of an infection. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #1/Unit Manager, on 06/21/18 at 12:07 PM, revealed it was important to complete wound care as ordered to ensure the wound was healing and to monitor the wound for changes. She stated if wound care was not performed as ordered, the wound could worsen or become infected, which could lead to sepsis or re-hospitalization of the resident. Interview with the Center Nurse Executive (CNE), on 06/26/18 at 1:46 PM, revealed a wound vacuum was used on more severe wounds and she would be concerned about staff not changing the dressing because the wound would not have been monitored for worsening or signs of infection. She stated Resident #16 might develop an infection if the dressings were not changed as ordered. She stated the facility did not provide care and services needed to the resident if wound dressing orders were not followed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28733 Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to secure the indwelling catheter for two (2) of twenty-three (23) sampled residents, Resident #12 and #20. The findings include: Review of facility's policy, Catheter: Care of Indwelling Urinary, revised 01/02/14, revealed catheter care was performed twice daily and as needed and catheter tubing was secured to keep the drainage bag below the level of the resident's bladder as well as off the floor. The catheter was positioned for straight drainage. Observation of Resident #12, on 06/21/18 at 10:43 AM, revealed the resident had an indwelling urine catheter and Certified Nurse Assistant (CNA) #7 performed catheter care. The indwelling catheter was not anchored upon the initiation of catheter care, nor, was it anchored upon completion of the catheter care. Interview with CNA #7, on 06/21/18 at 11:15 AM, revealed she clamped the catheter to the sheets with the plastic clamp that was on the collection bag tubing. She stated she never anchored the catheter tubing to the resident's leg and would put the collection bag through the pant leg of the resident's shorts or pants, depending on what the resident was wearing. Review of Resident #12's Annual Minimum Data Set (MDS), dated [DATE], revealed the facility assessed the resident with Brief Interview of Mental Status (BIMS) score of fifteen (15) out of fifteen (15) and determined the resident interviewable. Interview with Resident #12, on 06/21/18 at 11:20 AM, revealed the indwelling catheter was never attached to his/her leg and staff left it loose. He/she stated the catheter tugged, depending on the type of clothes he/she wore and what he/she was doing. Interview with Licensed Practice Nurse (LPN) #3, on 06/21/18 at 11:23 AM, revealed the facility had a clamp type device that stuck to the resident's leg and held the catheter tubing in place. She stated she would have to obtain one from the supply room for the Resident #12, as the resident took the anchoring device off. Review of Resident #20's Quarterly MDS, dated [DATE], revealed the facility assessed the resident with a BIMS score of fifteen (15) out of fifteen (15) and determined the resident was interviewable. Observation of Resident #20 with LPN #3, on 06/21/18 at 11:25 AM, revealed the resident had an indwelling urinary catheter and the catheter tubing was not secured. Interview with Resident #20, on 06/22/18 at 9:05 AM, revealed he/she did not have a device for securing the indwelling catheter and the catheter was not secured. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation with Central Supply Staff, on 06/22/18 at 9:10 AM, revealed she was not sure if they had any anchoring devices in the supply room, but it should be with the catheter supplies. Upon further search in the supply room, she found an unopened box of twelve (12) urinary catheter holders. Interview with the Center Executive Nurse (CEN), on 07/01/18 at 2:30 PM, revealed the catheter was not required to be anchored to the resident's leg for the purpose of securing the catheter. She stated Resident #20 experienced hemiplegia and hemiparesis and would not be able to tell if the catheter pulled or not. She stated Resident #12 took the securing device off. However, she stated the anchoring device would assist in the prevention of tugging and help to secure the indwelling catheter and aid in the prevention of the catheter being dislodged and replaced.

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31274 Based on interview, record review, facility policy review, and review of the Pharmacy Contract, it was determined the facility failed to have an effective system in place to ensure medications were available and administered to meet the needs for four (4) of twenty-three (23) sampled residents, Residents #23, #38, #40, and #51. Per record review, the facility readmitted Resident #40 on 06/09/18 from the hospital after treatment for Aspiration Pneumonia with an order for the facility to administer an antibiotic and breathing treatment. However, per interview, from 06/10/18 - 06/13/18, the antibiotic was not available for administration. In addition, the resident did not receive all doses of the breathing treatment and the resident was transferred back to the hospital for additional treatment on 06/13/18. According to the Advanced Practice Registered Nurse (APRN), the omission of the antibiotic and breathing treatments negatively affected the resident's condition, which brought about his/her transfer back to the hospital for further treatment. Additional record review revealed Resident #51 had a Physician order, dated 05/22/18, to administer an antibiotic to treat the resident's fatty liver disease. However, per interview, the antibiotic was not available for administration 05/22/18 - 05/29/18. Progress notes revealed the resident experienced periods of confusion and an ammonia level, dated 05/29/18, resulted in an elevated reading of 118 (normal range of 18-75). Per interview, the increased ammonia level, which resulted from failure to receive the antibiotic, caused the increase in confusion and behaviors. In addition, Residents #23 and #38 did not receive medications as ordered. The facility's failure to have an effective system in place to ensure residents received ordered medication, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 06/25/18 and was determined to exist on 05/22/18. The facility was notified of the IJ on 06/25/18. The facility provided an acceptable Allegation of Compliance (AOC) on 06/27/18, which alleged removal of the IJ on 06/28/18. The State Survey Agency (SSA) verified the IJ was removed on 06/28/18, prior to exit on 07/01/18. The Scope and Severity was lowered to a E while the facility develops and implements a Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility's policy, Medication Administration, revised 11/28/17, revealed if medication discrepancies, including medication not available, were identified, staff was to notify the Physician/advanced practice provider and/or the pharmacy. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy, Medication Shortages/Unavailable Medications, revised 01/01/13, revealed upon discovery of an inadequate supply of a medication to administer to a resident, staff should call the pharmacy to determine the status of the order. If the next available delivery caused delay or a missed dose in a resident's medications schedule, the nurse should obtain the medication from the Emergency Medication Supply. If the medication was not available in the Emergency Medication Supply, staff should notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, the nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the Pharmacist on duty to manage the plan of action, which might include emergency delivery or use of an emergency (back up) third party pharmacy. If an emergency delivery was unavailable, the nurse should contact the attending Physician to obtain orders or directions. If the medication was unavailable from the pharmacy or third party pharmacy, and could not be supplied from the manufacturer, the facility should obtain alternate Physician/Prescriber orders, as necessary. Review of the facility's Pharmacy Services Agreement, effective date 04/01/15, revealed the pharmacy agreed to provide services as requested by the facility pursuant to the order of the resident's attending physician or for the facility's account. The pharmacy would furnish and replenish, on a regular basis, an emergency and interim medication supply. The facility would assist the pharmacy in its efforts to allocate inventory removed from the interim supply to individual residents, and the facility agreed to pay the pharmacy directly for contents, which could not be so allocated. The pharmacy agreed to provide medication delivery during regular business hours, and on an emergency basis, twenty-four (24) hours per day/seven (7) days per week, except in circumstances and conditions beyond its control, which included, but not limited to, situations where the pharmacy's manufacturer/supplier was unable to provide the required item and the pharmacy was unable to provide an acceptable alternative. Continued review revealed the facility agreed to use its best efforts to support the provision of services by the pharmacy at all times. The facility agreed it was solely responsible for direct care rendered to the residents for provision of skilled nursing services including all direct and indirect intravenous nursing care, and for all activities necessary for the operation of the facility under applicable federal and state laws. 1. Review of Resident #40's clinical record revealed the facility readmitted the resident on 06/09/18 at 9:10 PM after treatment for Aspiration Pneumonia. Review of the Hospital Discharge Summary, dated 06/09/18, revealed Resident #40 had an order for Clindamycin (antibiotic) 150 milligrams (mg) capsule, three (3) capsules (450 mg) three (3) times a day for four (4) days. In addition, there was an order for Ipratropium-Albuterol (breathing treatment) 3 milliliters (ml) per nebulization three (3) times per day. Review of Resident #40's Progress Notes, dated 06/09/18 to 06/10/18, revealed the Physician was notified of the resident's admission and verified the orders. The nurse faxed the medication list to the pharmacy on 06/10/18 at 2:30 AM, and informed them to send the medication STAT (immediate) and was followed-up with a phone call to ensure the pharmacy received the fax. At 8:40 AM, the nurse called to inform the pharmacy Resident #40's medication had not arrived and reiterated the medication needed to be delivered STAT. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #40's Medication Administration Record (MAR), dated June 2018, revealed Clindamycin 450 mg scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive eight (8) doses of Clindamycin, on 06/10/18 at 8:00 AM, 12:00 PM, and 8:00 PM, 06/11/18 at 8:00 AM and 12:00 PM, 06/12/18 at 8:00 AM and 12:00 PM, and 06/13/18 at 8:00 AM. In addition, Ipratropium-Albuterol was scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive three (3) breathing treatments, on 06/10/18 at 12:00 PM, 12/11/18 at 12:00 PM, and 06/12/18 at 12:00 PM. Further review of the clinical record revealed the resident was transferred back to the hospital on 06/13/18, at approximately 9:00 AM per interview, with an elevated heart rate of 147 (normal 60-100), had difficulty breathing, had a cough, and an oxygenation level of 88% (normal 95%-100% on room air) while on two (2) liters of oxygen. Review of the Hospital Discharge Summary revealed the resident was diagnosed with Aspiration Pneumonia. Interview with the APRN, on 06/22/18 at 12:01 PM, revealed in her professional opinion, Resident #40 missing doses of the antibiotic and breathing treatments from 06/10/18 - 06/13/18, would have negatively impacted Resident #40's condition and necessitated his/her transfer back to the hospital for further treatment. Interview with the Medical Assistant for the Medical Director, on 06/21/18 at 10:15 AM, revealed she thought medications were not always available for administration because nurses would tell her medications were not in the medication cart, and had not been delivered. The Medical Assistant stated she did not think Resident #40 received his/her antibiotic and had to be transferred back to the hospital. Interview with Licensed Practical Nurse (LPN) #3, on 06/22/18 at 11:05 AM, revealed she was under the impression Resident #40's antibiotic had been ordered on 06/09/18; however, the medication was not available on 06/10/18 when she cared for the resident. She stated she did not call the pharmacy to follow up or notify the Center Nurse Executive (CNE), Physician, or APRN. She stated the APRN was in the facility that day, but she did not tell her about the antibiotic not being available and was not sure why because usually she informed the APRN of resident issues. She stated the pharmacy delivery staff delivered to the facility on [DATE] and told her the medication might be on the way, but she did not call the pharmacy to learn the status of the delivery. LPN #3 stated the next time she worked was 06/12/18, and the antibiotic was still not available and she thought she contacted the pharmacy that day, but did not inform the CNE that the antibiotic was still not available. Interview with Registered Nurse (RN) #3, on 06/29/18 at 7:05 AM, revealed she worked the night of 06/11/18 and administered Resident #40's evening dose of Clindamycin from the Emergency Drug Kit (EDK). RN #3 stated after using the EDK supply, there was not enough of the medication left in the EDK for the resident's next dose, so she notified pharmacy to refill the EDK, and also told the pharmacy the resident still needed his/her own supply of the medicine. RN #3 stated she thought she reported to the next shift nurses that she used the EDK supply of Clindamycin, because the doses previously ordered from the pharmacy on 06/10/18 at 2:30 AM, had not been delivered. RN #3 said she left a note for the CNE to inform her that the antibiotic had to be taken from the EDK to administer, as Resident #40's own supply of the antibiotic had not been delivered. Interview with LPN #8, on 06/30/18 at 11:38 AM, revealed she obtained Resident #40's evening does of antibiotic out of the EDK on 06/12/18 because it was not in the medication cart. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with LPN #4, on 06/22/18 at 3:25 PM, revealed on 06/13/18 around 7:30 AM - 7:45 AM, Resident #40 had difficulty breathing, was coughing, and sounded like he/she had mucous in his/her throat. LPN #4 stated the APRN arrived, assessed the resident, and gave orders for the resident to be transferred to the hospital for further evaluation. Interview with the Pharmacist, on 06/21/18 at 2:40 PM, revealed the pharmacy received the order for Resident #40's antibiotic (Clindamycin) on 06/10/18 at 2:00 AM by fax, but the medication was not delivered to the facility until 06/14/18. Continued interview at 3:15 PM revealed the Clindamycin order was cancelled because of a billing issue and with the product's National Drug Code (NDC) number. He stated the drug might have needed to be entered under another NDC number to get approval for payment and obtaining another NDC for the medication did not happen, which the pharmacy was responsible to obtain. He further stated the pharmacy did not call the facility to let them know and did nothing further about the issue until late on 06/13/18, when the facility contacted the pharmacy about non-delivery of the antibiotic. Continued interview with the APRN, on 06/22/18 at 12:01 PM, revealed she thought Resident #40 had received the Clindamycin as scheduled since 06/09/18, and was not informed he/she had not until the morning of 06/13/18, even though she saw the resident on 06/12/18 related to the resident vomiting. The APRN stated on 06/13/18, staff reported the resident was short of air with congestion and an oxygen saturation level of 88%, and she gave the order to transfer the resident to the hospital. Interview with LPN #1/Unit Manager (UM), on 06/22/18 at 1:45 PM, revealed for about two (2) months, she noticed medications would be unavailable for administration, and would call the pharmacy and was informed of billing issues that prevented delivery of the medications. She stated it was the nurse's responsibility to obtain the resident's medicine, and had noticed, during her two (2) months on duty as an LPN, that other nurses did not always notify the provider when medications were not available. The UM stated the EDK did not always have medication needed such as on 06/11/18, there was not enough antibiotic to administer to Resident #40 so the resident went without. Interview with the CNE, on 06/22/18 at 8:10 AM, revealed she was not aware Resident #40 had not received the antibiotic until 06/13/18. She stated she contacted the pharmacy on 06/13/18 to inquire about the resident's antibiotic and was informed the medicine had an incorrect NDC. 2. Review of Resident #51's clinical record revealed the facility admitted the resident on 05/22/18 with a diagnosis of Nonalcoholic Steatohepatitis (NASH-fatty liver). Review of the Physician Orders for Resident #51, dated 05/22/18, revealed Rifaximin (antibiotic) 550 mg by mouth every twelve (12) hours for NASH diagnosis. Review of Resident #51's MAR, dated May 2018, revealed fifteen (15) doses of Rifaximin were documented as not administered. The MAR revealed the 9:00 PM dose on 05/22/18 was blank. The doses scheduled on 05/23/18, 05/24/18, 05/25/18, and 05/26/18 at 9:00 AM and 9:00 PM had circled staff initials. The 9:00 AM dose on 05/27/18 had circled initials and the 9:00 PM dose was blank. The 05/28/18 and 05/29/18 scheduled doses at 9:00 AM and 9:00 PM had circled initials. Interview with the Pharmacist, on 06/28/18 at 11:51 AM, revealed the pharmacy received Resident #51's Rifaximin order on 05/22/18; however, the order was not filled because of a billing issue. He stated the order was delivered to the facility on [DATE]. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Progress Notes for Resident #51 revealed on 05/26/18, the resident was verbalizing confusion from time to time while packing clothes and wanting to go home. On 05/28/18, the resident showed signs of confusion, requiring redirection several times during the day. Review of laboratory results for Resident #51, dated 05/29/18 at 1:00 AM, revealed the resident's ammonia level was elevated at 118 (normal range of 18-75). Interview, on 06/22/18 at 3:45 PM, with LPN #3 revealed she did not administer Resident #51's Rifaximin because it was not available and stated she did not take any action such as call the pharmacy, Physician, and the CNE; however, stated she should have notified all of them. She stated she looked in the EDK but the medication was not there. Interview, on 06/22/18 at 4:35 PM, with LPN #4 revealed the nurse should call the pharmacy when medication was not available and have the medication delivered STAT. She stated intravenous medications, insulin, or any medication that caused a resident to have a negative outcome if not administered should be requested for STAT delivery. Interview, on 06/22/18 at 11:07 AM and 1:49 PM, with the LPN #1/UM revealed she reviewed the May 2018 MAR for Resident #51 and stated there were fifteen (15) doses of Rifaximin not administered, as the doses were circled not available and not administered. She stated the Rifaximin was for the resident's liver disease and the lack of the medication could lead to high ammonia levels and increase the resident's confusion. Interview, on 06/22/18 at 12:01 PM, with the APRN revealed the facility contacted her because Resident #51 was exhibiting increase in behaviors the week after admission and she learned the resident had not been receiving his/her doses of Rifaximin. Continued interview at 4:15 PM revealed she thought the facility had consistent issues with medications not being available for administration. 28733 35750 3. Review of Resident #23's clinical record revealed the facility admitted the resident on 04/27/18, with multiple diagnoses, which included Diabetes Mellitus Type 1. Review of Resident #23's MAR, dated May 2018, revealed an order for Lantus SoloStar Solution Pen-Injector (insulin), 8 units every morning at 8:00 AM for Diabetes, start date 04/28/18 and discontinued on 05/26/18. Continue reviewed revealed an order for Basaglar KwikPen Solution Pen-Injector (insulin), 8 units in the morning at 8:00 AM, start date 05/26/18. Documentation on the MAR revealed the resident did not receive the insulin for two (2) days for treatment of his/her Diabetes, as the Basaglar was not administered on 05/26/18 and 05/27/18. Review of Resident #23's Progress Notes, dated 05/26/18 to 05/28/18, revealed no documentation regarding the missed doses of insulin on 05/26/18 and 05/27/18, nor documentation the Physician was notified of the missed doses. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Continued review of Physician Orders revealed a verbal order, dated 05/29/18, to administered Lantus SoloStar Solution Pen-Injector 8 units until the Basaglar arrived. The order was signed by the APRN on 05/30/18. Interview with LPN #2, on 06/22/18 at 12:05 PM, revealed the pharmacy had a hard time delivering all medications at once and would send two (2) to three (3) medications instead of the entire order. LPN #2 stated if a resident did not receive his/her medication, their condition could get worse. Interview with the APRN, on 06/22/18 at 12:26 PM, revealed she received a request from the pharmacy to change the Lantus SoloStar insulin to Basaglar KwikPen insulin for Resident #23. However, she thought Resident #23 had not received the Basaglar KwikPen insulin for a few days because there was a mix-up with the insurance billing. The APRN stated she was concerned the nurses had not initiated a clarification order after the billing issue became known. Interview with the Center Nurse Executive (CNE) on, 06/22/18 at 8:22 AM, revealed she was aware about an issue with the insurance for Resident #23. However, she was unsure about the exact nature of the issue. She stated she was aware pharmacy would deliver partial medication orders instead of the entire order and the issue was even worse for STAT orders. 38038 4. Review of the clinical record for Resident #38 revealed the facility admitted the resident on 05/11/18, with diagnoses of Chronic Obstructive Pulmonary Disease, Shortness of Breath, Bacterial Pneumonia, and Type 2 Diabetes Mellitus. Review of Resident #38's MAR, dated May 2018, revealed an order for Heparin Sodium 5000 Units every twelve (12) hours for clotting prevention at 9:00 AM and 9:00 PM. Documentation revealed seven (7) doses of the medication were not administered, on 05/12/18 at 9:00 AM and 9:00 PM, 05/13/18 at 9:00 AM, 05/14/18 at 9:00 AM, 05/23/18 at 9:00 PM, and 05/30/18 at 9:00 AM and 9:00 PM. In addition, there was an order for Umeclidinium Bromide Aerosol Powder 62.5 mg, one (1) puff at 9:00 AM daily. Seven (7) doses of the medication were not administered, on 05/12/18, 05/13/18, 05/14/18, 05/19/18, 05/20/18, 05/29/18, and 05/30/18. Further review of the MAR revealed Xopenex Concentrate Nebulization Solution 0.5 ML via nebulizer every six (6) hours at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM. Documentation revealed fourteen (14) doses of the medication were not administered, on 05/12/18 at 2:00 AM, 8:00 AM, 2:00 PM, and 8:00 PM , 05/13/18 at 2:00 AM, 8:00 AM, and 2:00 PM, 05/14/18 at 8:00 AM, 05/16/18 at 2:00 AM, 05/21/18 at 2:00 PM, 05/25/18 at 2:00 AM, 05/26/18 at 2:00 AM, 05/28/18 at 2:00 AM, and 05/30/18 at 8:00 PM. Additional review revealed an order for Advair Diskus Aerosol Powder 250-50 microgram, one (1) puff two (2) times daily at 9:00 AM and 9:00 PM. The medication was not administered on 05/12/18 for either dose or at 9:00 AM on 05/13/18. Interview, on 06/26/18 at 10:44 AM, with LPN #1/UM revealed if staff did not initial a medication was given on the MAR, then it was not administered to the resident. The UM stated circled initials meant the medication was not administered. According to the UM, if staff did not give Resident #38 the Heparin as scheduled, it could result in the formation of a blood clot and failure to administer breathing treatments and inhalers could result in the resident experiencing respiratory distress. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview, on 06/28/18 at 11:51 AM, with the Pharmacist via telephone revealed the pharmacy received Resident #38's medication orders on 05/11/18 at 10:22 PM. He stated the Heparin, breathing treatment, and inhalers were not filled and sent to the facility immediately because there were issues with insurance coverage and the availability of the medications. He stated the Heparin was dispensed on 05/13/18. He revealed he did not have documentation the facility had called to follow-up on the medication orders. Interview with the Medical Director, on 06/21/18 at 11:30 AM, revealed she and the APRN saw residents on a weekly basis and addressed resident care issues brought to their attention. She stated attention was given regarding medication management about one (1) week ago when the APRN expressed concerns about residents not getting their medications, and learned from the CED about issues with not receiving medications timely from the pharmacy. Interview, on 06/21/18 at 4:00 PM, with the APRN revealed she, the Medical Director, and the facility had concerns with residents not receiving medications from the pharmacy. Per interview, they also became aware the nursing staff had not been administering medications to residents because of medications not being delivered to the facility. She stated she and the Medical Director discussed their concerns with the CED, and the facility started providing education to the nursing staff on notifying the prescriber when medications were not available for resident administration. Further interview with CNE, on 06/22/18 at 8:22 AM, revealed she started training nurses on the process of ordering medications. Part of the training was to either call her or the CED if medications were not delivered as expected. She stated the breakdown with deliveries was related to the fact the pharmacy had a lack of delivery drivers and the pharmacy was not meeting residents' medication needs timely. She further stated she escalated the issue up to the corporate nurse. However, the direction she received was to speak about the issue to the pharmacy manager who she already had spoken to and the direction from the corporate nurse was not helpful in resolving the ongoing issue. The CNE stated ultimately, the facility was responsible to assure medications were delivered and received as requested. Interview with the CED, on 06/21/18 at 5:14 PM, revealed there had been consistent issues identified with delayed delivery of medications for newly admitted residents, originally centered around delayed delivery of pain medications. She stated the nursing staff would ask the discharging hospital to provide the resident with a dose of pain medication, if possible, before discharge as they had experienced delays in delivery of medications. The CED stated issues with delayed or non-delivered medications were occurring more often after normal business hours, so the nurses were instructed to call the pharmacy and then notify the CNE or herself. She stated some medications would arrive but not in the four (4) hour window for delivery, as promised. In addition, not all medications ordered for a resident would arrive and the nurses had to frequently follow-up with the pharmacy on the status of medicines that had not been delivered. She stated issues had been discussed with the Pharmacy Manager and he told the CED if nurses did not transmit a newly admitted resident's face sheet/demographics to the pharmacy, it could impede/impact the billing process. She stated the Pharmacy Manager also stated pharmacy staff sometimes had difficulty reaching nurses by phone when clarification of an order or other resident information was needed. The CED stated an audit of residents' medication records was conducted by the CNE on 06/12/18 and about ten (10) residents were identified to have had issues with not receiving medications as ordered. Although meetings were held and some re-education of staff had occurred, the facility had not developed a written plan of action to implement, monitor, and evaluate the process to ensure residents were received their medications. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Continued interview with the CED, on 06/22/18 at 6:53 PM, revealed she had first learned about the pharmacy issue on 05/18/18 and was told medications were not in the EDK. She stated the situation revolved around new admissions and she heard nurses say why should we request medications stat, what is the point of it when the pharmacy did not deliver the medications as expected. She wanted to resolve the issue rather than finger point and recognized additional training for the nurses was needed. The CED revealed the CNE audited some clinical records and found a pattern that went beyond the pharmacy's lack of timely delivery of stat medication orders. The CNE realized nurses would document on the MAR medications were not administered, but would not notify the CNE or herself. The CED stated she knew at this point that pharmacy could not fix this and the facility began retraining on 06/08/18. Continued interview, on 06/26/18 at 3:28 PM with the CED, revealed the facility was ultimately responsible for ensuring care and services were provided in accordance with Physician orders and she was responsible for ensuring services were provided/delivered as agreed upon between the facility and the pharmacy. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. 5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. (continued on next page)

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F 0755 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed they began auditing for availability of medications and documentation of medications on 06/23/18. Record review revealed audits began on 06/23/18 and were signed by the CED or CNE daily. Random audits of the medication carts, conducted by the SSA on 06/30/18, revealed medications were available for randomly selected residents when compared to medications ordered by the Physician. 7. Review of the audit tools revealed missing medications were identified on 06/23/18 and medications were ordered from the pharmacy prior to medication dosages being missed. 8. Review of the sign-in sheet for the additional education related to care plans and following Physician orders revealed all licensed staff signed acknowledgement of education. Posttests reviewed for each of the licensed staff revealed a 100% pass rate. Review of the sign-in sheet for the additional education related to ordering medications for new admissions and re-admissions; re-ordering the EDK; and, the procedure for unavailable medications revealed all licensed staff and two (2) CMTs were educated. Posttests reviewed revealed a 100% pass rate. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had an understanding of the education provided. 9. Interview with the MDS Coordinator, on 06/30/18 at 9:26 AM, revealed she was present at a QAPI meeting and medication issues were discussed. Interviews with the CED on 07/01/18 at 10:33 AM an [TRUNCATED]

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31274 Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system in place to ensure residents were free from significant medication errors for three (3) of twenty-three (23) sampled residents, Residents #38, #40, and #51. The facility readmitted Resident #40 on 06/09/18 from the hospital after treatment for Aspiration Pneumonia with an order for the facility to administer an antibiotic and breathing treatment. From 06/10/18 - 06/13/18, the facility failed to administer the antibiotic as ordered, and did not administer all scheduled breathing treatments, and the resident was transferred back to the hospital for additional treatment on 06/13/18. Per interview with the Advanced Practice Registered Nurse (APRN), the omission of the antibiotics and breathing treatments negatively impacted the resident's condition, which necessitated his/her transfer back to the hospital for further treatment. The facility admitted Resident #51 on 05/22/18 with an order to administer an antibiotic to treat the resident's fatty liver disease. The facility did not administer the antibiotic as ordered 05/22/18 - 05/29/18. Record review revealed the resident experienced periods of confusion and behaviors, and an ammonia level was ordered on 05/29/18 that resulted in an elevated reading of 118 (normal range of 18-75). Per interview, the increased ammonia level, caused by failure to receive the antibiotic, had caused the confusion and behaviors. The facility admitted Resident #38 on 05/11/18 with orders to administer Heparin. However, interview and record review revealed the resident did not receive seven (7) doses of the medication in May 2018. The facility's failure to ensure residents were free of significant medication errors, has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 06/25/18 and was determined to exist on 05/22/18. The facility was notified of the Immediate Jeopardy on 06/25/18. The facility provided an acceptable Allegation of Compliance (AOC) on 06/27/18, which alleged removal of the IJ on 06/28/18. The State Survey Agency (SSA) verified the IJ was removed on 06/28/18, prior to exit on 07/01/18. The Scope and Severity was lowered to a D while the facility develops and implements a Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the facility/s policy, Medication Administration: General, revised 11/28/17, revealed if medication discrepancies, including medication not available, were identified, notify the Physician/advanced practice provider, and/or pharmacy. Review of the facility's policy, Medication Errors, last reviewed 03/01/16, revealed a medication error was identified as a discrepancy between what the Physician/mid-level provider ordered and what the resident received. Types of errors included medication omission; wrong patient, dose, route, rate, or time, incorrect preparation; and/or incorrect administration technique. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's policy, Medication Shortages/Unavailable Medications, revised 01/01/13, revealed upon discovery that the facility had an inadequate supply of a medication to administer to a resident, staff should call the pharmacy to determine the status of the order. If the medication had not been ordered, the nurse should place the order, or reorder, for the next scheduled delivery. If the next available delivery caused delay or a missed dose in a resident's medication schedule, the nurse should obtain the medication from the Emergency Medication Supply to administer the dose. If the medication was not available in the Emergency Medication Supply, staff should notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, the nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the Pharmacist on duty to manage the plan of action, which might include emergency delivery or use of an emergency (back up) third party pharmacy. If an emergency delivery was unavailable, the nurse should contact the attending Physician to obtain orders or directions. If the medication was unavailable from the pharmacy or third party pharmacy, and could not be supplied from the manufacturer, the facility should obtain alternate Physician/Prescriber orders, as necessary. 1. Review of Resident #40's clinical record revealed the facility readmitted the resident on 10/27/17, with multiple diagnoses, which included a history of Respiratory Failure and Pneumonitis (lung inflammation) due to Inhalation of Food and Vomit. The resident transferred to the hospital on 06/05/18 for low oxygenation, a pulse of 174, coughing up white thick sputum, and altered level of consciousness, and transferred back to the facility on [DATE] at 9:10 PM. Review of the nurses' notes revealed staff contacted the Physician and verified orders. Review of the Hospital Discharge Summary, dated 06/09/18, revealed Resident #40 was treated for Aspiration Pneumonia and had an order for Clindamycin (antibiotic) 150 milligrams (mg) capsule, three (3) capsules (450 mg), three (3) times a day for four (4) days. In addition, there was an order for Ipratropium-Albuterol (breathing treatment) 3 milliliters (ml) per nebulization three (3) times per day. Review of the Progress Notes, dated 06/10/18 at 2:30 AM, revealed the nurse faxed the medication list to the pharmacy and notified pharmacy to STAT (immediately) deliver the medications. According to the documentation, the nurse called the pharmacy and she left message to call and confirm receipt of the faxed orders. Continued review of the notes revealed on 06/10/18 at 8:40 AM, the nurse called the pharmacy and informed them the medications for Resident #40 had not been received. The pharmacy indicated the order was not sent as a STAT request for delivery, but the nurse reiterated the order faxed stated to please STAT the medications. The note also revealed pharmacy staff informed the nurse the medications would be sent as soon as possible. Review of Resident #40's Medication Administration Record (MAR), dated June 2018, revealed Clindamycin 450 mg scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the Clindamycin on 06/10/18 at 8:00 AM, 12:00 PM, and 8:00 PM, 06/11/18 at 8:00 AM and 12:00 PM, 06/12/18 at 8:00 AM and 12:00 PM, and 06/13/18 at 8:00 AM. In addition, Ipratropium-Albuterol 3 ml was scheduled for 8:00 AM, 12:00 PM, and 8:00 PM. Documentation revealed the resident did not receive the breathing treatment on 06/10/18 at 12:00 PM, 12/11/18 at 12:00 PM, and 06/12/18 at 12:00 PM. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Further review of the clinical record and interview with Licensed Practical Nurse (LPN) #4, on on 06/22/18 at 3:25 PM, revealed the resident was transferred back to the hospital, on 06/13/18 between 8:30 AM - 9:00 AM, with an elevated heart rate of 147, difficulty breathing with a cough, and an oxygenation level of 88% while on two (2) liters of Oxygen. Review of the Hospital Discharge Summary revealed the resident was diagnosed with Aspiration Pneumonia. Interview with LPN #3, on 06/22/18 at 11:05 AM, revealed she cared for Resident #40 on 06/10/18 and 06/12/18. LPN #3 stated she thought Resident #40's antibiotic was ordered on 06/09/18; however, the medication was not delivered on 06/10/18. She stated she did not call the pharmacy to follow-up when she realized she did not have the medication for the resident, nor did she notify the Center Nurse Executive (CNE), Physician, or APRN. LPN #3 stated when she came back to work on 06/12/18, Resident #40's antibiotic was still not available and she thought she contacted the pharmacy that day, but did not inform the CNE the antibiotic had not been delivered. Interview with Registered Nurse (RN) #3, on 06/29/18 at 7:05 AM, revealed she worked the night of 06/11/18 and administered Resident #40's evening dose of Clindamycin from the Emergency Drug Kit (EDK). RN #3 stated after using the EDK supply there was not enough of the medication left for another dose and she notified the pharmacy to refill the EDK and that the resident still needed his/her own supply of the medication. RN #3 stated she thought she left a note for the CNE informing her she had to use the EDK supply for Resident #40's night dose of antibiotic. Interview with LPN #8, on 06/30/18 at 11:38 AM, revealed she obtained Resident #40's evening does of antibiotic out of the EDK on 06/12/18 because it was not in the medication cart. Interview with LPN #4, on 06/22/18 at 3:25 PM, revealed she observed Resident #40 on 06/13/18 around 7:30 AM - 7:45 AM and he/she seemed to have difficulty breathing, was coughing, and sounded like he/she had mucous in his/her throat. LPN #4 stated the APRN arrived shortly, assessed Resident #40, and ordered the resident transferred to the hospital for further evaluation approximately 8:30 AM - 9:00 AM. Interview with the APRN, on 06/22/18 at 12:01 PM, revealed she did not learn Resident #40 had not received the Clindamycin until the morning of 06/13/18, even though she had been in to see the resident on 06/12/18 related to vomiting the resident had the day before. The APRN stated on 06/13/18, staff reported the resident was short of air, had congestion and an oxygen saturation of 88%, and she gave the order to transfer the resident to the hospital. Continued interview at 4:15 PM revealed she thought the facility had been having consistent issues with medications not being administered due to lack of availability of the medications. She further stated in her professional opinion, the omission of the antibiotics and breathing treatments, as ordered for the time period from 06/10/18 - 06/13/18, would have negatively impacted the resident's condition on 06/13/18, which necessitated his/her transfer back to the hospital for further treatment in the acute care setting. Interview with the Medical Director, on 06/21/18 at 11:30 AM, revealed Resident #40 missed scheduled doses of an antibiotic and had to be transferred back to the hospital. She stated the antibiotic was ordered but the pharmacy did not deliver the medication. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with LPN #1/Unit Manager (UM), on 06/22/18 at 1:45 PM, revealed on 06/11/18, during the day shift, Resident #40's medication was not available and she checked the EDK, but there was not enough of the antibiotic to provide a full dose. She notified the APRN the medicine was not available, but she did not document the notification. The UM stated when a medicine was not available for administration at the scheduled time, the nurse should try to obtain the medicine. She stated the nurse should notify the pharmacy to send the medicine, and the prescriber in case he or she would want to give additional orders. The UM further stated the nurse should notify the CNE and the Center Executive Director (CED), so they would be aware of the delayed deliveries and further address the matter with the pharmacy staff. Interview with the CNE, on 06/26/18 at 1:45 PM, revealed it was very concerning to her that Resident #40's medications were not administered. She stated nurses should administer medication as ordered by the Physician and if not, the nurse should make it clear in the clinical record why the medication was not administered. She stated if the resident refused medications or the medication was not effective, then that information should be documented and communicated so the providers and other members of the Interdisciplinary Team could attempt other care interventions. 28733 2. Review of Resident #51's clinical record revealed the facility admitted the resident on 05/22/18, with a diagnosis of Nonalcoholic Steatohepatitis (NASH-fatty liver). Review of the Physician Orders for Resident #51, dated 05/22/18, revealed Rifaximin (antibiotic) 550 mg by mouth every twelve (12) hours for NASH diagnosis. Review of Resident #51's MAR, dated May 2018, revealed fifteen (15) doses of Rifaximin were documented as not administered. The MAR revealed the 9:00 PM dose on 05/22/18 was blank. The doses scheduled on 05/23/18, 05/24/18, 05/25/18, and 05/26/18 at 9:00 AM and 9:00 PM had circled staff initials. The 9:00 AM dose on 05/27/18 had circled initials and the 9:00 PM dose was blank. The 05/28/18 and 05/29/18 scheduled doses at 9:00 AM and 9:00 PM had circled initials. Interview with the Pharmacist, on 06/28/18 at 11:51 AM, revealed the pharmacy received Resident #51's Rifaximin order on 05/22/18; however, the order was not filled because of a billing issue. He stated the order was delivered to the facility on [DATE]. Interview with LPN #3, on 06/22/18 at 3:45 PM, revealed when medication was not available for administration; staff initialed the MAR and circled the initials, which indicated the medication was not given. LPN #3 stated she did not do anything about Resident #51's missing Rifaximin such as call the pharmacy, Physician, or the CNE; however, she stated she should have notified all of them. She stated she looked in the EDK but Rifaximin was not there. She stated by not receiving the medication, the resident was not treated for his/her liver disease. Review of laboratory results for Resident #51, dated 05/24/18 at 12:50 AM, revealed the resident's ammonia level was elevated at 98 (normal range of 18-75). The Practitioner noted on the results to check the ammonia level again on 05/29/18. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Progress Notes for Resident #51, dated 05/26/18 at 3:55 PM, revealed the resident was verbalizing confusion from time to time, while packing clothes and wanting to go home. The Practitioner was notified and a new order obtained for a STAT ammonia level. Review of laboratory results, dated 05/26/18, revealed an ammonia level of 52. Review of the Progress Notes, dated 05/28/18 at 5:41 PM, revealed Resident #51 showed signs of confusion, requiring redirection several times during the day. The resident was taking his/her dressing off his/her foot and rolling away in his/her wheelchair from the intravenous (IV) pump/pole while the IV was infusing. Review of the follow-up ammonia laboratory results for Resident #51, dated 05/29/18 at 1:00 AM, revealed the resident's ammonia level was elevated at 118. Interview with LPN #4, on 06/22/18 at 4:35 PM, revealed the Rifaximin was for Resident #51's ammonia level and he/she did not benefit by the omission of his/her medication. Interview with LPN #1/UM, on 06/22/18 at 11:07 AM and 1:49 PM, revealed missing medications should be reported to the Physician, the pharmacy so it was placed on a STAT delivery, the responsible party, the CNE, and the CED. She stated as she reviewed the May 2018 MAR for Resident #51, there were fifteen (15) doses of Rifaximin not administered as the doses were circled not available and not administered. This was a significant medication error as a result of the omission of the Rifaximin, which contributed to elevated ammonia levels. She stated the Rifaximin treated Resident #51's liver disease and the lack of the medication could increase the resident's confusion. Continued interview, on 06/26/18 at 10:55 AM, revealed she was supposed to follow-up on all resident orders and monitor the MARs for holes/omissions. However, she stated she had been working on the floor and had not had an opportunity to monitor. Interview with the CNE, on 06/26/18 at 1:46 PM, revealed she was very concerned about missed medications for Resident #51 because the increased serum ammonia levels, caused by failure to receive the Rifaximin, had caused confusion and behavioral changes in the resident. She further stated the increased confusion could lead to refusal of other necessary care and treatment. She stated the facility failed to prevent a significant medication error and provide the resident with the care and services to meet his/her healthcare needs. Interview with the APRN, on 06/22/18 at 12:01 PM, revealed the facility contacted her about Resident #51 exhibiting an increase in behaviors the week after his/her admission. She stated it was around that time she learned the resident had not been receiving the Rifaximin for management of his/her fatty liver disease. She stated she ordered a urinalysis to rule out a Urinary Tract Infection and a serum ammonia level, which resulted as elevated at 118. She stated the high normal for serum ammonia was 75, and the elevated ammonia level could have been the result of the failure to administer the Rifaximin. 3. Review of the clinical record for Resident #38 revealed the facility admitted the resident on 05/11/18, with diagnoses of Chronic Obstructive Pulmonary Disease, Shortness of Breath, Bacterial Pneumonia, and Type 2 Diabetes Mellitus. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #38's MAR, dated May 2018, revealed an order for Heparin Sodium 5000 Units every twelve (12) hours at 9:00 AM and 9:00 PM. Documentation revealed seven (7) doses of the medication were not administered, on 05/12/18 at 9:00 AM and 9:00 PM, 05/13/18 at 9:00 AM, 05/14/18 at 9:00 AM, 05/23/18 at 9:00 PM, and 05/30/18 at 9:00 AM and 9:00 PM. Interview, on 06/28/18 at 11:51 AM, with the Pharmacist via telephone revealed the pharmacy received Resident #38's medication orders on 05/11/18 at 10:22 PM. He stated the Heparin was not filled and sent to the facility immediately because there were issues with insurance coverage. He stated the Heparin was dispensed on 05/13/18. He revealed he did not have documentation the facility had called to follow-up on the medication orders. Interview, on 06/26/18 at 10:44 AM, with LPN #1/UM revealed if staff did not give Resident #38 the Heparin as scheduled, it could result in the formation of a blood clot. Interview with the CED, on 06/22/18 at 8:50 AM, revealed the facility tracked medication errors, such as wrong doses, wrong medication given, or a medication given by the wrong route, but the facility had not been completing medication error forms when medications were not administered. Therefore, the facility had not been tracking the medication omissions. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. 5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. Additional education of licensed staff and two (2) CMTs was completed on 06/25/18. Education included procedure for sending medication orders to pharmacy; procedure for unavailable medications including refusals and notification of the pharmacy and physicians; when to notify the CNE and CED of unavailable medications; and the care plan process of revising and implementing the care plan with new orders. Posttests provided to validate understanding. 9. On 06/25/18, an adHoc QAPI meeting was conducted with the CED, the CNE, and the Medical Director to review additional education conducted. 10. Beginning 06/26/18, the Pharmacy Program Manager would contact the facility daily, including weekends, and speak with the CED, the CNE, or Registered Nurse (RN) Charge Nurse to confirm any medications needed would be sent to the facility stat (immediately). 11. On 06/26/18, the facility's EDK was re-stocked. 12. The CNE, CED, and/or Unit Manager will monitor MARs, conduct observations, and ensure daily communications occur with the Pharmacy Program Manager daily times two (2) weeks across all shifts; then three (3) times weekly for two (2) weeks; then weekly for two (2) months; then bi-weekly for two (2) months; and, then monthly for one (1) month to ensure medications were available as prescribed and the care plans were being followed. 13. The Regional [NAME] President of Operations and/or the Clinical Quality Specialist will review the QAPI minutes monthly for six (6) months and ongoing thereafter to ensure audits, education, and in-services are completed as needed. The SSA validated the facility implemented the following actions: 1. Record review of the MARs for Resident #51 revealed he/she had received all medications since 05/30/18 as ordered. 2. Record review revealed Resident #40 was no longer in the facility. 3. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had received and had an understanding of the education. Review of the sign-in sheet for the in-service education provided between 06/11/18 - 06/21/18 revealed all licensed staff and two (2) CMTs signed acknowledgement of the education. 4. Interview with the CNE, on 07/01/18 at 2:17 PM, revealed she completed medication audits for all resident MARs and documented twelve (12) residents had missed medications for June 2018. The Audit tool was reviewed against the MARs for the residents identified with missed medications. 5. Record review revealed assessments were completed for eleven (11) of the twelve (12) identified residents. The twelfth resident had been discharged home at the time of the discovery. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	6. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed they began auditing for availability of medications and documentation of medications on 06/23/18. Record review revealed audits began on 06/23/18 and were signed by the CED or CNE daily. Random audits of the medication carts, conducted by the SSA on 06/30/18, revealed medications were available for randomly selected residents when compared to medications ordered by the Physician. 7. Review of the audit tools revealed missing medications were identified on 06/23/18 and medications were ordered from the pharmacy prior to medication dosages being missed. 8. Review of the sign-in sheet for the additional education related to care plans and following Physician orders revealed all licensed staff signed acknowledgement of education. Posttests reviewed for each of the licensed staff revealed a 100% pass rate. Review of the sign-in sheet for the additional education related to ordering medications for new admissions and re-admissions; re-ordering the EDK; and, the procedure for unavailable medications revealed all licensed staff and two (2) CMTs were educated. Posttests reviewed revealed a 100% pass rate. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had an understanding of the education provided. 9. Interview with the MDS Coordinator, on 06/30/18 at 9:26 AM, revealed she was present at a QAPI meeting and medication issues were discussed. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed they discussed medication issues in the QAPI meeting held on 06/25/18. Review of the sign-in sheet for the QAPI meeting on 06/25/18 revealed the MDS Coordinator, the CED, the CNE, and the Medical Director attended the meeting. 10. Interview with the CED, on 07/01/18 at 10:33 AM, revealed conversations with pharmacy were occurring daily. Review of the log documenting daily pharmacy phone calls revealed calls occurred daily as alleged. 11. Observation of the EDK revealed the box had been refilled. Interview with the Unit Manager, on 06/30/18 at 11:10 AM, revealed if staff took medication out of the EDK, staff filled out a form and faxed it to the pharmacy. If the entire stock of the medication was used, pharmacy refilled the EDK the same day. 12. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed audits of the MARs and Physician orders would continue as outlined in the AOC. Review of the audits revealed the CNE or CED audited the MARs and Physician orders daily beginning 06/23/18. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13. Observations during the AOC validation revealed the Clinical Quality Specialist (CQS) was in the facility daily assisting with MAR/TAR audits and medication cart audits. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed the CQS or Regional [NAME] President would review QAPI minutes monthly. Review of the most recent QAPI sign-in sheet revealed the CQS attended the meeting.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40244 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure medications were labeled with the date opened and remained secured in locked compartments and inaccessible to residents and other unauthorized persons for one (1) of two (2) medication carts, the South Hall. The findings include: Review of the facility's policy, Storage and Expiration Dating Medications, Biologicals, Syringes and Needles, revised [DATE], revealed staff should record the date opened on the medication container when the medication had a shortened expiration date once opened. The policy further revealed the facility should ensure all medications and biologicals, including treatment items, were securely stored in a locked cabinet/cart or locked medication room that was inaccessible by residents or visitors. Observation of the South Hall medication cart, on [DATE] at 10:30 AM, revealed three (3) insulin flex pens were opened and not labeled with the date opened. Interview with Licensed Practical Nurse (LPN) #2, on [DATE] at 10:30 AM, revealed nurses should label insulin flex pens with the date opened as soon as they were opened to ensure residents received therapeutic doses of insulin and not expired insulin. Interview with LPN #1/Unit Manager (UM), on [DATE] at 10:30 AM, revealed the three (3) insulin flex pens in the medication cart on South Hall were not dated when opened, as was the facility policy to date insulin when first opened. The UM stated it was her responsibility to audit all medication carts to ensure expired and undated medications were removed for the cart. She was not able to recall the date the last audit was conducted and the results were not documented. The UM stated she had not had time to do education with staff on removing expired medication or ensuring opened medications were labeled due to working the floor often. She further stated she would be concerned that unlabeled insulin was in the medication cart because it would be difficult to determine when it expired, which could result in the resident receiving ineffective insulin. Interview with the Center Nurse Executive (CNE), on [DATE] at 3:25 PM, revealed she was not aware of the three (3) insulin flex pens not dated when opened. She stated she would be concerned about insulin flex pens not being labeled with the date opened because of the inability to maintain their integrity; and to support safe effective drug administration. The CNE stated education had been done with nurses but not documented and it was the responsibility of the UM and night shift supervisor to audit medication carts for expired or non-dated medication and remove them. However, she stated the audits were not documented and there was no specific schedule regarding the audits. In addition, the CNE stated the Pharmacy recently conducted a medication cart audit; however, the purpose was to ensure all medications needed for residents were available and she was unsure if they checked for unlabeled medications. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	31274 Observation, on [DATE] at 3:55 PM, near the South Hall nurses' station revealed an unlocked and unattended medication cart. Interview, on [DATE] at 4:15 PM, with LPN #3 revealed she was responsible for both medication carts on the South Hall and did not realize one of them was left unlocked. She stated the cart should remain locked when not in use to prevent residents from having access to the medications stored in the cart. Continued interview, on [DATE] at 11:25 AM, with the UM revealed medication carts should remain locked when not in use to prevent residents, visitors, or unauthorized staff from having access to the medications inside the carts. Continued interview with the CNE, on [DATE] at 1:45 PM, revealed leaving medication carts unlocked when the nurse was not using them was unacceptable because resident and visitors would have access to the medications inside the unlocked carts. She stated the medication carts should remain locked when not in use. The CNE stated when she made rounds on the units she checked to ensure all carts were locked and medications were secured to ensure resident and visitor safety.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35750 Based on observation, interview, and facility policy review, it was determined the facility failed to prepare and distribute food under sanitary conditions. Observation revealed three (3) dietary staff did not have all hair covered while in the kitchen. In addition, there was a dirty fan blowing in the kitchen with uncovered food on the counter. The findings include: Review of the facility's policy, Staff Attire, revised September 2017, revealed all staff would have their hair off the shoulders, confined in a hairnet or cap, and facial hair properly restrained. Review of the facility's policy, Personal Hygiene, revised 12/01/15, revealed hair restraints such as hats, hair coverings, or nets were worn to effectively keep hair from contacting exposed food. Observation of the kitchen, on 06/19/18 at 8:10 AM, revealed the Cook's hairnet did not cover her entire hair as bangs were hanging out during food preparation for breakfast. Observation of the kitchen, on 06/19/18 at 9:35 AM, revealed the Dietary Aide's hairnet did not cover her bangs. Observations of the kitchen, on 06/19/18 at 12:16 PM and 4:56 PM, revealed the Director of Dining Services (DDS) hair at the back of her head was uncovered. Observation of the kitchen, on 06/20/18 at 10:37 AM, revealed a large fan covered with dust particles blew air while uncovered pie slices were defrosting on the kitchen counter. Interview with the Cook, on 06/21/18 at 11:44 AM, revealed she was unaware all her hair was not covered. She stated hair should be covered to prevent hair from getting into the residents' food. Interview with the DDS, on 06/20/18 at 10:11 AM, revealed all kitchen staff had to wear either hair bonnets, hairnets, or a scarf to cover the entire scalp hair to prevent hair from falling in the food. However, she stated she was expected to wear a Chef's hat that only covered the top of her head. The DDS stated she was usually in the office but when she cooked, she put her hair up. She stated because hair was exposed during food preparation, the facility policy was not followed. Further interview at 11:47 AM revealed it was not sanitary for a dirty fan to blow air towards uncovered food and the frozen pie slices should have been covered. 31274 Interview, on 06/26/18 at 9:44 AM, with the Center Executive Director (CED) revealed the DDS was responsible for ensuring kitchen staff kept hair covered while working in the kitchen and for ensuring staff was educated on the importance of keeping hair restrained. In addition, she stated the DDS was responsible for ensuring soiled equipment was identified and ensure staff cleaned any soiled equipment.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. 31274 Based interview, record review, facility policy review, and review of the job description for the Center Executive Director, it was determined the facility failed to be effectively administered in a manner that enabled effective use of resources to attain and maintain the highest practicable physical, mental, and psycho-social wellbeing for three (3) of twenty-three (23) sampled residents, Residents #38, #40 and #51. The facility failed to procure medications for administration as ordered by the residents' physician. Record review revealed Resident #40 had a Physician order for Clindamycin (antibiotic) for treatment of Pneumonia, with a start date of 06/10/18. In addition, the resident had an order to receive a breathing treatment. However, the resident did not receive all doses of the antibiotic nor breathing treatments between 06/10/18 - 06/13/18. The resident was transferred to the hospital on 06/13/18 for difficulty breathing, an elevated heart rate, and a decrease in blood oxygenation. Resident #51 had a Physician order to receive Rifaximin (antibiotic) for the treatment of his/her fatty liver disease with a start date of 05/22/18. However, the resident did not receive fifteen (15) doses of the medication between 05/22/18 - 05/29/18. The resident had documented periods of confusion and an elevated ammonia level during the time when the medication was not administered, which according to interview was a result of not receiving the antibiotic. The facility admitted Resident #38 on 05/11/18 with orders to administer Heparin. However, interview and record review revealed the resident did not receive seven (7) doses of the medication in May 2018. The facility's failure to be administered in an effective manner to ensure procurement of medications for administration to residents has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 06/25/18, and determined to exist on 05/22/18. The facility was notified of the Immediate Jeopardy on 06/25/18. The facility provided an acceptable Credible Allegation of Compliance on 06/27/18, alleging the removal of Immediate Jeopardy on 06/28/18. The State Survey Agency verified Immediate Jeopardy was removed on 06/28/18 as alleged, prior to exit on 07/01/18. The Scope and Severity was lowered to a E while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the Job Description for the Center Executive Director (CED), effective 01/01/16, revealed the CED would create an environment where staff members were highly engaged and focused on providing the highest level of clinical care and compassion to patients, residents, and families. The CED would administer and coordinate all activities of the facility to assure the highest degree of quality of care was consistently provided to residents, subject to the rules and regulations promulgated by government agencies to ensure residents received the proper services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy, Medication Shortages/Unavailable Medications, revised 01/01/13, revealed upon discovery of an inadequate supply of a medication to administer to a resident, staff should call the pharmacy to determine the status of the order. If the next available delivery caused delay or a missed dose in a resident's medications schedule, the nurse should obtain the medication from the Emergency Medication Supply. If the medication was not available in the Emergency Medication Supply, staff should notify the pharmacy and arrange for an emergency delivery. If a medication shortage was discovered after normal pharmacy hours, the nurse should obtain the ordered medication from the Emergency Medication Supply. If the ordered medication was not available in the Emergency Medication Supply, the nurse should call the pharmacy's emergency answering service and request to speak with the Pharmacist on duty to manage the plan of action, which might include emergency delivery or use of an emergency (back up) third party pharmacy. If an emergency delivery was unavailable, the nurse should contact the attending Physician to obtain orders or directions. If the medication was unavailable from the pharmacy or third party pharmacy, and could not be supplied from the manufacturer, the facility should obtain alternate Physician/Prescriber orders, as necessary. Review of the facility's Pharmacy Services Agreement, effective date 04/01/15, revealed the pharmacy agreed to provide services as requested by the facility pursuant to the order of the resident's attending physician or for the facility's account. The pharmacy would furnish and replenish, on a regular basis, an emergency and interim medication supply. The facility would assist the pharmacy in its efforts to allocate inventory removed from the interim supply to individual residents, and the facility agreed to pay the pharmacy directly for contents, which could not be so allocated. The pharmacy agreed to provide medication delivery during regular business hours, and on an emergency basis, twenty-four (24) hours per day/seven (7) days per week, except in circumstances and conditions beyond its control, which included, but not limited to, situations where the pharmacy's manufacturer/supplier was unable to provide the required item and the pharmacy was unable to provide an acceptable alternative. Continued review revealed the facility agreed to use its best efforts to support the provision of services by the pharmacy at all times. The facility agreed it was solely responsible for direct care rendered to the residents for provision of skilled nursing services including all direct and indirect intravenous nursing care, and for all activities necessary for the operation of the facility under applicable federal and state laws. Review of the clinical record for Resident #40 revealed the facility readmitted the resident on 06/09/18, after a hospitalization for treatment of Aspiration Pneumonia. Post-hospitalization orders included Clindamycin three (3) times a day for four (4) days and Duoneb three (3) times daily for continued management of his/her compromised lung status. The facility ordered the Clindamycin on 06/10/18, but the pharmacy did not deliver the medication until 06/14/18, four (4) days later. The resident received only two (2) doses of the Clindamycin from 06/10/18 to 06/13/18, and according to interviews with licensed nurses, staff obtained those two (2) doses from the facility's Emergency Drug Kit (EDK). Further review of the clinical record for Resident #40 revealed the resident did not receive all scheduled breathing treatments from 06/10/18 - 06/13/18. The facility transferred Resident #40 back to the hospital on the morning of 06/13/18 with an elevated heart rate of 147 beats per minute, shortness of air, congestion, and a blood oxygen saturation of 88% while receiving oxygen at 2 liters per minute. (continued on next page)

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	185333	A. Building B. Wing	07/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of clinical record for Resident #51 revealed the facility admitted the resident on 05/22/18 multiple diagnoses which included Nonalcoholic Steatohepatitis (NASH-fatty liver). Review of the Physician Orders for Resident #51, dated 05/22/18, revealed Rifaximin (antibiotic) 550 mg by mouth every twelve (12) hours for NASH diagnosis. However, continued review of the clinical record revealed from 05/22/18 - 05/29/18 no scheduled doses of Rifaximin, for management of diagnosed fatty liver disease, were administered. During this time period the resident exhibited periods of confusion, as documented in the clinical record. The facility contacted the APRN, who ordered a urinalysis and labs which revealed Resident #51 experienced elevated Serum Ammonia levels during the time when the Rifaximin was not administered. Interview with the CED, on 06/22/18 at 6:50 PM, revealed the facility leadership became aware the week of 05/07/18, the contracted pharmacy was not delivering ordered medications for newly admitted residents. Additionally, medications ordered and requested for STAT delivery from contracted pharmacy, were not delivered in the specified four (4) hour time frame. The CED stated she had not instructed nursing leadership to conduct audits of the residents' Medication Administration Records (MARs) during the month of May, when she learned there were delays in the delivery of medications. The CED stated a conference call with the pharmacy was held on 05/18/18, and an in-person meeting occurred on 06/08/18, to discuss medications not delivered as delineated in the facility contract with the pharmacy, as well as the issues of non-timely refilling of the EDK. The CED stated she learned, during these meetings, the facility contract with the pharmacy allowed for a back-up, third party pharmacy option for obtaining medications. The CED further stated the Center Nurse Executive (CNE) managed the nursing staff and the CNE should ensure the nurses notified the pharmacy, the prescribers, and the nursing and administrative leadership when there were issues with non-timely delivery of scheduled medications. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. 5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. 8. Additional education of licensed staff and two (2) CMTs was completed on 06/25/18. Education included procedure for sending medication orders to pharmacy; procedure for unavailable medications including refusals and notification of the pharmacy and physicians; when to notify the CNE and CED of unavailable medications; and the care plan process of revising and implementing the care plan with new orders. Posttests provided to validate understanding. 9. On 06/25/18, an adHoc QAPI meeting was conducted with the CED, the CNE, and the Medical Director to review additional education conducted. 10. Beginning 06/26/18, the Pharmacy Program Manager would contact the facility daily, including weekends, and speak with the CED, the CNE, or Registered Nurse (RN) Charge Nurse to confirm any medications needed would be sent to the facility stat (immediately). 11. On 06/26/18, the facility's EDK was re-stocked. 12. The CNE, CED, and/or Unit Manager will monitor MARs, conduct observations, and ensure daily communications occur with the Pharmacy Program Manager daily times two (2) weeks across all shifts; then three (3) times weekly for two (2) weeks; then weekly for two (2) months; then bi-weekly for two (2) months; and, then monthly for one (1) month to ensure medications were available as prescribed and the care plans were being followed. 13. The Regional [NAME] President of Operations and/or the Clinical Quality Specialist will review the QAPI minutes monthly for six (6) months and ongoing thereafter to ensure audits, education, and in-services are completed as needed. The SSA validated the facility implemented the following actions: 1. Record review of the MARs for Resident #51 revealed he/she had received all medications since 05/30/18 as ordered. 2. Record review revealed Resident #40 was no longer in the facility. 3. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had received and had an understanding of the education. Review of the sign-in sheet for the in-service education provided between 06/11/18 - 06/21/18 revealed all licensed staff and two (2) CMTs signed acknowledgement of the education. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	4. Interview with the CNE, on 07/01/18 at 2:17 PM, revealed she completed medication audits for all resident MARs and documented twelve (12) residents had missed medications for June 2018. The Audit tool was reviewed against the MARs for the residents identified with missed medications. 5. Record review revealed assessments were completed for eleven (11) of the twelve (12) identified residents. The twelfth resident had been discharged home at the time of the discovery. 6. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed they began auditing for availability of medications and documentation of medications on 06/23/18. Record review revealed audits began on 06/23/18 and were signed by the CED or CNE daily. Random audits of the medication carts, conducted by the SSA on 06/30/18, revealed medications were available for randomly selected residents when compared to medications ordered by the Physician. 7. Review of the audit tools revealed missing medications were identified on 06/23/18 and medications were ordered from the pharmacy prior to medication dosages being missed. 8. Review of the sign-in sheet for the additional education related to care plans and following Physician orders revealed all licensed staff signed acknowledgement of education. Posttests reviewed for each of the licensed staff revealed a 100% pass rate. Review of the sign-in sheet for the additional education related to ordering medications for new admissions and re-admissions; re-ordering the EDK; and, the procedure for unavailable medications revealed all licensed staff and two (2) CMTs were educated. Posttests reviewed revealed a 100% pass rate. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had an understanding of the education provided. 9. Interview with the MDS Coordinator, on 06/30/18 at 9:26 AM, revealed she was present at a QAPI meeting and medication issues were discussed. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed they discussed medication issues in the QAPI meeting held on 06/25/18. Review of the sign-in sheet for the QAPI meeting on 06/25/18 revealed the MDS Coordinator, the CED, the CNE, and the Medical Director attended the meeting. 10. Interview with the CED, on 07/01/18 at 10:33 AM, revealed conversations with pharmacy were occurring daily. Review of the log documenting daily pharmacy phone calls revealed calls occurred daily as alleged. 11. Observation of the EDK revealed the box had been refilled. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the Unit Manager, on 06/30/18 at 11:10 AM, revealed if staff took medication out of the EDK, staff filled out a form and faxed it to the pharmacy. If the entire stock of the medication was used, pharmacy refilled the EDK the same day. 12. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed audits of the MARs and Physician orders would continue as outlined in the AOC. Review of the audits revealed the CNE or CED audited the MARs and Physician orders daily beginning 06/23/18. 13. Observations during the AOC validation revealed the Clinical Quality Specialist (CQS) was in the facility daily assisting with MAR/TAR audits and medication cart audits. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed the CQS or Regional [NAME] President would review QAPI minutes monthly. Review of the most recent QAPI sign-in sheet revealed the CQS attended the meeting.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 31274 Based on interview, record review, and review of the facility's policy, it was determined the governing body for the facility failed to effectively ensure full and timely implementation of policies and procedures for addressing a systems failure related to administration of residents' medications. The facility recognized the week of 05/07/18, the pharmacy was not delivering residents' medications per the agreed upon time frames and nursing staff was not administering medications, as ordered by the prescriber(s). Record review revealed Resident #40 had a Physician order for Clindamycin (antibiotic) for treatment of Pneumonia, with a start date of 06/10/18, and an order to receive a breathing treatment. However, the resident did not receive all doses of the antibiotic nor breathing treatments between 06/10/18 - 06/13/18. The resident was transferred to the hospital on 06/13/18 for difficulty breathing, an elevated heart rate, and a decrease in blood oxygenation. Resident #51 had a Physician order to receive Rifaximin (antibiotic) for the treatment of his/her fatty liver disease with a start date of 05/22/18. However, the resident did not receive fifteen (15) doses of the medication between 05/22/18 - 05/29/18. The resident had periods of confusion and an elevated ammonia level during the time when the medication was not administered, which according to interview was a result of not receiving the antibiotic. The facility admitted Resident #38 on 05/11/18 with orders to administer Heparin. However, interview and record review revealed the resident did not receive seven (7) doses of the medication in May 2018. The facility's governing body's failure to ensure full and timely implementation of policies and procedures for addressing system failures related to medication administration has caused, or is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 06/25/18, and determined to exist on 05/22/18. The facility was notified of the Immediate Jeopardy on 06/25/18. The facility provided an acceptable Allegation of Compliance on 06/27/18, alleging the removal of Immediate Jeopardy on 06/28/18. The State Survey Agency verified Immediate Jeopardy was removed on 06/28/18 as alleged, prior to exit on 07/01/18. The Scope and Severity was lowered to a E while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy, Governing Body: Centers, revised 06/01/17, revealed the governing body consisted of the Center Executive Director, Center Nurse Executive, and the Regional [NAME] President of Operations of the Center's administrative services provider. Additionally, the governing body was legally responsible for: establishing and implanting policies regarding the management and operation of the Center; appointing a licensed administrator for the management of the Center, and Maintenance of the Quality Assurance Performance Improvement (QAPI) Program. Review of the clinical record for Resident #40 revealed the facility readmitted the resident on 06/09/18, after a hospitalization for treatment of Aspiration Pneumonia. Post-hospitalization orders included Clindamycin three (3) times a day for four (4) days and Duoneb three (3) times daily for continued management of his/her compromised lung status. The facility ordered the Clindamycin on 06/10/18, but the pharmacy did not deliver the medication until 06/14/18, four (4) days later. The resident received only two (2) doses of the Clindamycin from 06/10/18 to 06/13/18, and according to interviews with licensed nurses, staff obtained those two (2) doses from the facility's Emergency Drug Kit (EDK). Further review of the clinical record for Resident #40 revealed the resident did not receive all scheduled breathing treatments from 06/10/18 - 06/13/18. The facility transferred Resident #40 back to the hospital on the morning of 06/13/18 with an elevated heart rate of 147 beats per minute, shortness of air, congestion, and a blood oxygen saturation of 88% while receiving oxygen at 2 liters per minute. Review of clinical record for Resident #51 revealed the facility admitted the resident on 05/22/18 multiple diagnoses which included Nonalcoholic Steatohepatitis (NASH-fatty liver). Review of the Physician Orders for Resident #51, dated 05/22/18, revealed Rifaximin (antibiotic) 550 mg by mouth every twelve (12) hours for NASH diagnosis. However, continued review of the clinical record revealed from 05/22/18 - 05/29/18 no scheduled doses of Rifaximin, for management of diagnosed fatty liver disease, were administered. During this time period the resident exhibited periods of confusion, as documented in the clinical record. The facility contacted the APRN, who ordered a urinalysis and labs which revealed Resident #51 experienced elevated Serum Ammonia levels during the time when the Rifaximin was not administered. Interview with the Center Executive Director (CED), on 06/22/18 at 6:50 PM, revealed facility leadership had awareness, since the week of 05/07/18, the contracted pharmacy had not delivered medications, as ordered, for newly admitted residents. In addition, the contracted pharmacy failed to deliver STAT medications in the specified four (4) hour time frame, and staff nurses requested hospitals administer a dose of pain medication to residents before transferring the resident to the facility, as pharmacy delivery was known to be slow and pain medications may not be delivered timely. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. 5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. 8. Additional education of licensed staff and two (2) CMTs was completed on 06/25/18. Education included procedure for sending medication orders to pharmacy; procedure for unavailable medications including refusals and notification of the pharmacy and physicians; when to notify the CNE and CED of unavailable medications; and the care plan process of revising and implementing the care plan with new orders. Posttests provided to validate understanding. 9. On 06/25/18, an adHoc QAPI meeting was conducted with the CED, the CNE, and the Medical Director to review additional education conducted. 10. Beginning 06/26/18, the Pharmacy Program Manager would contact the facility daily, including weekends, and speak with the CED, the CNE, or Registered Nurse (RN) Charge Nurse to confirm any medications needed would be sent to the facility stat (immediately). 11. On 06/26/18, the facility's EDK was re-stocked. 12. The CNE, CED, and/or Unit Manager will monitor MARs, conduct observations, and ensure daily communications occur with the Pharmacy Program Manager daily times two (2) weeks across all shifts; then three (3) times weekly for two (2) weeks; then weekly for two (2) months; then bi-weekly for two (2) months; and, then monthly for one (1) month to ensure medications were available as prescribed and the care plans were being followed. 13. The Regional [NAME] President of Operations and/or the Clinical Quality Specialist will review the QAPI minutes monthly for six (6) months and ongoing thereafter to ensure audits, education, and in-services are completed as needed. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The SSA validated the facility implemented the following actions: 1. Record review of the MARs for Resident #51 revealed he/she had received all medications since 05/30/18 as ordered. 2. Record review revealed Resident #40 was no longer in the facility. 3. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had received and had an understanding of the education. Review of the sign-in sheet for the in-service education provided between 06/11/18 - 06/21/18 revealed all licensed staff and two (2) CMTs signed acknowledgement of the education. 4. Interview with the CNE, on 07/01/18 at 2:17 PM, revealed she completed medication audits for all resident MARs and documented twelve (12) residents had missed medications for June 2018. The Audit tool was reviewed against the MARs for the residents identified with missed medications. 5. Record review revealed assessments were completed for eleven (11) of the twelve (12) identified residents. The twelfth resident had been discharged home at the time of the discovery. 6. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed they began auditing for availability of medications and documentation of medications on 06/23/18. Record review revealed audits began on 06/23/18 and were signed by the CED or CNE daily. Random audits of the medication carts, conducted by the SSA on 06/30/18, revealed medications were available for randomly selected residents when compared to medications ordered by the Physician. 7. Review of the audit tools revealed missing medications were identified on 06/23/18 and medications were ordered from the pharmacy prior to medication dosages being missed. 8. Review of the sign-in sheet for the additional education related to care plans and following Physician orders revealed all licensed staff signed acknowledgement of education. Posttests reviewed for each of the licensed staff revealed a 100% pass rate. Review of the sign-in sheet for the additional education related to ordering medications for new admissions and re-admissions; re-ordering the EDK; and, the procedure for unavailable medications revealed all licensed staff and two (2) CMTs were educated. Posttests reviewed revealed a 100% pass rate. Interviews with RN #5 on 06/30/18 at 10:50 AM; the MDS Coordinator on 06/30/18 at 10:15 AM; the Unit Manager on 06/30/18 at 11:10 AM; RN #1 on 06/30/18 at 11:00 AM; CMT #1 on 06/30/18 at 11:22 AM; LPN #3 on 07/01/18 at 10:45 AM; and, RN #4 on 07/01/18 at 10:45 AM, revealed they had an understanding of the education provided. 9. Interview with the MDS Coordinator, on 06/30/18 at 9:26 AM, revealed she was present at a QAPI meeting and medication issues were discussed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed they discussed medication issues in the QAPI meeting held on 06/25/18. Review of the sign-in sheet for the QAPI meeting on 06/25/18 revealed the MDS Coordinator, the CED, the CNE, and the Medical Director attended the meeting. 10. Interview with the CED, on 07/01/18 at 10:33 AM, revealed conversations with pharmacy were occurring daily. Review of the log documenting daily pharmacy phone calls revealed calls occurred daily as alleged. 11. Observation of the EDK revealed the box had been refilled. Interview with the Unit Manager, on 06/30/18 at 11:10 AM, revealed if staff took medication out of the EDK, staff filled out a form and faxed it to the pharmacy. If the entire stock of the medication was used, pharmacy refilled the EDK the same day. 12. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM, revealed audits of the MARs and Physician orders would continue as outlined in the AOC. Review of the audits revealed the CNE or CED audited the MARs and Physician orders daily beginning 06/23/18. 13. Observations during the AOC validation revealed the Clinical Quality Specialist (CQS) was in the facility daily assisting with MAR/TAR audits and medication cart audits. Interviews with the CED on 07/01/18 at 10:33 AM and the CNE on 07/01/18 at 2:17 PM revealed the CQS or Regional [NAME] President would review QAPI minutes monthly. Review of the most recent QAPI sign-in sheet revealed the CQS attended the meeting.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 31274 Based on interview, record review, and facility policy review, it was determined the facility failed to maintain complete and accurate clinical records for seven (7) of twenty-three (23) sampled residents, Resident #5, #23, #28, #40, #42, #47, and #51. The findings include: Review of the facility's policy, Nursing Documentation, last reviewed 03/01/16, revealed nursing documentation would be concise, clear, pertinent, and accurate to communicate the resident's status and provide an accurate accounting of care and monitoring provided. Review of the facility's policy, Medication Administration: General, revised 11/28/17, revealed if a medication was refused by a resident, discard the medication and attempt to administer again at a later time. For medication refused by the resident, circle staff initials in the date and time space where that medication was ordered and document the refusal of the medication on the back of the Medication Administration Record (MAR). 1. Review of Resident #40's MAR, for June 2018, revealed an order for Clindamycin three (3) times scheduled for administration at 08:00 AM, 12:00 PM, and 8:00 PM. On 06/10/18, revealed the 8:00 AM dose was not administered as the staff's initials were circled. The 12:00 PM dose was blank and the 8:00 PM dose was circled. On 06/11/18 and 06/12/18, the 8:00 AM and 12:00 PM doses had circled staff initials. On 06/13/18, the 8:00 AM dose had circled staff initials. Continued review of the MAR revealed an order for Ipratropium-Albuterol three (3) times a day at 8:00 AM, 12:00 PM, and 8:00 PM. On 06/10/18, 06/11/18, and 06/12/18, the medication was not administered at 12:00 PM, as the spaces on the MAR were blank. There was no documentation on the MAR for the reason the medication was not administered. Review of Resident #40's Progress Notes for 06/10/18 - 06/13/18 revealed no documentation for the reason the Clindamycin and Ipratropium-Albuterol were not administered. Interview, on 06/22/18 at 11:05 AM, with Licensed Practical Nurse (LPN) #3 revealed she provided care for Resident #40 on 06/10/18 and 06/12/18. She stated the Clindamycin was not available for administration on 06/10/18, nor on 06/12/18. She stated she thought she administered the Ipratropium-Albuterol on 06/10/18 at 12:00 PM, but did not document it as given. Interview, on 06/22/18 at 1:45 PM, with LPN #1/Unit Manager (UM) revealed she was the nurse who circled Resident #40's Clindamycin as not given on 06/11/18 because the medication was not available. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident #42's MAR, for May 2018, revealed an order for insulin every morning and every bedtime. There was no documentation the morning dose of insulin was administered on 05/09/18, 05/14/18, and 05/30/18, as the spaces for those doses were blank on the MAR. In addition, there was no documentation the bedtime dose of insulin was administered on 05/12/18 and 05/13/18, as the spaces for those doses were blank on the MAR. There was no documentation on the MAR for the reason the insulin was not administered. Review of the MAR, for June 2018, revealed the morning dose of insulin was not administered on 06/23/18 and the bedtime dose was not administered on 06/21/18, as the spaces for those doses were blank on the MAR. There was no documentation on the MAR for the reason the insulin was not administered. Interview with LPN #1/UM, on 06/26/18 at 11:25 AM, revealed if Resident #42's insulin was not documented on the MAR as administered, it was assumed the insulin was not given. She stated staff should have documented in the clinical record the reason for not administering the insulin. 3. Review of Resident #28's MAR, for May 2018, revealed orders for Risperidone twice a day and Singulair in the morning. Documentation revealed the resident was not administered the medications for the month, as all the doses had circled staff initials in the spaces on the MAR. Review of the MAR, for June 2018, revealed orders for Aspirin every morning and Januvia every morning. Documentation revealed from 06/01/18 - 06/22/18, the resident received the medications on 06/06/18 and 06/15/18. The resident did not receive the medications on the other days, as the spaces on the MAR had circled staff initials. In addition, the Risperidone and Singulair were not administered during that time, as the spaces had circled staff initials except for the Risperidone on 06/09/18 and 06/12/18 at 8:00 PM, those spaces were blank. Upon initial review of the MARs, it appeared the medications had not been administered, but review of the resident's Care Plan, revised 05/11/18, revealed the resident had a history of refusing care and medications. However, there was no documentation on the MAR to explain the multiple medication dosages circled on the MAR. 28733 4. Review of Resident #47's MAR, for June 2018, revealed an order for Hydrocodone-Acetaminophen (narcotic) every six (6) hours as needed for moderate pain. Review of the Narcotic Book, for 06/01/18 - 06/27/18, revealed staff sign out fifteen (15) doses of the Hydrocodone-Acetaminophen, on 06/01/18 at 10:45 AM, 06/02/18 at 9:00 PM, 06/11/18 at 8:00 PM, 06/13/18 at 10:00 AM, 06/15/18 at 9:00 PM, 06/17/18 at 12:30 AM and 8:00 PM, 06/18/18 at 6:30 PM, 06/20/18 at 8:00 PM, 06/21/18 at 11:30 AM, 06/22/18 at 10:00 PM, 06/24/18 at 11:30 AM, 06/26/18 at 11:10 AM and 8:32 PM, and 06/27/18 at 11:40 AM. However, continued review of the MAR revealed no documentation the medication was administered on those dates and times. Interview with LPN #3, on 07/01/18 at 10:20 AM, revealed staff should sign out the narcotic in the narcotic book, and once administered, document on the MAR. She stated the MAR and the narcotic book should match for when the resident was administered the medication. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident #51's MAR, for May 2018, revealed an order for Rifaximin scheduled at 9:00 AM and 9:00 PM. Documentation revealed the 9:00 PM dose on 05/22/18 was blank. The 9:00 AM and 9:00 PM doses on 05/23/18, 05/24/18, 05/25/18, and 05/26/18 had circled staff initials. The 9:00 AM dose on 05/27/18 had circled initials and the 9:00 PM dose was blank. The 9:00 AM and 9:00 PM dosed on 05/28/18 and 05/29/18 had circled initials. Continued review of the MAR for May 2018, revealed Flomax was scheduled every bedtime and the spaces on 05/22/18 and 05/23/18 were blank. Florastor was schedule twice a day and the space on 05/22/18 was blank. Zocor was scheduled every bedtime and the space on 05/22/18 was blank. Zosyn was scheduled for 4:00 AM, 10:00 AM, 4:00 PM, and 10:00 PM. The spaces for the 4:00 AM doses on 05/23/18, 05/26/18, and 05/27/18 were blank. The space for the 10:00 AM dose on 05/29/18 was blank. The spaces for the 4:00 PM doses on 05/28/18 and 05/29/18 were blank. The space for the 10:00 PM dose on 05/28/18 was blank. Levemir was scheduled every bedtime and the space on 05/28/18 was blank. There was no documentation for the reason the medications were not given. Review of the June 2018 MAR, revealed the 9:00 AM spaces for the Florastor on 06/01/18, 06/07/18, and 06/16/18, were blank. The spaces for Zocor on 06/01/18 and 06/04/18 were blank. Acetazolamide and Escitalopram Oxalate were scheduled for every morning and the spaces on 06/01/18, 06/07/18, and 06/16/18 were blank. Ferrous Sulfate was scheduled for twice a day and the spaces for the 9:00 AM doses on 06/01/18, 06/07/18, and 06/16/18 were blank. Zyprexa was scheduled twice a day and the spaces for the 9:00 AM doses on 06/01/18, 06/03/18, and 06/16/18 were blank. Lasix was scheduled for 9:00 AM and the spaces for 06/03/18, 06/07/018, 06/09/18, 06/10/18, 06/16/18, and 06/18/18 were blank. Vitamin C was scheduled for 8:00 AM and the spaces on 06/14/18 and 06/16/18 were blank. There was no documentation for the reason the medications were not administered. 35750 6. Review of Resident #23's MAR, for May 218, revealed an order for SoloStar insulin scheduled for 8:00 AM. The spaces on 05/07/18 and 05/14/18 were blank. The order was changed to Basaglar insulin, to start on 05/26/18; however, on 05/26/18 and 05/27/18, the spaces had circled staff initials. Interview with LPN #2, on 06/22/18 at 12:05 PM, revealed if there were blank spaces on the MAR, the insulin was not administered. Interview with LPN #4, on 06/22/18 at 4:33 PM, revealed she gave Resident #23 the insulin and if the MAR was blank, it meant she had not documented her administration. However, she stated it was important to document the administration of insulin to inform all nursing staff the resident received the insulin. 7. Review of Physician Orders for Resident #5 revealed Bactroban and Santyl compound was to be applied to the buttocks wound bed and covered with 1/8 strength Dakin's gauze twice a day, start date 05/07/18. In addition, apply Santyl Ointment 250 unit/gram to the left heel, cover with 1/8 strength Dakins moist gauze every night, start date 05/07/18. Review of Resident #5's MAR, for May 2018, revealed no documentation the left heel wound care was performed on 05/08/18 and 05/20/18. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Treatment Administration Record (TAR), for May 2018, revealed the buttocks wound care was scheduled for 6:00 AM - 2:00 PM and 10:00 PM - 6:00 AM. There was no documentation wound care was performed on six (6) occasions, on 05/08/18 and 05/21/18 at 10:00 PM - 6:00 AM, and on 05/11/18, 05/14/18, 05/17/18, and 05/24/18 at 6:00 AM - 2:00 PM. Review of Resident #5's TAR, for June 2018, revealed no documentation wound care for the left heel was performed on five (5) occasions, on 06/08/18, 06/15/18, 06/19/18, 06/20/18, and 06/21/18. There was no documentation the buttocks wound care was performed on six (6) occasions, on 06/01/18, 06/08/18, 06/11/18, and 06/22/18 at 6:00 AM - 2:00 PM, and on 06/15/18 and 06/21/18 at 10:00 PM - 6:00 AM. Interview with LPN #2, on 06/20/18 at 10:35 AM, revealed if there was no documentation on the TAR, staff would not know if a treatment was performed. Observation of the wound revealed it was healing. Continued interview with LPN #3, on 06/22/18 at 11:05 AM, revealed nurses were supposed to document medications and treatments provided to residents to have a complete record of the care provided. She stated proper documentation would prevent potential medication errors, such as providing a double dose of a medication. She stated accurate documentation on the MAR would prove the residents received all treatments as ordered by the Physician. She further stated the reason for not administering medication should also be documented. Interview, on 06/22/18 at 3:43 PM, with LPN #1/UM revealed if medication was not available from the pharmacy, it should be documented in the progress notes so the clinical record was complete and accurate. Continued interview on 06/26/18 at 10:44 AM, revealed the MAR was part of the clinical record and the clinical record told the story of the resident and documentation should be complete and accurate so staff understood what had been occurring with the resident. Interview with the CNE, on 06/26/18 at 1:46 PM, revealed if medication was not administered due to the resident's refusal or medication unavailability, staff should document the reason in the clinical record or the record would not be complete. She stated accurate charting painted a picture of the resident and served as a method of communicating across all shifts.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 31274 Based on interview, record review, review of the facility's policy, and the Center's Executive Director (CED) job description it was determined the facility failed have an effective system to address a broader systems failure related to pharmacy services through regularly scheduled Quality Assurance Performance Improvement (QAPI) meetings. The QAPI Committee, aware of delays in medication delivery for newly admitted residents, did not implement a formal plan. In addition, the QAPI Committee failed to identify discrepancies in resident Medication Administration Records (MARs), for medications not administered due to the pharmacy's delayed delivery of the medications. Record review revealed Resident #40 had a Physician order for Clindamycin (antibiotic) for treatment of Pneumonia, with a start date of 06/10/18, and an order to receive a breathing treatment. However, the resident did not receive all doses of the antibiotic nor breathing treatments between 06/10/18 - 06/13/18. The resident was transferred to the hospital on 06/13/18 for difficulty breathing, an elevated heart rate, and a decrease in blood oxygenation. Resident #51 had a Physician order to receive Rifaximin (antibiotic) for the treatment of his/her fatty liver disease with a start date of 05/22/18. However, the resident did not receive fifteen (15) doses of the medication between 05/22/18 - 05/29/18. The resident had periods of confusion and an elevated ammonia level during the time when the medication was not administered, which according to interview was a result of not receiving the antibiotic. The facility admitted Resident #38 on 05/11/18 with orders to administer Heparin. However, interview and record review revealed the resident did not receive seven (7) doses of the medication in May 2018. The facility's failure to address systems failures and implement correction plans for these issues has caused, or is likely to cause, serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 06/25/18, and determined to exist on 05/22/18. The facility was notified of the Immediate Jeopardy on 06/25/18. The facility provided an acceptable Credible Allegation of Compliance on 06/27/18, alleging the removal of Immediate Jeopardy on 06/28/18. The State Survey Agency verified Immediate Jeopardy was removed on 06/28/18 as alleged, prior to exit on 07/01/18. The Scope and Severity was lowered to a E while the facility develops and implements the Plan of Correction and monitors the effectiveness of the systemic changes. The findings include: Review of the Job Description for the Center's Executive Director (CED), effective 01/01/16, revealed the CED would assure the QAPI Process was understood and utilized by all members of the Center Leadership Team to continually improve all aspects of Center performance. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy, Center Quality Assurance Performance Improvement (QAPI) Process, revised 02/13/17, revealed the Center was committed to incorporating the principles of Quality Assurance and Performance Improvement (QAPI) into all aspects of the Center work processes, service lines, and departments. All staff and stakeholders were involved in QAPI to improve the quality of life and quality of care for the patients' experience. Further review of the policy, revealed the QAPI program was ongoing, integrated, data driven, and comprehensive, addressing all aspects of care, quality of life, and patient centered rights and choice. The Center Executive Director (CED) led the center's QAPI processes and involved departments, staff and stakeholders-balancing a culture of safety, quality, and patient centeredness. The QAPI processes and improvements were based on evidence drawing from multiple sources, prioritizing improvement opportunities, and bench marking results against developed targets. Improvement Activities and Performance Improvement Projects were the structure and means through which identified problem areas were addressed. The learning, through applied QAPI plans, was continuous, systematic and organized. Continued review of the policy revealed the QAPI Committee met at least ten (10) times annually to monitor quality within the Center, identify issues, and develop and implement appropriate plans of action to correct identified quality issues. Attendees included the CED, the Chief Nurse Executive (CNE), the Medical Director, the Infection Preventionist, a representative from each department, including one (1) Certified Nursing Assistant (CNA), and divisional support leaders, as appropriate, to provide further insight and resource management. Review of the clinical record for Resident #40 revealed orders for Clindamycin three (3) times a day for four (4) days and Duoneb three (3) times daily for continued management of his/her compromised lung status. The facility ordered the Clindamycin on 06/10/18, but the pharmacy did not deliver the medication until 06/14/18. The resident received only two (2) doses of the Clindamycin from 06/10/18 to 06/13/18, and according to interviews with licensed nurses, staff obtained those two (2) doses from the facility's Emergency Drug Kit (EDK). Further review of the clinical record for Resident #40 revealed the resident did not receive all scheduled breathing treatments from 06/10/18 - 06/13/18. The facility transferred Resident #40 back to the hospital on the morning of 06/13/18 with an elevated heart rate of 147 beats per minute, shortness of air, congestion, and a blood oxygen saturation of 88% while receiving oxygen at 2 liters per minute. Review of clinical record for Resident #51 revealed the facility admitted the resident on 05/22/18 with an order for Rifaximin, 550 mg by mouth every twelve (12) hours. Continued review of the clinical record revealed from 05/22/18 - 05/29/18 no scheduled doses of Rifaximin were administered. During this time period the resident exhibited periods of confusion, as documented in the clinical record. The facility contacted the APRN, who ordered a urinalysis and labs which revealed Resident #51 experienced elevated serum ammonia levels during the time when the Rifaximin was not administered. Record review revealed the facility conducted an audit, dated 06/13/18, for twelve (12) residents to determine if the facility had the physician ordered medications available for administration. However, medication administration was audited only for the month of June 2018. Those medications determined not administered to residents were listed and forwarded to the Medical Director for their review of the records of the applicable residents. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Interview with the CNE, on 06/28/18 at 11:16 AM, revealed her audit consisted of only a random sample of residents on the North and South units, but not for all residents on census. The CNE did not note missed breathing treatments for Resident #40, as she did not recall auditing the entire MAR for Resident #40. Additionally, the CNE stated she only audited regularly scheduled medications to ensure the medications were available for the selected residents. The CNE forwarded the results of the audit to the CED who reviewed it prior to forwarding to the Medical Director for their review. Interview with the Medical Director, on 06/21/18 at 11:30 AM, revealed attention was given regarding medication management about one (1) week ago when the APRN expressed concerns about residents not getting their medications, and learned from the CED about issues with not receiving medications, and/or not receiving them timely from the pharmacy. She stated the CNE conducted a medication cart audit on 06/13/18 and at least ten (10) residents were identified with medication administration concerns. Continued interview with the CNE, on 06/26/18 at 1:45 PM, revealed while not positive, she believed the issues with medications was discussed at the May 2018 QAPI meeting. She stated she was concerned with the holes in the medication administration records (MAR), and failure of staff to not notify the Physicians when medications were not available for use. She further stated the nurses could not explain why they did not document as expected, other than too busy during their shifts. Interview with the CED, on 06/22/18 at 6:50 PM, revealed Nursing leadership had not routinely audited the residents' MARS, but stated night shift nurses performed a 24-hour chart checks. The CED stated the facility should conduct routine audits of resident clinical records, specifically the MARs and Treatment Administration Records (TARS), but these audits had not been done routinely. Continued interview, on 06/22/18 at 6:50 PM, with the CED revealed facility leadership was aware, since the week of 05/07/18, the contracted pharmacy had not delivered medications, as ordered, for residents newly admitted to the facility. As a result, she stated nurses requested hospitals administer a dose of pain medication before transferring the resident to the facility, as pharmacy delivery was known to be slow and pain medications might not be delivered timely, and nurses questioned why they requested medications be sent by STAT delivery when they were not being delivered in the delineated four (4) hour time frame. She stated a meeting with the Contracted Pharmacy Management needed to occur. Further interview with the CED revealed she initiated conversation via a conference call with the Pharmacy's Manager on 05/18/18 and discussed staff and leadership's concerns with delayed delivery of medications for newly admitted residents and for other residents with new Physician orders. The CED stated two (2) additional conference calls with the Pharmacy Manager scheduled for 05/25/18 and 06/01/18 were not attended by Pharmacy Manager. The CED stated the first in-person meeting with the Pharmacy Manager occurred on 06/08/18 when they discussed issues surrounding delayed delivery of medications and delayed refills of the Emergency Drug Kit (EDK). She stated the Pharmacy Manager expressed concerns regarding his staff's ability to reach facility nurses by telephone for order clarification, and not receiving face sheet/demographic information from the facility for newly admitted residents, as that information was necessary for billing purposes. (continued on next page)

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	185333	A. Building B. Wing	07/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Klondike Nursing and Rehabilitation Center	3802 Klondike Lane Louisville, KY 40218

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Continued interview with the CED, on 06/22/18 at 8:50 PM, revealed the QAPI Committee had not finalized training and monitoring related to the identified delayed pharmacy deliveries and for additional training and monitoring of the nursing staff to ensure they communicated effectively with the pharmacy, prescribers, and with facility administration when medications were not delivered within an appropriate time frame. Further interview with the CED, on 06/25/18 at 4:50 PM, revealed the QAPI Committee reviewed medication errors, when reported correctly, and included errors such as wrong medication, wrong dose, and wrong route. However, the facility did not record medication omissions as errors, therefore, the QAPI committee had not reviewed documents that recorded medication omissions. The CED stated data collected from routine audits of MARs and Chart Checks should have been available for review and discussion during monthly QAPI meetings, and review of that data should have already been in place prior to the identification of the issues with the contracted pharmacy. The facility had not fully implemented a Plan of Action to the address the Quality Assurance Issue related to omitted medications/medication errors. The facility implemented the following actions to remove the Immediate Jeopardy: 1. Resident #51 had received the Rifaximin since 05/30/18. 2. Resident #40 was no longer in the facility. 3. From 06/11/18 - 06/21/18 re-education of staff nurses and Certified Medication Technicians (CMT) occurred. Education included the facility policy on ordering and obtaining medications from the pharmacy for all admissions, re-admissions, and new physician orders. Education also included policies and processes for obtaining medications that are unavailable from the Emergency Drug Kit (EDK), as well as notification of the Physician when medications were not available from the pharmacy and were not available in the EDK. 4. The Center Nurse Executive (CNE) conducted an audit of all resident Medication Administration Records (MAR) from 06/01/18 - 06/13/18. Twelve (12) residents were identified to have missed medication dosages. On 06/14/18, a pharmacy consultant conducted an audit of available medications in comparison to the Physician orders. 5. The Medical Director was notified of the twelve (12) residents that had missed medication dosages on 06/14/18. The Medical Director assessed the identified residents and findings were documented in the resident charts. No new medication or laboratory orders were received. 6. On 06/14/18, an adHoc QAPI meeting was conducted with the Medical Director, the CNE, and the Center Executive Director (CED). During the meeting, audits, education, and compliance monitors were developed and to be implemented on 06/23/18. 7. Two (2) additional discrepancies of missed medications were self-identified by the CNE and the CED during audits performed on 06/23/18. (continued on next page)

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