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uses their rubber stamp and keeps it in their possession at all times and we do not have signed verification for electronic physician signatures."

E1 on 6-10-2008 at 10:41am stated, "Z12 uses a rubber stamp and electronic signature for resident's orders. Z1 has used a rubber stamp for resident's orders and has just recently gone to electronic signing. The facility and Corporate do not have electronic signature verification on file of physician signatures and we do not have a statement that the physician is the only user of their rubber stamp and that the stamp is kept in their possession at all times."

F9999 FINAL OBSERVATIONS F9999

LICENSURE VIOLATIONS

300.1210a)
300.1210b)1)2)3)5)
300.1220b)2)3)
300.1620a)
300.1630b)d)e)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care
a) The facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.
b) General nursing care shall include at a

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minimum the following and shall be practiced on a 24-hour, seven day a week basis:
1) Medications including oral, rectal, hypodermic, intravenous and intramuscular shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.
5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24 hour, seven day a week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy.
3) Developing an up-to-date resident care plan

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for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

Section 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication
b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current

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F9999	Continued From page 41 medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility. d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record. e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by:	F9999		

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Based on interview and record review, the facility neglected to process the admissions orders, transcribe and follow the physician orders regarding the administration of medications, provide treatment as ordered to a pressure ulcer for one residents, R3. The facility's failure to administer prescribed medications placed R3 at risk for potential deterioration of other identified medical conditions. The facility neglected to follow their policies and procedures for Neglect, Medication Administration, Admission Of A Resident, Pre-Admission, Admission and Orientation of Residents, and Pharmaceutical Policies. They neglected to ensure staff nurses carried out their responsibilities as listed in the Job Description for Staff Nurse. These failures resulted in R3 being admitted to the hospital with an elevated blood pressure and being placed at risk for potential deterioration of other identified medical conditions.

Findings include:

Hospital Transfer Sheet dated 05/20/08 provides the following information: R3 was admitted to the facility on 05/20/08 after a hospital stay from 05/12/08 through 05/20/08. R3's blood pressures with the administration of prescribed medications were within normal limits. Diagnoses listed are cerebral vascular accident, hypertension, atrial fibrillation and diabetes. Medications prescribed for R3 are: Amiodarone 400mg. daily. Lopressor 100mg. twice daily.
Hydrochlorothiazide-Triamterene 50mg.-75mg. one tablet daily. Coumadin 2mg. daily.
Humulin R sliding scale with four time a day blood sugar checks. Sinemet 25mg.-100mg. daily. Zocor 40mg. daily. Docusate Sodium 100mg. daily. Bisacodyl suppository 10mg. three

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times a week. Naprosyn 500mg. daily. Lexapro 10mg. daily. Senokot S 50mg.-8.6mg. three times a week, as specified in order).

Facility "Nursing Body Assessment" form completed with R3's name states: Admission Date: 05/20/08 Admission Time: 5:00pm Blood Pressure 148/98. Facility "Progress Notes" from 05/20/08 through 05/21/08 (four entries were made) indicate R3 did not verbalize his needs, is completely dependent for all his care and does not have control of his bowels and/or bladder. On 05/21/08 at 10:06pm the "Progress Notes" state: "After checking res. v.s. b/p was 188/124 and respirations were 26 breaths per min. Res. temp was 99.2 axillary. Contacted POA and notified of situation. Call transport and sent to local hospital. Call for follow-up report. Res has been admitted but no admitting diagnosis has been established at this time."

Emergency Department records "Assessment Sheet" dated 05/21/08 states R3 arrived at the hospital at 5:56pm. No explanation of time discrepancy with facility "Progress Note" could be provided by Z6 (Nurse Consultant) when requested on 5/29/08 at 3:00pm. The assessment contains the following information: R3 was initially discharged on 5/20/08 from the hospital to the facility. R3's medications at the time of his hospital discharge on 05/20/08 were not filled or administered by the facility. Upon arrival to the Emergency Department on 05/21/08, R3 was not responding verbally. R3's blood pressure was elevated at 188/120, elevated heart rate at 136 with sinus tachycardia and a temperature of 100.7 degrees F. The hospital had "concerns of possible facility neglect due to failure to administer medications." IV

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Lopressor was administered at 9:27pm with no response. R3's response at 10:09pm to medication (Lopressor) was a decreased heart rate. R3's echocardiogram interpretation at 10:14pm was sinus tachycardia. At 10:19pm, R3 was admitted to hospital.

Z7's Admission Report dated 5/22/08 at 12:00am for R3 documents the following information: "R3 was brought into ER secondary to fever and high b/p. Pt. was discharged to (facility) yesterday evening after being admitted for a stroke......The stroke was thought to be secondary to embolic event from his new a.(atrial) flutter.....R3 was discharged to nursing home last evening. R3 has stayed at nh (nursing home) only for one night from records it seems like pt. did not receive any medication there and his blood pressure went high. It was also felt R3 may have had neglect in nh. In the meantime he also developed high fever. He is totally aphasic so I was not able to get a good history. While in the Emergency department R3 was tachycardic and received Lopressor." Hospital physician progress note dated 05/23/08 states "blood pressure stable once medications restarted."

On 5/29/08 at 8:45am., Z2 stated, "If R3 did not receive Amiodarone, Coumadin, and Antihypertensive medications, it is no wonder R3 was tachycardic and was probably in atrial fibrillation. There is also a concern due to R3 not receiving four times a day blood sugar checks and insulin for a risk of hyper or hypoglycemia."

Z3 stated on 05/27/08 that R3 had a stroke and was discharged on 5/20/08 to the facility and then on 5/21/08 around 5:30pm. was readmitted to the hospital with a blood pressure of 188/120. R3

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F9999	Continued From page 45 had not received any medications while at the facility. Z3 also stated a family member informed E1 that R3 had not receiving any medication while residing at the facility. Z3 stated on 6/9/08 at 11:55am., "a family member stayed with R3 for the entire stay at the facility, but in shifts. I first became aware that R3 didn't receive medication when the ambulance driver handed a paper to Z4 and said the facility had not given medication to R3, have them explain this to you." E2 stated on 5/28/08 at 1:37pm. that the facility documentation states E1 was informed by R3's family member that no medications had been administered during R3's stay at the facility. E2 stated on 5/28/08 at 2:16pm. after contact with E3 that E3 affirmed R3's family member was the source that informed the Administrator that R3 had not received any medication during R3's stay at the facility. E3 also stated to E2 that Z1 was not notified of R3's lack of medication administration or R3's 5/20/08 increased blood pressure and temperature and did not order R3's transfer to the hospital. Z1 was also not notified of R3's hospital admission. E1 stated on 06/02/08 that R3's family notified him that R3 did not receive any medications during R3's stay at the facility. Medication Error Report involving E10 dated 05/22/08 documents the following information: "On 5-21-2008 (R3's) 8:00am. medications were not administered." "The medication error could have endangered the life or welfare of (R3) due to diagnosis of stroke, lack of medications for blood pressure stabilization and blood thinner, diabetes with no (glucometer checks) or insulin." "The actual effect the medication error had on R3 was blood pressure became elevated and R3 was sent back	F9999		

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to hospital." "The error was discovered by R3's family telling E1." "5-22-2008 at 5:30pm. E3 notified Z8."

Medication Error Report involving E11 dated 05/22/08 documents the following information: "On 5-20-2008 and 5-21-2008 R3's 4:00pm. medications were not administered."
"The medication error could have endangered the life or welfare of R3 due to diagnosis of stroke, lack of medications for blood pressure stabilization and blood thinner."
"The actual effect the medication error had on R3 was blood pressure became elevated and was sent back to hospital." "The error was discovered by R3's family telling E1.
On "5-22-2008 at 5:30pm. E3 notified Z8."

Employee Disciplinary Action Report for E12 dated 05/23/08 documents on 5/20/08 and 5/21/08 "no follow through on R3's new admission orders from prior shift-filing of transfer papers into chart. MARs not all updated. Medication errors occurred due to no medications available."

On 6/2/08 at 3:50pm. Z9 stated, "I have looked in our computer system and do not have medication orders, or any information on R3." After informing Z9 of R3's
5/19/08 diagnoses and ordered medications, Z9 stated, "with that many medications it's difficult, but with R3's diagnoses, not receiving medication would make it a dangerous situation. It could certainly contribute to the diagnoses."

On 5/29/08 at 3:00pm. Z6 stated the facility policy for all residents is to verify signed physician orders at admission, input the residents'

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medications in the computer, create a MAR and contact the pharmacy for resident medications as ordered by the physician. Z6 also stated Employee Disciplinary Action reports for E10, E11, and E12 all document that R3's medications were not entered into the computer system and the pharmacy was not contacted to provide R3's medications. Z6 also stated if any additional information relating to this incident with (R3) was available indicating R3's physician was made aware of the incident it would be provided. On 6/2/08 at 11:03am. E1 stated no further information would be provided.

On 6/3/08 at 9:44am. Z10 stated the facility creates their own computerized MARs and monthly POS. Z10 stated the pharmacy usually receives medication orders from the physician and then we create the monthly MARs and monthly POSs for each resident; this facility creates their own. Z10 also stated, "I am not aware of MAR or monthly POS problems at the facility or for R3."

E10 stated on 06/04/08 at 2:38pm. the following information: "On 5/20/08 I was the medication administration nurse on (R3's) wing. On 5/20/2008 around 6:00am R3's admission papers were in a packet on the nursing desk. E12 worked third shift and told me that E11 hadn't entered some of R3's medication orders due to not having a diagnosis. E12 handed me R3's packet and E14 took R3's packet to complete it. I received report on the residents and started the residents' medication pass. I also showed E2 the packet and reported R3's medications hadn't been entered into the computer or ordered from the pharmacy. The resident Medication Administration Book that contains the MAR for

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F9999	Continued From page 48 R3 was empty when I passed medications on that wing. One of my residents was having behaviors and I had a new admission in the afternoon, my thought was that E4 was working on it. On 5/21/08, R3's specialty physician called me regarding R3's diagnostic testing and Coumadin dosage. Coumadin is administered in the evening, so I didn't think about R3 not receiving Coumadin the night before. On 5/22/08 facility Administration told me R3 was hospitalized due to not receiving medications. If R3 didn't receive his blood pressure medication, blood thinners, and insulin he could probably have another stroke. I wish to God I had known his medical history." Hospital Transfer Sheet dated 5/20/2008 provided the following information: Stage II pressure ulcer to right gluteal fold and a right knee abrasion. R3's treatment is apply Xenoderm twice a day and as needed to the right gluteal fold and clean right knee with wound cleaner and apply a dressing to the right knee, change weekly and as needed. Z4 on 5/29/08 at 12:40pm stated "the only care R3 had at the facility was to have an incontinence pad roughly removed and that R3 has a sore on his bottom. They never changed the dressing, a family member was with R3 for the entire stay." E15 (LPN/Treatment nurse) stated on 6/4/08 at 3:35pm., "I did R3's 5/21/08 right knee treatment, I did not do the right gluteal fold treatment." E15 also stated "we did not have R3's right knee dressing, so the family went out and got it." R3's "Progress Notes" of 5/21/08 at 3:38am. state "Stage II pressure ulcer in the right gluteal fold. Treatment done to ulcer." R3's TAR (Treatment	F9999		