DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. BUILDING ______ B. WING ______	C 10/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLEVILLE HEALTHCARE & REHAB	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Complaint Investigation #1142789/IL 54448 (F157, F327, F333, F425) #1143069/IL 54756 - no deficiencies #1143114/IL 54803 (F225, F226, F282, F323)	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		11/4/11

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

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.

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F 157	Continued From page 1	F 157		

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to inform the physician promptly for a change in condition, vomiting and of a missed dose of pain medications for 1 of 4 residents (R1) reviewed for pain management in a sample of 13.

The findings include:

R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer, congestive heart failure, chronic renal failure and chronic pain. R1 was receiving Hospice services. On admission, R1 had physician orders for Fentanyl Transdermal 12 mcg (micrograms)/hour every three days. The hospital "Medication Reconciliation Discharge" noted R1 had a Fentanyl patch placed on 9/7/11 and R1 would require a new patch on 9/10/11.

R1's facility Medication Administration Record for September had no documentation the Fentanyl patch was changed on the 9/10/11. There is no documentation that any PRN (as needed) morphine was given to R1.

Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM that she did not receive a call regarding R1. Z1 stated Z6, Physician Assistant, received calls when R1 was admitted regarding the pain medication on 9/9/11 and 9/10/11 but no calls about R1's change in condition which included vomiting. Z1 stated she was not aware R1 had not received his pain medication or that he was vomiting until after the fact.

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F 157	Continued From page 2 Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM she received a call from the facility staff on Friday that they were having problems getting R1's pain medication. On Saturday, 9/10/11, she also received a call from the facility that they could not get the medication. Both times Z6 stated she told the facility staff to call Hospice to get the medications. Z6 stated she did not receive a call from the Facility on Sunday, 9/11/11, regarding R1 not receiving the pain medication or vomiting. Z6 stated she did talk to the Hospice nurse, Z3, on Sunday evening and Z3 stated no one from the facility had called her about the pain medication. Z6 stated that at no time was she contacted regarding R1 vomiting until Z3 contacted her on the evening of 9/11/11. Z3 was not aware R1 had not received the Fentanyl patch until after the fact. Z3 stated in an interview on 10/12/11 that she was on call the weekend of 9/10/11 and 9/11/11 and had not been contacted regarding R1's pain medication or vomiting by the Facility. Z3 stated the family of R1 called her on the evening of 9/11/11 due to concerns with his condition and she went to the facility. Z3 stated when she arrived at the facility, R1 was "begging" for water, had a large indentation on his left leg due to the side rail, was very agitated, had a low blood pressure and was vomiting. Z3 stated the facility staff told her they had not given R1 any fluids due to the vomiting. Z3 stated she called Z2, Hospice Physician, who ordered R1 sent to the emergency room. R1 was admitted for acute on chronic renal failure, congestive heart failure, nausea and vomiting possibly due to uremia. R1's blood urea nitrogen was elevated at 126 (8-23 mg/dl) (milligram/deciliter) and creatinine was 2.71	F 157		

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F 157	Continued From page 3 (0.70-1.20 mg/dl). Z2 noted that R1's creatinine level was 1.7 on 9/9/11. Z2 documented in the hospital progress notes that R1's family had called Z3 due to concern with his condition. Z2 documented in the progress note on 9/12/11 that she spoke to Z1 and Z1 had not been contacted by the facility. R1 expired on 9/16/11.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225		11/4/11

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F 225	Continued From page 4 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the Facility failed to immediately report to the Department and thoroughly investigate an allegation of abuse and an injury of unknown origin for 1 of 4 residents (R11) reviewed for abuse in a sample of 13. The findings include: E2, Director of Nursing, stated in an interview at 9:40 AM on 10/17/11 that she was not aware of any abuse allegations especially involving a staff throwing a resident in bed. E1, Administrator, also stated on 10/17/11 at 9:40 AM that she was not aware of any abuse allegations. At 10:45 AM on 10/17/11, E1 stated E2 did have a report of staff being rough with a resident during a transfer but didn't think it was abuse. E1 stated she was not sure who the staff or resident was and there was no abuse or incident investigation or report. E2 stated in an interview on 10/17/11 at 10:50 AM, that on 10/5/11 E3, Licensed Practical Nurse had reported to her that R11's roommate, R10, had stated a staff was "rough" with R11. E2 stated E18, Certified Nurse Aide, picked R11 up to transfer her and R11 landed roughly in the bed.	F 225		

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F 225	Continued From page 5 E2 stated she talked to E18 who told her she did put R11 in the bed by herself and it was rough but not intentional. E2 stated she did not fill out a incident investigation nor did she conduct an abuse investigation because she "didn't feel it was abuse". E2 stated she did not report the abuse allegation to the Department because she didn't think it was abuse. E2 stated at the time there were no bruises on R11. R11 was unable to say what had occurred. R10 stated in an interview on 10/17/11 at 11:50 AM that staff had thrown R11 in bed and her feet got twisted in the wheelchair. R10 stated R11 was crying. R10 stated she didn't want to get anyone in trouble but she didn't like how R11 was treated so she reported it. R10 would not state who the staff was. On 10/17/11 at 1:30 PM, R11's arms were observed. R11 had three finger shaped bruises on the top of her right forearm. There was a dark circular lemon sized bruise on the underside of her forearm. On the left arm there was some light bruising on the top of her forearm with a dark circular lemon sized bruise on the underside of the forearm. There is no incident report or investigation for bruises of unknown origin for R11. R11 did have a fall out of bed on 10/13/11, however, the report does not identify any injuries or any bruises on the arms. The nurses notes from 10/1/11 to 10/17/11 do not identify any bruising on R11. Weekly skin checks were ordered, however, none were done. E20, Treatment Nurse, confirmed in an interview on 10/17/11 at 12:00 PM, there were no weekly skin checks being done and she had not observed the bruising nor documented on it.	F 225		
F 226	483.13(c) DEVELOP/IMPLMENT	F 226		11/4/11

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F 226 SS=D

Continued From page 6

ABUSE/NEGLECT, ETC POLICIES

F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the Facility failed to follow their written abuse policies and procedures for 1 of 4 residents (R11) reviewed for abuse in a sample of 13.

The findings include:

In an interview at 10:45 AM on 10/17/11, E1, Administrator, stated E2, Director of Nursing, had received a report of staff being rough with a resident during a transfer but didn't think it was abuse. E1 stated she was not sure who the staff or resident was and there was no abuse or incident investigation or report.

E2 stated in an interview on 10/17/11 at 10:50 AM, that on 10/5/11 E3, Licensed Practical Nurse had reported to her that R11's roommate, R12, had stated a staff was "rough" with R11. E2 stated she did not fill out a incident investigation nor did she conduct an abuse investigation because she "didn't feel it was abuse". E2 stated she did not report the abuse allegation to the Department because she didn't think it was abuse. E2 stated at the time there were no bruises on R11.

On 10/17/11 at 1:30 PM, R11's arms were observed and bruising was observed on the top and underside of both forearms. There is no

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F 226	Continued From page 7 incident report or investigation for bruises of unknown origin for R11. R11 did have a fall out of bed on 10/13/11, however, the report does not identify any injuries or any bruises on the arms. The nurses notes from 10/1/11 to 10/17/11 do not identify any bruising on R11. Weekly skin checks were ordered, however, none were done. E20, Treatment Nurse, confirmed in an interview on 10/17/11 at 12:00 PM, there were no weekly skin checks being done and she had not observed the bruising nor documented on it. The Facility "Abuse Prevention Program Facility Procedures" state "Employees are required to report any occurrences of potential mistreatment they observe, hear about, or suspect to the administrator". It also states "Upon learning of the report, the administrator shall initiate an incident investigation" and "The nursing staff is additionally responsible for reporting on a facility incident report the appearance of bruises, lacerations, or other abnormalities as they occur. Upon report of such occurrences, the nursing supervisor is responsible for assessing the resident, reviewing the documentation and reporting to the administrator or designee". The facility abuse policy states "If during the course of an incident investigation, the administrator has determined there is reasonable cause to suspect mistreatment has occurred, the residents representative and the Department of Public Health shall be informed immediately" which does not follow the regulations which states all alleged violations of potential abuse must be reported immediately.	F 226		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		11/4/11

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F 282	Continued From page 8	F 282		

must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on record review, observation and interview, the facility failed to follow the plan of care for 1 of 4 residents (R11) reviewed that required assistance with transfers in a sample of 13.

The findings include:

E18, Certified Nurse Aide, stated on 10/17/11 at 11:00 AM that on 10/5/11 she stood in front of R11, picked R11 up under her arms and sat her on the bed with no assistance from other staff. E18 stated she did not have a gait belt on R11 nor was she using the sit to stand lift as required by R11's plan of care. E18 stated R11 said "OW" but she was not sure why. E18 stated she had scraped R11's foot on her wheelchair earlier as her feet had got caught in the wheelchair. E18 stated she didn't drop R11 hard on the bed.

The Care Plan with the target date of 12/2/11 identified R11 requires assist with daily care. Interventions include, in part, "sit to stand lift with 2 assist" with the "sit to stand" crossed through and "Mechanical" written in. There is no date. E2 stated on 10/17/11 at 12:00 PM they changed R11 to a mechanical lift after the transfer incident on 10/5/11. E2 confirmed that R11 was a 2 person assist with the sit to stand lift at the time of the incident.

The care plan also states to provide R11 a "Skin assessment weekly". Weekly skin checks

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F 282	Continued From page 9 were ordered, however, none were done. E20, Treatment Nurse, confirmed on 10/17/11 at 12:00 PM, there were no weekly skin checks being done and she had not observed the bruising nor documented on it. On 10/17/11 at 1:30 PM, R11's arms were observed. R11 had three finger shaped bruises on the top of her right forearm. There was a dark circular lemon sized bruise on the underside of her forearm. On the left arm there was some light bruising on the top of her forearm with a dark circular lemon sized bruise on the underside of the forearm.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A). Based on record review, observation and interview, the Facility failed to follow the plan of care for transfers for 1 of 4 residents (R11) reviewed for transfers in a sample of 13. The findings include: At 10:45 AM on 10/17/11, E1, Administrator, stated in an interview that E2, Director of Nursing, had received a report of staff being rough with a resident during a transfer. E2 stated in an	F 323		11/4/11

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F 323	Continued From page 10 interview on 10/17/11 at 10:50 AM, that on 10/5/11 E3, Licensed Practical Nurse had reported to her that R11's roommate, R10, had stated a staff was "rough" with R11. E2 stated E18, Certified Nurse Aide, picked R11 up to transfer her and R11 landed roughly in the bed. E2 stated she talked to E18 who told her she did put R11 in the bed by herself and it was rough but not intentional. E2 stated she did not fill out a incident investigation nor did she conduct an abuse investigation because she "didn't feel it was abuse". E2 stated at the time there were no bruises on R11. E2 stated in an interview at 12:30 PM on 10/17/11 that she had gone to talk to R10 and R10 stated E18 was rough with R11 and had picked her up and sat her down in bed. E2 stated there was no bruising at the time but did think there was some bruising afterwards. E18, Certified Nurse Aide, stated on 10/17/11 at 11:00 AM that on 10/5/11 she stood in front of R11, picked R11 up under her arms and sat her on the bed with no assistance from other staff. E18 stated she did not have a gait belt on R11 nor was she using the sit to stand lift as required by R11's plan of care. E18 stated R11 said "OW" but she was not sure why. E18 stated she had scraped R11's foot on her wheelchair earlier as her feet had got caught in the wheelchair. E18 stated she didn't drop R11 hard on the bed. R11 was unable to say what had occurred. R10 stated in an interview on 10/17/11 at 11:50 AM that staff had thrown R11 in bed and her feet got twisted in the wheelchair. R10 stated R11 was crying. R10 stated she didn't want to get anyone in trouble but she didn't like how R11 was treated so she reported it. R10 would not state who the staff was.	F 323		

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F 323	Continued From page 11 On 10/17/11 at 1:30 PM, R11's arms were observed. R11 had three finger shaped bruises on the top of her right forearm. There was a dark circular lemon sized bruise on the underside of her forearm. On the left arm there was some light bruising on the top of her forearm with a dark circular lemon sized bruise on the underside of the forearm. There is no incident report or investigation for bruises of unknown origin for R11. R11 did have a fall out of bed on 10/13/11, however, the report does not identify any injuries or any bruises on the arms. The "Shower Record/Skin Report" dated 10/4/11 noted R11 had no bruising. On 10/7/11 "bruising" was checked but there was no description of the bruising. E19, shower aide, stated in an interview on 10/18/11 at 10:30 AM that R11 had a red bruise area on her chest and there were no bruises on her arms. E19 stated she did report the area to the nurse. There is no nurse signature on the shower record. The shower sheets dated 10/11/11 and 10/17/11 do not identify any bruising. The nurses notes from 10/1/11 to 10/17/11 do not identify any bruising on R11. Weekly skin checks were ordered, however, none were done. E20, Treatment Nurse, confirmed in an interview on 10/17/11 at 12:00 PM, there were no weekly skin checks being done and she had not observed the bruising nor documented on it. The Care Plan with the target date of 12/2/11 identified R11 requires assist with daily care. Interventions include, in part, "sit to stand lift with 2 assist" with the "sit to stand" crossed through and "Mechanical" written in. There is no date. E2 stated on 10/17/11 at 12:00 PM they changed R11 to a mechanical lift after the transfer incident on 10/5/11. E2 confirmed that R11 was a 2	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12	F 323		

person assist with the sit to stand lift. The care plan also states to provide R11 a "Skin assessment weekly".

B). Based on observation, record review and interview, the Facility failed to monitor and supervise 1 of 1 residents (R12) reviewed for use of oxygen in a smoking area in a sample of 13.

The findings include:

On 10/17/11 at 12:35 PM, R12 was observed in the outside smoking area seated in a wheelchair next to R13, who was smoking. R12 was wheeled around by an activity staff to come back into the building and a metal oxygen cannister was observed on the back of R12's wheelchair. R12 was putting the oxygen tubing back on her nose and the staff brought R12 back into the building.

E2, Director of Nursing, was immediately notified of R12 in the smoking area with oxygen. E2 stated she should not be out there with the oxygen tank. E2 approached the activity staff and told them they could not take R12 out with the oxygen cannister. The activity staff stated that they had turned the oxygen off. E2 stated they could not take the tank out in the smoking area.

At 1:00 PM staff was taking R12 back out to the smoking area with the oxygen tank on her wheelchair. E2 stopped the staff and told them they had to take the tank off of the wheelchair. The staff replied the tank was turned off. Staff took the tank off of the wheelchair before R12 went out to smoke.

The facility policy and procedure "Oxygen Precautions" states "To reduce the fire hazard in

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F 323	Continued From page 13 the administration of oxygen, the following precautions should be taken:...SMOKING, OPEN FLAMES AND ELECTRICAL APPLIANCES THAT CREATE SPARKS MUST BE PROHIBITED IN ROOMS WHERE OXYGEN IS IN USE".	F 323		
F 327 SS=G	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to assess risk factors, fluid intake and output and monitor the fluid needs for 1 of 4 residents (R1) reviewed to be at risk for dehydration in a sample of 13. This failure resulted in a low fluid intake, dehydration and hospitalization for R1. R1 expired on 9/16/11. The findings include: R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer, congestive heart failure, chronic renal failure and chronic pain. R1 was receiving Hospice services. E3, Licensed Practical Nurse, stated in an interview on 10/11/11 at 12:40 PM that R1 was vomiting small amounts of clear liquid during the 6 AM to 2 PM shift. E3 stated she did not call the physician due to the small amount. E3 stated the family of R1 gave R1 water and he did vomit the water. E3 stated she asked the family not to give him any more fluids. E3 stated R1 did not	F 327		11/4/11

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F 327	Continued From page 14 complain of nausea so she didn't give him any anti-nausea medication. E3 stated R1`kept asking for water and was voiding "OK". E3 stated the urine was not concentrated. The nurses notes by E3, dated 9/10/11 documented "fluids given as tolerated, asks for water constantly, Foley patent and draining dark amber urine to gravity...". The nurses notes by E3 and dated 9/11/11 at 3:44 PM documented "asks for water continuously, water given, total care given, denies pain or discomfort, no s/s (signs/symptoms) of distress noted. Resident had moderate amount of clear emesis, RP (family) here and was giving him water, nurse did ask RP (family not to give anymore water for now)...". E5, Registered Nurse, stated in an interview on 10/18/11 at 11:05 AM that she did not recall R1 asking for water. E5 stated she was told R1 had an emesis and they were reluctant to give R1 any fluids due to aspiration. E5 stated she did not give R1 anything for nausea nor did she call the physician. E5 stated the family had called hospice and the hospice nurse came in to check on him. E5 stated R1 was incontinent of a large bowel movement also. E5 stated there was about 100-150 cc's (cubic Centimeters) in the catheter bag and she was not sure if it had been emptied before that. E5 stated she thought Z3 sent R1 to the hospice because she was not sure of the urinary output. E5 stated she was not sure if the intake and output sheet was done. The nurses notes dated 9/12/11 at 12:03 AM documented "Resident continues on hospice care...Advised to hold fluids, as resident had emesis of liquids, water," and "Spoke to (Z3) hospice nurse, following call from (family).	F 327		

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Advised that medications given 1 mg Ativan, and 0.5 ml liquid morphine but holding liquids".

The "Intake and Output" sheet for September, 2011 documented no fluid intake for 9/10/11 or 9/11/11. The urine output for 9/10/11 was documented as 500 for Days, 300 for Evenings, and 300 for Nights. The only documentation of output for 9/11/11 was on days with 350 documented. There was no documentation for bowel or emesis output for 9/11/11. Fluid needs are estimated for R1's weight of 104 kilograms at 2614 to 3120 cc's (cubic centimeters) per day.

The "Initial Care Plan" dated 9/9/11 documented R1 was at risk for dehydration due to Lasix administration. The Initial Care Plan documented to maintain adequate hydration, R1 would be "assessed for dehydration", "follow hydration protocol", "I & O (intake and output)", "offer fluids", and "monitor skin turgor".

E8, Certified Nurse Aide (CNA), stated in an interview on 10/17/11 at 1:15 PM that R1 asked for water a lot. E8 stated he worked the 6 AM to 2 PM shift on 9/11/11 and R1 had not vomited but didn't eat a lot. E8 stated R1 seemed uncomfortable.

E21, CNA, stated in an interview on 10/11/11 at 11:40 AM that he worked from 2 PM to 11 PM on 9/11/11. E21 stated R1 was calling out for water. E21 stated the nurse, E5, said to stop giving fluids because R1 was throwing up the water all day. E21 stated the family kept giving him water. E21 stated he stopped giving water around 5:30 PM.

E9, CNA, stated in an interview on 10/11/11 at 11:10 AM that he worked the 6 AM to 2 PM shift on 9/11/11. E9 stated they didn't give R1 fluids on Sunday because the nurses were afraid to give him too much water. E9 stated the nurse,

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E3, told him not to give fluids. E9 stated R1 always wanted water and would call out all the time.

E7, CNA, stated in an interview on 10/17/11 at 8:25 AM stated R1 was calling out for water. E7 stated she worked the 11 PM to 6 AM shift that started on 9/11/11. E7 stated the hospice nurse was there when she came in. R1 had a huge bowel movement that went all over the bed. E7 stated R1 kept asking for water and she gave him some. No one said not to and he had not vomited on her shift.

Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM that she did not receive a call regarding R1 that weekend. Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM that at no time was she contacted regarding R1 vomiting until Z3 contacted her on the evening of 9/11/11.

Z3 stated in an interview on 10/12/11 that she was on call the weekend of 9/10/11 and 9/11/11 and had not been contacted regarding R1's vomiting by the Facility. Z3 stated the family of R1 called her on the evening of 9/11/11 due to concerns with his condition and she went to the facility about 11:00 PM.

Z3 stated when she arrived, R1 was "begging" for water, had a large indentation on his left leg due to the side rail, was very agitated, had a low blood pressure and was vomiting. Z3 stated the facility staff told her they had not given R1 any fluids due to the vomiting. Z3 stated she gave R1 some anti-nausea medications and he calmed down. Z3 stated she called Z2, Hospice Physician, who ordered to send R1 to the emergency room.

The hospice progress notes dated 9/11/11 at 8:30 PM documented Z3 called the facility and

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F 327	Continued From page 17 talked to E5. The note states E5 reported to her that R1 was "the same as he was last night when I was here, just hollering out, begging for water, but he has been throwing up so we haven't given him anything to drink". The note also states E5 was asked if R1 had been given sips of water or at least swabbing his mouth and E5 stated "no". Z3 asked E5 if R1 had been eating and she stated "he hasn't been eating". Z3 then called Z2, Hospice Physician, and was told to make a visit to the facility. The hospice progress note dated 9/11/11 at 10:00 PM documented that Z3 found R1 "literally begging for water stating "water, ice water, I need water, please, help me". The urine was dark yellow. Z3 provided toothettes, ice water sips, Tylenol and phenergan suppositories. Z3 gave R1 a drink and he vomited. Z3 called Z2 who immediately ordered to send R1 to the emergency room "for pain and symptom control related to the N/V (nausea/vomiting) and his restless state and condition a the LTCF (long term care facility)". The "Triage Assessment" emergency room notes dated 9/12/11 documented "(Hospice) nurse was visiting patient per family request. Patient has not been given anything to drink all day. The amount of urine in catheter is output for the day..." . There was no amount documented. The assessment documented the urine as "yellow" and "concentrated". According to the hospital notes by Z2, Hospice Physician, R1 was admitted for acute on chronic renal failure, congestive heart failure, nausea and vomiting possibly due to uremia. R1's blood urea nitrogen was elevated at 126 (8-23 mg/dl) (milligram/deciliter) and creatinine was 2.71 (0.70-1.20 mg/dl). Z2 documented in the	F 327		

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F 327	Continued From page 18 hospital progress notes that R1's family had called Z3. Z2 noted that she spoke to Z1 and she had not been contacted by the facility. Z2 noted that R1's creatinine level was 1.7 on 9/9/11. R1 expired on 9/16/11.	F 327		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to provide pain medications as ordered by the physician to 1 of 4 residents (R1) reviewed for pain medication in a sample of 13. The findings include: R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer, congestive heart failure, chronic renal failure and chronic pain. On admission R1 had physician orders for Fentanyl Transdermal 12 mcg (micrograms)/hour every three days. R1 also had orders for Morphine Sulfate Concentrate 10 milligrams every three hours routinely and every 1 hour as needed for severe pain. The hospital "Medication Reconciliation Discharge" noted R1 had a Fentanyl patch placed on 9/7/11 and would require a new patch on 9/10/11. The "Admission Nursing Assessment" dated 9/10/11 documented R1 had pain daily with the intensity of the pain noted "Times when pain is horrible or excruciating". The "Pain Assessment" dated 9/10/11 documented R1's pain as "severe"	F 333		11/4/11

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F 333	Continued From page 19 with limitations in sleeping and activities due to the pain. The facility Medication Administration Record for September for R1 had no documentation the Fentanyl patch was changed on 9/10/11. There is no documentation that any PRN (as needed) morphine was given to R1. E5, Registered Nurse, stated on 10/18/11 at 11:05 AM that she only gave R1 his scheduled morphine and she did not recall giving R1 any PRN morphine. E5 could not recall the Fentanyl patch for R1. E5 stated R1 was "agitated" and "restless" during sleep. E5 stated R1 was "thrashing around" before the hospice nurse came that evening. The nurses notes dated 9/12/11 at 12:03 AM by E5 documented "Resident admitted previous night on hospice with Foley catheter, hematuria, in renal failure....Cries out with movement or while stationary. Medicated on 0.5 ml liquid morphine q (every) 3 hrs (hours). Resident sleeping but has restless movements @ (at) times". On 9/12/11 R1 was sent to the hospital emergency room for vomiting according to the emergency room record. The hospital emergency department noted a patch was on R1's shoulder dated 9/7/11. Z2, Hospice Physician, documented in the "Progress Notes" "Unclear if pt (patient) had rec'd (received) meds (medication) as ordered @ (at) NH (nursing home)-Fentanyl patch never changed (due 9/10 and changed today (at) hosp (hospital). PRN (As Needed) meds (medication) not being given." E2, Director of Nursing, stated in an interview on 10/11/11 at 10:30 AM, that R1 did not get the Fentanyl patch or PRN Morphine because the pharmacy didn't send the patches or the	F 333		

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F 333	Continued From page 20 morphine. E2 stated it was the weekend and they couldn't get the physician authorization for the pharmacy to send the medications. E2 stated she was not aware he didn't get the patch until after the fact. E2 stated staff got the morphine out of the emergency kit and R1 received the scheduled morphine but not the PRN morphine. On 10/13/11 the packing slip from the pharmacy was obtained. The slip shows "1.0 Fentanyl Dis (disc) 12 mcg/hr" was sent for R1. The packing slip also documented "30.0 Morphine Sul (Sulfate) Sol (Solution) 20 mg/ml (milligrams/milliliter)" was sent to the facility. The medications were received by E5, Registered Nurse, on 9/10/11. No time was documented. Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM, that R1 came in to the facility on a Friday evening, 9/9/11. Z1 stated there was some confusion with the medication and Z6, Physician Assistant, had taken the call that weekend. Z1 stated she did talk to Z2, Hospice Physician, after R1 was admitted to the hospital on 9/12/11. R1 was having more pain than before his admission to the facility and Z2 was concerned about pain management. Z1 stated if R1 did not get the Fentanyl patch as ordered or the PRN medication then his pain could have increased. Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM that she received a call from the facility staff on Friday that they were having problems getting R1's pain medication. Z6 stated she called the pharmacy Friday evening about 11 PM and spent an hour trying to get them to send the medication. On Saturday Z6 also received a call from the facility that they could not get the medication. Both times Z6 stated she told the facility staff to call	F 333		

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F 333	Continued From page 21 Hospice to get the medications. Z6 stated R1 was in pain and the staff were trying to get the pain medication. Z6 stated she did talk to the Hospice nurse, Z3, on Sunday evening and Z3 stated no one from the facility had called her about the pain medication. Z3, Hospice Nurse, stated in an interview on 10/12/11 at 9:05 AM that she did not receive any calls from the facility regarding R1's pain medications. Z3 stated that the family of R1 called her on the evening of 9/11/11 regarding R1's change of condition.	F 333		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425		11/4/11

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F 425	Continued From page 22 by: Based on record review and interview, the Facility failed to obtain, receive and administer pain medications for 1 of 4 residents (R1) reviewed for pain in a sample of 13. The findings include: R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer, congestive heart failure, chronic renal failure and chronic pain. On admission R1 had physician orders for Fentanyl Transdermal 12 mcg (micrograms)/hour every three days. R1 also had orders for Morphine Sulfate Concentrate 10 milligrams every three hours routinely and every 1 hour as needed (PRN) for severe pain. The hospital "Medication Reconciliation Discharge" noted R1 had a Fentanyl patch placed on 9/7/11 and would require a new patch on 9/10/11. The facility Medication Administration Record for September for R1 had no documentation the Fentanyl patch was changed on 9/10/11. There is no documentation that any PRN or "as needed" morphine was given to R1. On 9/12/11 R1 was sent to the hospital emergency room for vomiting. The hospital emergency department noted a patch was on R1's shoulder dated 9/7/11. Z2, Hospice Physician, documented in the "Progress Notes" "Unclear if pt (patient) had rec'd (received) meds (medication) as ordered @ (at) NH (nursing home)-Fentanyl patch never changed (due 9/10 and changed today (at) hosp (hospital). PRN (As Needed) meds (medication) not being given." E2, Director of Nursing, stated in an interview on 10/11/11 at 10:30 AM, that R1 did not get the Fentanyl patch because the pharmacy didn't send	F 425		

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F 425	Continued From page 23	F 425		

the patches or the morphine. E2 stated it was the weekend and they couldn't get the physician authorization for the pharmacy to send the medications. E2 stated she was not aware he didn't get the patch until after the fact. E2 stated they got the morphine out of the emergency kit so R1 did get the scheduled morphine but not the PRN.

Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM, that R1 came in to the facility on a Friday evening, 9/9/11. Z1 stated there was some confusion with the medication and Z6, Physician Assistant, had taken the call that weekend. Z1 stated she did talk to Z2, Hospice Physician, after R1 was admitted to the hospital on 9/12/11. R1 was having more pain than before his admission to the facility and Z2 was concerned about pain management. Z1 stated if R1 did not get the Fentanyl patch as ordered or the PRN medication then his pain could have increased.

Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM that she received a call from the facility staff on Friday that they were having problems getting R1's pain medication. Z6 stated she called the pharmacy Friday evening about 11 PM and spent an hour trying to get them to send the medication. On Saturday she also received a call from the facility that the facility staff stated they could not get the medication. Both times Z6 stated she told the facility staff to call Hospice to get the medications. Z6 stated R1 was in pain and they were trying to get the pain medication. Z6 stated she did talk to the Hospice nurse, Z3, on Sunday evening and Z3 stated no one from the facility had called her about the pain medication.

Z3, Hospice Nurse, stated in an interview on

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F 425	Continued From page 24 10/12/11 at 9:05 AM that she did not receive any calls from the facility regarding R1's pain medications. Z3 stated that the family called her on the evening of 9/11/11 regarding R1's change of condition. On 10/13/11 the packing slip, dated 9/10/11, from the pharmacy was obtained. The slip shows "1.0 Fentanyl Dis (disc) 12 mcg/hr" was sent for R1. The packing slip also documented "30.0 Morphine Sul (Sulfate) Sol (Solution) 20 mg/ml (milligrams/milliliter)" was sent to the facility. The medications were received by E5, Registered Nurse, on 9/10/11. No time was documented.	F 425		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.1010h) 300.1210b) 300.3240a) Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. Section 300.1210 General Requirements for Nursing and Personal Care	F9999		

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b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

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:

Based on record review and interview, the facility failed to assess risk factors, fluid intake and output and monitor the fluid needs for 1 of 4 residents (R1) reviewed to be at risk for dehydration in a sample of 13. This failure resulted in a low fluid intake, dehydration and hospitalization for R1. R1 expired on 9/16/11. The facility failed to notify (R1) physician of nausea and low fluid intake.

The findings include:

R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer, congestive heart failure, chronic renal failure and

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chronic pain. R1 was receiving Hospice services.
E3, Licensed Practical Nurse, stated in an interview on 10/11/11 at 12:40 PM that R1 was vomiting small amounts of clear liquid during the 6 AM to 2 PM shift. E3 stated she did not call the physician due to the small amount. E3 stated the family of R1 gave R1 water and he did vomit the water. E3 stated she asked the family not to give him any more fluids. E3 stated R1 did not complain of nausea so she didn't give him any anti-nausea medication. E3 stated R1`kept asking for water and was voiding "OK". E3 stated the urine was not concentrated.
The nurses notes by E3, dated 9/10/11 documented "fluids given as tolerated, asks for water constantly, Foley patent and draining dark amber urine to gravity...". The nurses notes by E3 and dated 9/11/11 at 3:44 PM documented "asks for water continuously, water given, total care given, denies pain or discomfort, no s/s (signs/symptoms) of distress noted. Resident had moderate amount of clear emesis, RP (family) here and was giving him water, nurse did ask RP (family not to give anymore water for now)...".
E5, Registered Nurse, stated in an interview on 10/18/11 at 11:05 AM that she did not recall R1 asking for water. E5 stated she was told R1 had an emesis and they were reluctant to give R1 any fluids due to aspiration. E5 stated she did not give R1 anything for nausea nor did she call the physician. E5 stated
the family had called hospice and the hospice nurse came in to check on him. E5 stated R1 was incontinent of a large bowel movement also. E5 stated there was about 100-150 cc's (cubic Centimeters) in the catheter bag and she was not sure if it had been emptied before that. E5 stated

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she thought Z3 sent R1 to the hospice because she was not sure of the urinary output. E5 stated she was not sure if the intake and output sheet was done.

The nurses notes dated 9/12/11 at 12:03 AM documented "Resident continues on hospice care...Advised to hold fluids, as resident had emesis of liquids, water," and "Spoke to (Z3) hospice nurse, following call from (family). Advised that medications given 1 mg Ativan, and 0.5 ml liquid morphine but holding liquids".

The "Intake and Output" sheet for September, 2011 documented no fluid intake for 9/10/11 or 9/11/11. The urine output for 9/10/11 was documented as 500 for Days, 300 for Evenings, and 300 for Nights. The only documentation of output for 9/11/11 was on days with 350 documented. There was no documentation for bowel or emesis output for 9/11/11. Fluid needs are estimated for R1's weight of 104 kilograms at 2614 to 3120 cc's (cubic centimeters) per day.

The "Initial Care Plan" dated 9/9/11 documented R1 was at risk for dehydration due to Lasix administration. The Initial Care Plan documented to maintain adequate hydration, R1 would be "assessed for dehydration", "follow hydration protocol", "I & O (intake and output)", "offer fluids", and "monitor skin turgor".

E8, Certified Nurse Aide (CNA), stated in an interview on 10/17/11 at 1:15 PM that R1 asked for water a lot. E8 stated he worked the 6 AM to 2 PM shift on 9/11/11 and R1 had not vomited but didn't eat a lot. E8 stated R1 seemed uncomfortable.

E21, CNA, stated in an interview on 10/11/11 at 11:40 AM that he worked from 2 PM to 11 PM on 9/11/11. E21 stated R1 was calling out for water. E21 stated the nurse, E5, said to stop giving

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fluids because R1 was throwing up the water all day. E21 stated the family kept giving him water. E21 stated he stopped giving water around 5:30 PM.

E9, CNA, stated in an interview on 10/11/11 at 11:10 AM that he worked the 6 AM to 2 PM shift on 9/11/11. E9 stated they didn't give R1 fluids on Sunday because the nurses were afraid to give him too much water. E9 stated the nurse, E3, told him not to give fluids. E9 stated R1 always wanted water and would call out all the time.

E7, CNA, stated in an interview on 10/17/11 at 8:25 AM stated R1 was calling out for water. E7 stated she worked the 11 PM to 6 AM shift that started on 9/11/11. E7 stated the hospice nurse was there when she came in. R1 had a huge bowel movement that went all over the bed. E7 stated R1 kept asking for water and she gave him some. No one said not to and he had not vomited on her shift.

Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM that she did not receive a call regarding R1 that weekend. Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM that at no time was she contacted regarding R1 vomiting until Z3 contacted her on the evening of 9/11/11.

Z3 stated in an interview on 10/12/11 that she was on call the weekend of 9/10/11 and 9/11/11 and had not been contacted regarding R1's vomiting by the Facility. Z3 stated the family of R1 called her on the evening of 9/11/11 due to concerns with his condition and she went to the facility about 11:00 PM.

Z3 stated when she arrived, R1 was "begging" for water, had a large indentation on his left leg due to the side rail, was very agitated, had a low

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blood pressure and was vomiting. Z3 stated the facility staff told her they had not given R1 any fluids due to the vomiting. Z3 stated she gave R1 some anti-nausea medications and he calmed down. Z3 stated she called Z2, Hospice Physician, who ordered to send R1 to the emergency room.

The hospice progress notes dated 9/11/11 at 8:30 PM documented Z3 called the facility and talked to E5. The note states E5 reported to her that R1 was "the same as he was last night when I was here, just hollering out, begging for water, but he has been throwing up so we haven't given him anything to drink". The note also states E5 was asked if R1 had been given sips of water or at least swabbing his mouth and E5 stated "no". Z3 asked E5 if R1 had been eating and she stated "he hasn't been eating". Z3 then called Z2, Hospice Physician, and was told to make a visit to the facility.

The hospice progress note dated 9/11/11 at 10:00 PM documented that Z3 found R1 "literally begging for water stating "water, ice water, I need water, please, help me". The urine was dark yellow. Z3 provided toothettes, ice water sips, Tylenol and phenergan suppositories. Z3 gave R1 a drink and he vomited. Z3 called Z2 who immediately ordered to send R1 to the emergency room "for pain and symptom control related to the N/V (nausea/vomiting) and his restless state and condition a the LTCF (long term care facility)".

The "Triage Assessment" emergency room notes dated 9/12/11 documented "(Hospice) nurse was visiting patient per family request. Patient has not been given anything to drink all day. The amount of urine in catheter is output for the day..." . There was no amount documented.

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The assessment documented the urine as "yellow" and "concentrated".

According to the hospital notes by Z2, Hospice Physician, R1 was admitted for acute on chronic renal failure, congestive heart failure, nausea and vomiting possibly due to uremia. R1's blood urea nitrogen was elevated at 126 (8-23 mg/dl) (milligram/deciliter) and creatinine was 2.71 (0.70-1.20 mg/dl). Z2 documented in the hospital progress notes that R1's family had called Z3. Z2 noted that she spoke to Z1 and she had not been contacted by the facility. Z2 noted that R1's creatinine level was 1.7 on 9/9/11. R1 expired on 9/16/11.

(B)

300.1210b)
300.1630d)
300.3220f)
300.3240a)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall 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 resident care plan. 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. Restorative measures shall include, at a minimum, the following procedures:

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F9999	Continued From page 31 Section 300.1630 Administration of Medication 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 Care 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: Based on record review and interview the facility failed to provide pain medications as ordered by the physician to 1 of 4 residents (R1) reviewed for pain medication in a sample of 13. The findings include: R1 was admitted to the Facility on 9/9/11 with diagnoses, in part, of bladder and kidney cancer,	F9999		

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F9999	Continued From page 32 congestive heart failure, chronic renal failure and chronic pain. On admission R1 had physician orders for Fentanyl Transdermal 12 mcg (micrograms)/hour every three days. R1 also had orders for Morphine Sulfate Concentrate 10 milligrams every three hours routinely and every 1 hour as needed for severe pain. The hospital "Medication Reconciliation Discharge" noted R1 had a Fentanyl patch placed on 9/7/11 and would require a new patch on 9/10/11. The "Admission Nursing Assessment" dated 9/10/11 documented R1 had pain daily with the intensity of the pain noted "Times when pain is horrible or excruciating". The "Pain Assessment" dated 9/10/11 documented R1's pain as "severe" with limitations in sleeping and activities due to the pain. The facility Medication Administration Record for September for R1 had no documentation the Fentanyl patch was changed on 9/10/11. There is no documentation that any PRN (as needed) morphine was given to R1. E5, Registered Nurse, stated on 10/18/11 at 11:05 AM that she only gave R1 his scheduled morphine and she did not recall giving R1 any PRN morphine. E5 could not recall the Fentanyl patch for R1. E5 stated R1 was "agitated" and "restless" during sleep. E5 stated R1 was "thrashing around" before the hospice nurse came that evening. The nurses notes dated 9/12/11 at 12:03 AM by E5 documented "Resident admitted previous night on hospice with Foley catheter, hematuria, in renal failure....Cries out with movement or while stationary. Medicated on 0.5 ml liquid morphine q (every) 3 hrs (hours). Resident sleeping but has restless movements @ (at) times".	F9999		

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F9999	Continued From page 33 On 9/12/11 R1 was sent to the hospital emergency room for vomiting according to the emergency room record. The hospital emergency department noted a patch was on R1's shoulder dated 9/7/11. Z2, Hospice Physician, documented in the "Progress Notes" "Unclear if pt (patient) had rec'd (received) meds (medication) as ordered @ (at) NH (nursing home)-Fentanyl patch never changed (due 9/10 and changed today (at) hosp (hospital). PRN (As Needed) meds (medication) not being given." E2, Director of Nursing, stated in an interview on 10/11/11 at 10:30 AM, that R1 did not get the Fentanyl patch or PRN Morphine because the pharmacy didn't send the patches or the morphine. E2 stated it was the weekend and they couldn't get the physician authorization for the pharmacy to send the medications. E2 stated she was not aware he didn't get the patch until after the fact. E2 stated staff got the morphine out of the emergency kit and R1 received the scheduled morphine but not the PRN morphine. On 10/13/11 the packing slip from the pharmacy was obtained. The slip shows "1.0 Fentanyl Dis (disc) 12 mcg/hr" was sent for R1. The packing slip also documented "30.0 Morphine Sul (Sulfate) Sol (Solution) 20 mg/ml (milligrams/milliliter)" was sent to the facility. The medications were received by E5, Registered Nurse, on 9/10/11. No time was documented. Z1, Primary Care Physician, stated in an interview on 10/11/11 at 1:00 PM, that R1 came in to the facility on a Friday evening, 9/9/11. Z1 stated there was some confusion with the medication and Z6, Physician Assistant, had taken the call that weekend. Z1 stated she did talk to Z2, Hospice Physician, after R1 was admitted to the hospital on 9/12/11. R1 was	F9999		

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F9999	Continued From page 34 having more pain than before his admission to the facility and Z2 was concerned about pain management. Z1 stated if R1 did not get the Fentanyl patch as ordered or the PRN medication then his pain could have increased. Z6, Physician Assistant for Z1, stated in an interview on 10/12/11 at 9:45 AM that she received a call from the facility staff on Friday that they were having problems getting R1's pain medication. Z6 stated she called the pharmacy Friday evening about 11 PM and spent an hour trying to get them to send the medication. On Saturday Z6 also received a call from the facility that they could not get the medication. Both times Z6 stated she told the facility staff to call Hospice to get the medications. Z6 stated R1 was in pain and the staff were trying to get the pain medication. Z6 stated she did talk to the Hospice nurse, Z3, on Sunday evening and Z3 stated no one from the facility had called her about the pain medication. Z3, Hospice Nurse, stated in an interview on 10/12/11 at 9:05 AM that she did not receive any calls from the facility regarding R1's pain medications. Z3 stated that the family of R1 called her on the evening of 9/11/11 regarding R1's change of condition. (B)	F9999		