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	145275	A. BUILDING ____ B. WING ____	C 04/26/2010

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F 364 — F 364

Continued From page 66
b-wing.

E1, (Administrator) on 4-1-2010 at 11:26am. provided a list of eight residents that received 3-31-2010 noon meal room trays from the B-wing cart, (R2, R6, R7, R8, R9, R10, R11, and R12).

On 3-31-2010 at 1:37pm. R2 stated, "The meat and potatoes were cold and I don't like beets." R2 did not eat the meat, vegetables, potatoes and gravy from the 3-31-2010 noon meal.

F9999 — F9999

FINAL OBSERVATIONS

LICENSURE VIOLATIONS

300.1210a)
300.1210b)1)2)
300.1630c)
300.1630d)
300.3220f)
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 minimum the following and shall be practiced on a 24-hour, seven day a week basis:

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F9999	Continued From page 67 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. Section 300.1630 Administration of Medication c) Medications prescribed for one resident shall not be administered to another resident. 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. 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 2-104(b) of the Act) Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These REGULATIONS are not met as evidenced by: Based on interview and record review the facility failed to verify Physician Orders and administer	F9999		

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F9999	Continued From page 68	F9999		

blood pressure medications, diuretics, renal medications, blood thinner, cardiac, and congestive heart failure medications to one of one residents recently admitted with a pacemaker (R4).

The facility's failure to administer medications and verify Physician Orders occurred from R4's time of admission to the facility, on a Friday afternoon, 2-26-2010 until the following Monday morning, 3-1-2010. As a result of the facility failure to administer medications R4 suffered a decline in his medical condition and two falls The facility failed to notify R4's physician, at any time, that medications were not administered for this two and a half day period of time.

The facility staff did not follow their Admission Process/Nursing Admission Checklist, Medication Administration Policy and Procedure, The Long Term Care Facility Pharmaceutical Services Policy and Procedure Manual and Pharmacy After Hour Procedure.

Findings include:

R4's 2-26-2010 Hospital discharge summary documents R4 has diagnoses that include diabetes, kidney disease, hypertension, gout, and a pacemaker.

The 2-26-2010 Hospital Patient Transfer Form documents R4 was discharged from the hospital and transferred to the facility on 2-26-2010. This same form contains the hospital physician medication orders, for verification by R4's facility prescribing physician, for admission to the facility. R4's documented medications on this form and the pharmacologic category, use,

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F9999	Continued From page 69 warning/precautions obtained from Lexi-Comp's Drug reference, Geriatric Dosage Handbook 12th Edition, are listed below: Labetalol 100mg. (milligrams) twice a day. Labetalol is a beta blocker used for treatment of mild to severe hypertension (high blood pressure). Warnings/Precautions, "Avoid abrupt discontinuation in patients with a history of coronary artery disease." Page 846. Cardura 8mg. every night at bedtime. Cardura is a alpha-blocking agent used for treatment of hypertension. Page 463. Nifedipine XL 30mg. daily. Nifedipine is a calcium channel blocker used to treat angina (severe constricting heart pain), cardiac problems and hypertension. Warnings/Precautions, "Abrupt withdrawal may cause rebound angina in patients with coronary artery disease." Page 1100. Zaroxolyn 5mg. daily. Zaroxolyn is a diuretic used for management of hypertension and in treatment of edema in congestive heart failure and kidney disease. Page 1005. Bumetanide 2mg. twice a day. Bumetanide is a diuretic used to manage swelling associated with congestive heart failure or renal disease and in combination with antihypertensives to control hypertension. Page 187. Novolog Insulin on a sliding scale before meals and at bedtime after blood sugar testing results, (four times a day). Novolog is an antidiabetic agent used to treat diabetics to control hyperglycemia. Page 789.	F9999		

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F9999	Continued From page 70	F9999		

Zyprexa 2.5mg. at bedtime. Zyprexa is an antipsychotic agent used for treatment of schizophrenia and bipolar disorders. Page 1129.

Allopurinol 150mg. daily. Allopurinol is used to treat gouty arthritis and kidney disease. Page 46.

Darvocet N 100mg. every four hours as needed. Darvocet N is a narcotic analgesic used to manage mild to moderate pain. Page 1309.

Aspirin 325mg. daily, used prophylactically for stroke and heart attack prevention, blood thinner. Page 122 and 123.

The 2-26-2010 at 4:00pm. Nursing Note, documented by E15 (LPN/Licensed Practical Nurse) is, "(R4) admitted from hospital. Doctor notified of arrival. Pharmacy notified and Physician Order Sheet faxed." (2-26-2010 was a Friday).

On 4-13-2010 at 2:18pm. E15 (LPN) stated, "I did (R4's) admission on 2-26-2010 at 4:00pm. I think I administered (R4's) insulin from the house insulin. I know (R4) didn't get some of his meds, pills but I don't know which ones. I borrowed some medications from other residents. I don't know which residents I borrowed medications from. I don't recall which meds (R4) had and which ones he didn't have. I paid the resident's back the meds I borrowed. I know we aren't supposed to do that, borrow meds. We have had discipline and rule changes, if one nurse does an entire admission, and now we have to keep a copy of med requests to the pharmacy, with the date and time of doctor notification and fax a med list to the doctor office and fax confirmation.

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F9999	Continued From page 71 (R4's) meds weren't faxed to his doctor on the 26th of February 2010, for verification and to pharmacy. We talked about this at staff meeting, around March 10th., 2010. I thought days verified (R4's) meds and faxed them to the doctor and days had not, it was a miscommunication. (R4's) MAR (Medication Administration Record) was completed by (E22 / LPN), a float. The facility does not want a med not to be given. You are to make sure it's brought to the building. The pharmacy is available twenty-four hours a day with a back-up pharmacy. (E2 /DON, Director of Nursing and E1/Administrator) talked to me together about these issues and disciplined me." E22 (LPN) on 4-14-2010 at 11:49am. stated, "I am familiar with (R4). I worked days on 2-26-2010. (R4) did not arrive at the facility before my shift ended at 2:00pm. I started (R4's) MAR. The hospital faxed (R4's) medication list me, and the only part of (R4's) admission I did was to complete the MAR. (E15/LPN) was the second shift nurse. I gave (E15/LPN) report, at shift change, that he was getting an admission, and that I had started filling out (R4's) MAR. I at no time told (E15/LPN) that Physician Orders had been verified or that the pharmacy had been faxed the request for (R4's) medications because all of the Physician Orders would need to be verified with (R4's) physician. (R4) did not arrive at the facility until 4:00pm. on 2-26-2010, so how could I verify anything before the resident's arrival?" The 2-26-2010 MAR for R4 completed by E15 (LPN) on second shift is blank for the following medication administrations, 4:00pm. Labetalol and Bumetanide, 8:00pm. Cardura and Zyprexa. E15 (LPN) on second shift, 2-27-2010,	F9999		

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F9999	Continued From page 72	F9999		

documented the following on R4's MAR for 4:00pm. Labetalol and Bumetanide are initialed and circled for not given, R4's 8:00pm. Cardura and Zyprexa are initialed and circled for not given. The back of the same MAR is blank, on the spaces provided, for documenting the reason/rationale for the omission. The Bumetanide, Cardura, and Zyprexa additionally are initialed below the circled initials. A time and rationale for this is not documented on the 2-27-2010 MAR.

E20 (LPN/Licensed Practical Nurse) on 4-15-2010 at 9:25am. stated, "On Sunday the 28th of February 2010 when I worked third shift, from 10:00pm. to 6:00am., I went to chart on (R4) and I didn't see any physician orders for him at the end of my shift except (R4's) Hospital Transfer Orders. So then I looked around for (R4's) medications and couldn't find them. I told E21 (LPN/Minimum Data Set and Care Plan Coordinator) this, as she was the only administrative person in the building, when I left at 6:00am. (E21) said she would take care of the situation, and handle it immediately. I am just floored by this, the fact that I couldn't locate medications and Physician Orders, other than the Transfer Orders, on Monday morning 3-1-2010, for a resident admitted 2-26-2010 at 4:00pm. The pharmacy and doctor call services are available twenty-four hours a day. I've used the pharmacy after hours before and they are accommodating and pleasant. I could not locate (R4's) Physician Orders and showed this and (R4's) file to (E18/LPN) and (E21/LPN, Minimum Data Set and Care Plan Coordinator)."

On 4-5-2010 at 11:00am. Z3 (Pharmacy Director/General Manager) stated, "The first time

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F9999	Continued From page 73 Physician Orders and a request for (R4's) medications, that was made to the pharmacy, was 3-1-2010 at 9:30am. by (E18/LPN). (E18/LPN) requested an immediate fill and delivery at this time. The pharmacy logs all facility requests, with the date and time, by phone or fax. The pharmacy also retains a copy of delivery receipts for facility medication deliveries. This date and time on the delivery receipt is for when the medications leave our pharmacy for delivery to the facility. We do not document what time the facility receives the medication. The pharmacy is contracted to the facility for medication dispensing, deliveries, and is available twenty-four hours a day. Additionally we have a local back-up pharmacy for dispensing medication, should it be necessary. I will fax copies of (R4's) 3-1-2010 medication request, Physician Orders, delivery ticket, and pharmacy information and hours. The facility has a copy of our pharmacy hours, after hours procedures, and telephone/fax numbers for posting." The facility fax dated 3-1-2010 at 9:33am. documents E18 (LPN) faxed R4's Physician Orders on 3-1-2010 at 9:30am. E18 also wrote on this fax cover sheet, "Could you please send meds as soon as possible." The pharmacy delivery ticket documents (R4's) medications left the pharmacy 3-1-2010 at 11:10am. for delivery to the facility. The pharmacy hours, after hour procedures, and telephone/fax numbers, for facility posting, document and affirm the information Z3 (Pharmacy Director/General Manager) provided on 4-5-2010 at 11:00am. On 4-13-2010 at 1:10pm. E18 (LPN) stated, "I worked days on 3-1-2010. I don't know anything other than (R4) didn't have any meds in his	F9999		

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F9999	Continued From page 74 drawer. I then went and told (E2/DON/ Director of Nursing). I don't remember if the 2-26, 2-27, and 2-28-2010 MAR, I think the MAR was blank, I'm not 100% sure. I don't know. But, I don't think anything (medication) was signed out. I told one nurse (R4) didn't have any meds. I don't remember who. I didn't have any conversations about (R4) not having meds on the weekend with (E2/DON). I contacted (R4's) facility physician (Z5) for verification of orders, including medication, on 3-1-2010 and sent (R4's) medication request to the pharmacy." R4's 3-1-2010 MAR documents Nifedipine XL, Aspirin, Allopurinol, Zaroxolyn, Bumetanide, and Labetalol were administered to R4 at 8:00am. by E18, (LPN). (The 3-1-2010 pharmacy delivery ticket documents R4's medications left the pharmacy at 11:10am. for delivery to the facility). On 4-15-2010 at 2:20pm. Z6 (LPN/Z5 Physician's Nurse) stated, "If a facility admits a resident after hours they are to call our after hours number for the on-call physician to verify the resident's Physician Orders. If (R4's) 2-26-2010 Telephone Orders document the time of the facility faxing those Orders to our office as 3-2-2010 at 8:04am. and document the time our office faxed the Telephone Orders back, with (Z5/Physician)'s stamped signature as 3-3-2010 at 4:45pm. then that is when it occurred. Our office does not keep any other documentation of this. (Z5/Physician) does not date when he then signs the hard copy of those Physician (Telephone) Orders. The date on the Telephone Orders is when the nurse fills them out. (Z5/Physician) never saw this resident." After review of R4's 2-26-2010 through	F9999		

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F9999	Continued From page 75 2-28-2010 MAR, E17 (LPN) on 4-13-2010 at 1:20pm. stated, "I am familiar with (R4). I worked days on 2-27-2010 and 2-28-2010. On 2-27-2010 I borrowed medications from somebody else, a resident, I can't think of. I did circle my initials on the MAR as not given. I replaced the other resident's medications. I must have done this on 2-28-2010 also, borrowed meds for (R4). I don't know why I left the 2-28-2010 MAR blank. I must have forgotten to initial it." The 2-27-2010 day shift MAR documents R4's 8:00am. Labetalol, Nifedipine XL, Aspirin, Allopurinol, Zaroxolyn, and Bumetanide as not given, per circled initials by E17 (LPN). Beneath these same circled initials E17 re-initialed these medications. The back of the same MAR is blank, on the spaces provided for documenting the reason/rationale for the omission. A rationale is not documented for the re-initialing of these medications or time. The 2-28-2010 day shift MAR documents R4's 8:00am. Zaroxolyn, Bumetanide, and Labetalol are initialed and circled as not given with initials below these entries. A rationale is not documented for the omission and re-initialing of these medications by E17 (LPN). The 2-28-2010 MAR is blank for the 8:00am. administration of Nifedipine XL, Aspirin, and Allopurinol. On 4-19-2010 at 10:53am. E19 (RN/Registered Nurse) stated, "Nurses always receive report when beginning their shift from the nurse ending their shift. I do not recall receiving any information from (E17/LPN) about (R4's) medications on the 28th of February 2010. I circle my initials on a resident's MAR when medications aren't administered. For example if	F9999		

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F9999	Continued From page 76 medications are not in house, unable to be given, I would have circled my initials. I have not received any phone calls from (E2/DON) about (R4's) medications. Nor has (E2/DON) left any messages on my home answering machine or cell phone for me to contact her for any reason about (R4). (E2/DON) has not spoken to me at all, ever, about (R4's) medications. I did work 3-28-2010 on second shift." The 2-28-2010 MAR documents R4's second shift 4:00pm. Labetalol and Bumetanide were not administered per E19 (RN)s circled initials. The MAR entry on second shift, 2-28-2010 at 8:00pm. documents Cardura and Zyprexa were not administered per E19's circled initials. A rationale is not documented for the omission of R4's 2-28-2010 4:00pm. and 8:00pm. medications. The 3-3-2010 at 1:00pm. Nursing Note documents R4 was sent to the hospital. R4's 3-8-2010 at 4:00pm. Nursing Note documents R4's return to the facility from the hospital on comfort care with all previous medications prior to the 3-3-2010 at 1:00pm. hospital admission discontinued. The 3-9-2010 at 6:00am. Nursing Note documents R4 expired on 3-9-2010 at 4:25am. Z3 (Pharmacy Director/General Manager) on 4-19-2010 at 10:22am. stated, "(R4's) medications were returned to the pharmacy on 3-9-2010 after (R4) expired. I will fax the list of (R4's) medications returned to the pharmacy and amounts on 3-9-2010."	F9999		

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On 4-19-2010 at 11:45am. E15 (LPN) stated, "I worked on 2-26-2010 and 2-27-2010. I did borrow medications from, I think greater than three residents for (R4). I don't remember which residents or which medications. I did return the medications to the other residents I borrowed from, the next time I worked, I think on 3-1-2010. I taped the pills I returned onto the back of the resident's medication punch out cards. I don't remember if I told any nurses about (R4's) meds not being delivered or having to borrow other residents' medications at shift change. I don't know if when getting shift report if any other nurse discussed not having (R4's) medications."

On 4-19-2010 at 11:50am. E1 (Administrator) verified E17 (LPN) worked February 27th and 28th of 2010 on day shift. The next time E17 worked was 3-2-2010. (The synopsis of E2/DON's investigation was completed on 3-1-2010. The pharmacy delivered R4's medications to the facility on 3-1-2010. E17 did not work until 3-2-2010 to return borrowed medications from R4's 3-1-2010 pharmacy delivered medications.) Additionally E17 on 4-13-2010 at 1:20pm. stated, "I borrowed on 2-27-20210 and 2-28-2010 medications from somebody else, a resident, I can't think of. I replaced the other resident's meds I borrowed from. I must have done this on 2-28-2010."

E1 (Administrator) on 4-19-2010 at 11:50am. verified E15 (LPN) worked February 26th and 27th 2010 on second shift. The next time E15 worked was 3-1-2010 from 6:00pm. to 10:00pm. E15 called in on 3-2-2010 and next worked 3-4-2010. (The synopsis of E2/DON's investigation was completed on 3-1-2010. The pharmacy delivered R4's medications to the

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F9999	Continued From page 78 facility on 3-1-2010. E15 did not work until 3-1-2010 from 6pm. to 10:00pm. to return borrowed medications from R4's 3-1-2010 pharmacy delivered medications.) Additionally E15 on 4-19-2010 at 11:45am. stated, "I did return the medication to the other residents I borrowed from the next time I worked. I think on 3-1-2010." R4's Pharmacy documented medications dispensed on 3-1-2010 and returned on 3-9-2010 by the facility are as follow: Labetalol 100mg. twice a day, Pharmacy dispensed 60 pills, Facility returned 55 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Nifedipine XL 30mg. one daily, Pharmacy dispensed 30, Facility returned 27 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Allopurinol 150mg. one daily, Pharmacy dispensed 15-300mg. pills, Facility returned 12.5 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Cardura 8mg. one daily, Pharmacy dispensed 30 pills, Facility returned 27 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Bumetanide 2mg. twice a day, Pharmacy dispensed 60 pills, Facility returned 55 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Zaroxolyn 5mg. one daily, Pharmacy dispensed 30 pills, Facility returned 27 pills. Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010. Zyprexa 2.5mg. one daily, Pharmacy dispensed 30 pills, Facility returned 27 pills.	F9999		

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Medications are documented as administered to R4 on the March 2010 MAR for 3-1-2010 through 3-3-2010.

R4's medications returned to the pharmacy from the 3-1-2010 delivery and usage until hospitalization on 3-3-2010 documented by the Pharmacy is inconsistent for E15 (LPN) and E17 (LPN) "borrowing", administering, and returning medications after R4's medication delivery on 3-1-2010. Medications documented on R4's 3-1-2010 through 3-3-2010 MAR, up to hospitalization on 3-3-2010 reconcile with the documented amount of medications returned to the pharmacy by the facility. (Had E15 [LPN] and E1 [LPN] borrowed other resident's medications for two and a half days, the facility would have returned two and a half more days of R4's medications to the pharmacy).

On 4-22-2010 at 1:15pm. E1 (Administrator) stated, "The pharmacy receipt or MAR for (R4), documenting the medications and quantity returned to the pharmacy on 3-9-2010 could not be located."

The 3-1-2010 at 8:00pm. Investigation Report for Falls documents R4 was found on "knees in front of wheel chair." This same report documents R4's blood pressure as 130/104.

R4's 3-2-2010 at 3:10pm. Investigation Report for Falls documents an unwitnessed fall.

The 3-3-2010 at 12:15pm. Nursing Note documents, "Certified Nursing Aide came to Nurse and requested she come to resident's room. Could not wake (R4). Went to room, resident would not wake up, did sternal rub,

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F9999	Continued From page 80 moved legs, moaned, but did not wake up. 12:25pm. blood sugar 49. 12:43pm. called 911." On 4-14-2010 at 9:20am. Z7 (Hospital Physician) stated, "The lack of medications on Friday evening, all day Saturday and Sunday after (R4's) admission to the Nursing Home would have definitely added to his decline. I followed (R4) from 3-3-2010 until 3-5-2010. He was in really bad shape. Missing even one dose of Labetalol, Cardura, Nifedipine, and Zaroxolyn would affect (R4). Regarding the falls on 3-1-2010 and 3-2-2010, I would expect (R4's) blood pressure to be elevated because (R4) would not have received medication to control his blood pressure over the weekend prior to these falls." R4's 3-3-2010 Hospital History and Physical documents, "Decompensated heart failure, chronic kidney disease, low blood sugar, and sepsis." On 4-15-2010 at 2:20pm. Z6 (LPN/Z5 Physician's Nurse) stated, "(Z5 / Physician) never saw this resident. (Z5/Physician) will not provide a statement for a resident he did not see." Additionally a telephone number was left, should Z5 (Physician) recall any further information." On 4-14-2010 at 1:11pm. E2 (DON) stated, "(R4's) Physician (Z5) was not contacted regarding the possibility that he did not receive meds from admission (2-26-2010) until 3-1-2010, because the nurses borrowed meds, on 3-1-2010 or 3-3-2010, when (R4) went to the hospital, or at any time. (Z5/Physician) is our Medical Director as well."	F9999		

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F9999	Continued From page 81 E2 (DON) on 4-15-2010 at 10:19am. stated, "(R4's) Physician (Z5) was never contacted regarding the possibility (R4) had not received his medications." E1 (Administrator) on 4-14-2010 at 11:09am. stated, "It was brought to my attention on 3-1-2010 by the Nursing Department that (R4) didn't receive his pills over the weekend. I don't know if (R4) didn't get his insulin or not. (E2/DON) was in charge of the investigation and discipline. (E2/DON) said that the nurses said the meds (pills) were borrowed from residents or from the back up insulin. (E2/DON) and I are Co-Directors of the Abuse/Neglect Committee. (Z5) is our Medical Director and I'm pretty sure he was aware of this. (Z5) is (R4's) doctor. Based on the investigative report, a synopsis by (E2/DON) and interviews with (E15/LPN and E17/LPN) which were conducted by (E2) regarding this incident, both were disciplined. I obviously don't believe it was a willful act by the nurses." After review of R4's 2-26-2010 telephone Physician Orders with a facility fax date of 3-2-2010 at 8:04am. and Z5's verification and stamped signature fax time of 3-3-2010 at 4:25pm., E2/DON on 4-14-2010 at 1:11pm. stated, "I don't know when (R4's) 2-26-2010 Physician Orders were signed and verified by (Z5/Physician). I don't know if our Facility Medication Policy addresses staff members borrowing resident's medications. (E15/LPN and E17/LPN) told me they borrowed the medications, pills. (R4) told me on 3-1-2010 he had his medications. (R4's) vital signs and blood sugars were within normal on that weekend."	F9999		

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The 3-11-2010 Initial MDS (Minimum Data Set), provided by E2 (DON) on 4-16-2010 at 2:49pm., Section B. Cognitive Patterns documents R4 has short-term memory deficits and is moderately impaired in daily decision making. E21 (LPN/MDS/Care Plan Coordinator) on 4-15-2010 at 10:00am. affirmed the 3-11-2010 MDS was the correct Initial MDS for R4.

On 4-13-2010 at approximately 12:30pm. E2 (DON) stated, "My investigation regarding (R4's) medication after his 2-26-2010 admission was, I talked with (R4), interviewed (E15/LPN and E17/LPN), and did this synopsis."

E2 (DON) provided a typed "synopsis" on white copy paper on 4-13-2010 at approximately 12:30pm. with a 3-1-2010 date (time is not documented) of the investigation completed regarding R4's 2-26-2010 through 3-1-2010 medication administration. E2 additionally signed this "synopsis" at that time. This same synopsis documented the following information, "Informed by (E18/LPN) that (R4) didn't have any meds in the building. Upon investigation noted that meds on MAR were circled and then signed below. (E18/LPN) stated that as she was doing her medication pass she noted that the new admission was missing some medications. She informed the DON that the medications were missing and was instructed to get the medications from back up pharmacy. Medication was then delivered from back up pharmacy. (E15/LPN) stated that he had circled medications during medication pass because he was unable to find meds at that time. He later was able to borrow meds in the medication cart to supplement medications until medications arrived

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F9999	Continued From page 83 from Pharmacy. When he was able to give medications he then initialed as medications being given. He stated that he had assumed that first shift on the day (R4) was admitted had notified doctor and pharmacy because first shift had started the paperwork/admission. He also assumed that the medication would be delivered from pharmacy. (E17/LPN) stated that she had circled medications as she to, [sic] was unable to find medications during medication pass. She then was able to borrow the medications in the medication cart to give to resident until medications came in. She stated that she thought they would be coming in that night, and thought that the nurse on seconds had faxed pharmacy. Spoke with resident (R4) regarding medications being given over the weekend. Resident states that he took medications, stated he doesn't really know what medications he took but does remember taking medications and receiving insulin and (blood sugar testing). Asked if everything else was ok and he stated that everything seemed to be ok. In looking at the residents vitals throughout the weekend it appears that even though there were not medications specifically in the building for this resident, it appears that based on the types of medication resident was receiving that medications were given as vital signs remained stable for this resident. Resident is on several different blood pressure medications and a diabetic. I believe that if resident was not receiving medication that his blood pressure and blood sugar would have been out of range. Plan of Correction: Medications were immediately requested from back up pharmacy. Admission policy was changed - if an admission comes in on a shift then that shift is responsible for every part of the admission. It was also suggested that	F9999		

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F9999	Continued From page 84 nurses keep all fax confirmations related to admissions to verify confirmation. Nurses were disciplined on the proper procedure for acquiring back up medications, for borrowing medications and not ensuring that a new admission had medications. All nurses were also education on admission process, back up pharmacy, and circling medications. Patient Care Coordinator is responsible for doing the new admission chart checks, will also check to ensure that all medications have been received from pharmacy." E20 (LPN) on 4-15-2010 at 9:25am. stated, "Part of the third shift nurse duties and responsibilities, on the last day of every month, are that the third shift nurse takes the entire wing's monthly MARS out of the individual resident's of the wing MAR book to be filed in the resident's chart and replaces it with the current MAR. After checking the next month's MAR with the actual resident's Physician Order. This is when I went searching through the C-wing medication cart and (R4's) file. I could not find any medications for (R4) or his Physician Orders in (R4's) chart. We (Nurses) transcribe a resident coming from a facility to our facility, the Physician Orders from the Facility Transfer Sheet to a Telephone Order Sheet that has a top sheet to fax to the resident's doctor for signature and keep the bottom carbon copy in the residents file. I could not locate this. I could only find (R4's) Hospital Transfer Orders in his file. At the time of admission, the admitting nurse transcribes the transferring facility Physician Orders, including medications to this duplicate carbon copy Physician Telephone Order Sheet, and contacts the resident's facility doctor responsible for the resident's entire plan of care to verify all physician orders and the medications, prior to faxing the physician verified	F9999		

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F9999	Continued From page 85 medication list to the pharmacy. I told (E18/LPN) at shift change I could not locate (R4's) medications or current Physician Orders in the file, as I discovered this shortly before shift change. It seems unlikely nurses working first and second shift two days in a row would go through all of the unnecessary work and trouble to borrow medications from another resident when pharmacy is available to us twenty-four hours a day, and very time consuming. I don't see how we as nurses would even have time to do all of this by either checking every resident's file, or every resident's MAR on C-wing, or look through the cart to borrow another resident's medications, and not call the pharmacy. I guess a nurse might know who might take a same medication, but the nurse I relieved from second shift (E19/RN) is as-needed and doesn't work very often. It still seems very unlikely. It doesn't make sense to me, especially for this length of time and the nurses working two days in a row. It seems unlikely they borrowed medications. I don't understand why the delay. I don't know how a nurse would return borrowed meds back to a resident they borrowed them from. The pharmacy sends resident medications monthly on a blister punch card with each days and times medications counted and the nurse pushes this blister pack and the medication is then put in a medication cup and administered to the resident. I don't know how the medication would be returned back to another resident as their medications would be off as the med would have been punched out of the card for that residents administration for another date and time. I just don't know. As I've said it just floors me. In the years I've been an LPN, I have not come upon a situation where a resident did not have any medications and for this length of time after	F9999		

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F9999	Continued From page 86 admission." On 4-15-2010 at 10:19am. E2 (DON) stated, "(E19/RN) works as needed for us. She picks up at least one shift a month. I think the last time she worked was the first part of March 2010. I checked the schedule and (E19/RN) worked 3-27-2010 and 2-28-2010, second shift. I didn't get a chance to talk to (E19/RN) about (R4). I tried to call her twice and didn't get ahold of her. I didn't get a chance to talk to her, I didn't get a call back. If the nurse were wanting to borrow medications from another resident's medications a nurse would determine what medications another resident was taking by checking each resident's chart, or checking each resident's monthly MAR, Physician Orders, or checking all the single dose medication cards in the C-wing medication cart. Our census today is 120, so half of that is 60 residents roughly with meds on the C-wing cart. On average how many medications a resident takes is difficult to say. I've had residents with thirty medications before, but I would say a good average of different types of medications a resident takes would be around ten. So C-wing medication cart would average six hundred different single dose medication cards from the pharmacy. I will count the medication cards on the C-wing cart today, it will not include narcotics." E2 (DON) was asked if (R4) is prescribed nine different medications in pill form and insulin to be administered on days and second shift, and pharmacy is available twenty-four hours a day, why would two nurses working first and second shift, two days in a row, and a third nurse working second shift, go through this very time consuming task and not just call the twenty-four hour pharmacy for R4's medications? Additionally isn't borrowing another	F9999		

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F9999	Continued From page 87 resident's medications against Facility Medication Administration Policy and violating Professional Standards? E2 (DON) then replied, "I can't answer that, I don't know. No, it doesn't seem odd, I think it depends on the nurse. I did not ask (E15/LPN or E17/LPN) that. Well another possibility is that other residents routinely take the same meds and finding the medications wouldn't take as long. I don't know how or when they replaced the borrowed medications, or which residents they borrowed medications from. I didn't ask (E15/LPN or E17/LPN) that. Well I don't know if I could call it an investigation, an official investigation of (R4). With all these questions I feel I should have done a more thorough investigation, like which resident's medications were borrowed, checking the C-wing med cart. I interviewed (R4) and he said he had gotten medication over the weekend. I interviewed (E15/LPN and E17/LPN) and they said they borrowed other people's medications so I disciplined them for obtaining medications and the admission process." On 4-15-2010 at 9:45am. and 4-19-10 at 10:53am E19 (RN) was reached by telephone at telephone numbers provided by E2 (DON) on 4-1-2010 at 11:07am. The 3-31-2010 at 10:44am. Resident Roster provided by E1 (Administrator) documents the Facility census as 126 residents, 66 residents residing on C-wing. E2 (DON) on 4-16-2010 provided a fax with a time of 2:49pm. documenting, "You had asked for the amount of (medication) cards in C-wing (medication) cart - there are approximately 230." (This number does not include narcotics or	F9999		

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refrigerated medications, pills only).

On 4-21-2010 at 11:57am. E1 (Administrator) stated, "A Medication Error Report was not completed and sent to the pharmacy due to, at the time, we thought (R4's) meds had been borrowed."

E1 (Administrator) on 4-21-2010 at 1:00pm. provided a list of medications in the pharmacy convenience box. The generally used medications in the convenience box can be administered, on a short-term basis, until pharmacy medication delivery occurs. R4's medications, pills prescribed at the time of his admission to the facility, on 2-26-2010, are not included in the convenience box medication list.

The revised 10-2007 Facility Medication Administration Policy is:

Definition:
Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person n,[sic] accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container, (including a unit dose container), verifying it with the Physician's Orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.

Procedure:
16. After a drug is given, record the date, time, name of drug dose and route on the resident's individual Medication Administration Record.

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F9999	Continued From page 89 19. Document any medications not administered for any reason by circling initials and documenting on the back of the MAR the date, the time, the medication and dosage, reason for omission and initials. 20. Destroy medications prepared for a resident if not used immediately. Do not return a medication to its container. 21. If the medication is not available for a resident, call the pharmacy and notify the physician when the drug is expected to be available. Like medications are not to be "Borrowed" from one resident for another. 22. Notify the physician as soon as practical when a scheduled dose of a medication has not been administered for any reason. 23. Report errors in medication administration immediately per policy. The Long Term Care Facility Pharmaceutical Services Policy and Procedure Manual provided by E1 (Administrator) on 4-21-2010 at 11:02am. documents the following information: V. (Medication dispensing card) System B. Characteristics (Material) card each have neatly cut windows numbered 1 through 30, or 32. Applied to the back inside of card is a foil and vinyl FDA, (Food and Drug Administration) approved coating. VI. Medication Orders and Patient's Charts A. All medications must be prescribed by a licensed physician, or other individuals allowed by law to prescribe. C. Telephone orders are to be written on the special Physician Telephone Orders form, and signed by the nurse taking the order. The original is then immediately sent to the physician	F9999		

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TIMBERCREEK REHAB & HEALTHCARE CENTER	**2220 STATE STREET** **PEKIN, IL 61554**

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F9999	Continued From page 90 for signature. The duplicate is to be kept in the chart until the signed original is returned. VIII. New Medication Orders and Returns Returns A. Returned medications should be returned to the pharmacy in the following manor: 1. Document on MAR the quantity being returned to the pharmacy. 2. Write a reason for returning on card/label (i.e. -discharged, discontinued, changed). 3. Place cards in tote to be picked up with the next scheduled delivery. XIV. Convenience Box A. A convenience box will be at the nursing station designated. B. It will consist of the most generally used medications in the facility, and will be selected by the Pharmaceutical Services Committee. E. A list of medications in the convenience box will be kept at the nursing station and a list is posted on the outside of the convenience box. XVIII Adverse Drug Reactions and Drug Errors C. A medication error has been made when one of the following occurs: 6. Medication not administered. H. A Medication Error Report shall be completed for any of the above occurrences. Every section of the report must be completed accurately. I. Reports are reviewed to identify any possible trends in the facility. XXVI. Medication Administration D. Procedure for Medication Pass 12. Return to med cart and document any medications held or refused by circling initials, and documenting on the back of the MAR,	F9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145275	A. BUILDING ______ B. WING ______	C 04/26/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TIMBERCREEK REHAB & HEALTHCARE CENTER	2220 STATE STREET PEKIN, IL 61554

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F9999	Continued From page 91	F9999		

Continued From page 91

(routine medications) or as needed (medication) sheet, the date, time, medication and dose, reason for omission and initials.

XXVII. Store Hours
Any orders that are needed after our driver has left for the day, or prior to the daily delivery should be called in using the after hours number. Arrangements will be made to provide you the medication orders.
(Name of Pharmacy) provides emergency service twenty-four hours a day, seven days a week. After regular business hours, telephone our answering service at (number). A pharmacist will call you back and your medication order will be filled.

On 4-13-2010 at 8:10am. E1 (Administrator) stated, "We do not have a Facility Admission Policy per se, we have a Nursing Admission Checklist we use." The Nursing Admission Checklist provided by E1 at this time documents the following information.
Verify Physician orders if not attending physician or no signed medical doctor orders.
Place all verified orders on the Physician Order Sheet.
Fax Face Sheet and Physician Order Sheet to pharmacy.
Transfer verified orders to the MAR and TAR, (Treatment Administration Sheet).

As a result of the facility's failure to administer medications and verify Physician Orders, from R4's time of admission to the facility, on a Friday afternoon, 2-26-2010 until the following Monday morning, 3-1-2010, R4 suffered a decline in his medical condition and sustained two falls The facility failed to notify R4's physician, at any time,