STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. BUILDING _____ B. WING _____	C 07/29/2013

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F 333	Continued From page 15 5:20pm on 7/6/13." On 7/18/13 at 11:00am, Z1 Medical Doctor for R3 stated, "I think that the missing doses of the Meropenem worsened the infection for R3. The Meropenem was more for the Pseudomonas in the lungs causing the infection." Lexi-Comp ' s Drug Reference Handbook, 12th Edition documented that Meropenem/Merrem (Antibiotic, Carbapenem) is used to treat intra-abdominal infection, treatment of complicated skin and skin structure infections caused by susceptible organisms. The Manufacturer of Meropenem documented " To reduce the development of drug-resistant bacteria and maintain the effectiveness of Merrem I.V. and other antibacterial drugs. Merrem I.V. should only be used to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. Under the patient counseling information, it documented " ...Skipping doses or not completing the full course of therapy may decrease the effectiveness of the treatment and increase the likelihood that bacteria will develop resistance and will not be treatable by Merrem I.V. or other antibacterial drugs in future ... "	F 333		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1010h) 300.1210b) 300.3220f) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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F9999	Continued From page 16 a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 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	F9999		

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F9999	Continued From page 17	F9999		

resident to meet the total nursing and personal care needs of the resident.

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 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 REQUIREMENTS WERE NOT MET AS EVIDENCED BY:

Based on Record Review and Interview the facility neglected to develop and/or follow policies to ensure residents receive medications ordered by physicians, provide timely care, monitor vital signs and care of residents with fever and infection. This failure resulted in the worsening of R3's infection, R3 required hospitalization in the Intensive Care Unit and needed mechanical ventilation.

This applies to 1 of 9 residents (R3) reviewed for infections in the sample of 9.

The Findings Include:

R3 was first admitted to the facility on 6/25/13

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F9999	Continued From page 18	F9999		

with diagnoses of ESBL (Extended Spectrum Beta Lactamase), Gastrostomy Tube, Cerebral Infarction with Dementia, and Aphasia, per Physician Order Sheet for 6/25/13. The Nursing note dated for 6/25/13 documents that R3 is in on tube feeding with nothing by mouth, unable to communicate, alert, and confused. This note also shows that R3's temperature was 99.0 degrees F (Fahrenheit) on 6/25/13 at 5:00pm. The nursing note for 6/27/13 at 6:00pm shows that R3 had a temperature of 104.4. R3 was sent to the community hospital Emergency Room and subsequently was admitted with diagnoses of Urosepsis and Pneumonia.

On 7/3/13 at 6:00pm R3 was readmitted to the facility. The diagnoses included Urosepsis, ESBL of the urine, respiratory distress, and Pneumonia. The Physician Order Sheet for the readmission at that time shows that Meropenem 1000 milligrams intravenous was to be administered every eight hours. E6 (Registered Nurse, RN) timed the doses to start on 7/4/13 for 6:00am, 2:00pm, and 10:00pm. E6 reported R3's vital signs as blood pressure of 110/68, pulse being very high at 150 beats per minute, respiratory rate of 20, oxygen saturation of 99 % on three liters of oxygen per nasal cannula, and a temperature of 97.7 F. There is no documentation of the physician being notified of the Pulse.

A review of R3 ' s Medication Administration Record showed that no doses of Meropenem were given until 7/7/13 at 6:00am (3 days later). On 7/22/13 at 11:05am E7 (Registered Nurse, RN) stated, "I was working on 7/6/14 on the three to eleven shift on 2 north. I administered the IV (Intravenous) Meropenem for R3. The assigned nurse for R3 was a LPN (Licensed Practical

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F9999	Continued From page 19	F9999		

Nurse) and only a RN can administer IV's. I forgot to sign it off on the Medication Administration Sheet. R3 was feverish and the LPN told me it was R3's first dose of the Meropenem. It was about 10:00pm." The review of R3's MAR and staff interview showed that R3 did not get 8 doses of the ordered Meropenem. On 7/23/13 at 11:50am, E12, (RN who worked on 7/4/13, 11-7 shift) stated, "I didn't have the drug. R3's first dose was due at 6:00am. I called the pharmacy and they told me the drug needed to be authorized by the facility. I endorsed it to the next shift as it was two o'clock in the morning. I know we are supposed to call the DON but it was 2:00am."

On 7/17/13 at 1:45pm, E9 (Registered Nurse, RN) stated, "On the morning of 7/4/13, I called the pharmacy to see where the Meropenem was. They faxed me a sheet the DON (Director of Nurses) needed to sign. I went to the DON's office. The DON was not there and the ADON (Assistant Director of nursing) told me to leave it on the DON's desk. On 7/5/13 around 11:30 to 12:00pm I still did not have the Meropenem. I called the pharmacy but I did not call the DON. The pharmacy said the form was still not signed." On 7/10/13 at 2:20pm, E2 (Director of Nurses, DON) was unable to give a specific timeline as to the delay in obtaining the drug. E2 stated, "I found out on 7/4/13 that the drug needed a signed document to authorize payment for the drug as R3's insurance would not pay for the drug. I am not sure exactly when the drug was sent over. I do know that on 7/6/13, E13 (RN) called and told me the drug was not available. This was in the morning. I told E13 to sign the paper and fax the sheet and call the pharmacy." On 7/10/13 at 3:10pm, E2 confirmed that there

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F9999	Continued From page 20	F9999		

was no policy and procedure for ordering and receiving medication requiring prior authorization. The facility's policy and procedure titled " Unavailable Medications, Medication Shortage " dated 7/08/13 does not address how to obtain medications requiring prior authorization.
On 7/11/13 at 10:20am, Z2 (Pharmaceutical Representative) stated, "We faxed an authorization to the facility on 7/4/13 that needed to be signed by the Director of Nurses, or facility staff authorized to sign for this drug as it was not covered by his insurance. Nothing was faxed back. On 7/6/13 we finally got the authorization signed and sent back to us at around 3:30pm. This order (Meropenem) was then sent out at 5:20pm on 7/6/13."
On 7/18/13 at 10:44am Z4 (R3's Neurologist) stated, "The infection did worsen his neurologic status. If he did not get the ordered antibiotics (Meropenem) this did not help his infection."

On 7/18/13 at 10:45am, Z5 (R3's Epidemiologist) stated, "Missing that many doses of Meropenem certainly worsened his infection. R3's prognosis is poor and R3 is now a Hospice patient with comfort care only. "

On 7/18/13 at 11:00am Z1 (R3's Attending Physician) stated, "I did not know R3 missed 8 doses. I would have wanted to know right away if the temperature was too high. I would expect that a resident with a fever and infection at nursing home to have vital signs assessed at least once every shift. Vital Signs should also be assessed more frequently if needed. I think that the missing doses of the Meropenem worsened the infection for R3. The Meropenem was more for the Pseudomonas in the lungs causing the infection. "

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F9999	Continued From page 21	F9999		

On 7/4/13 through 7/7/13, R3's nursing notes and July 2013 Medication Administration Record (MAR) showed no documentation of vital signs on 7/5/13 for the day, evening or night shifts. No vital signs were documented for 7/6/13 for the day or night shift. On 7/7/13 no vital signs were documented until after 5:00pm when the nursing note shows that R3's temperature was 107.0 F. R3's nursing note for 9:50pm was written and crossed out with the word error written. The next nursing note written for 7/7/13 started at 5:00pm and did not clearly show the time that the assessment/actions occurred. R3's nursing note says that on 7/7/13 at 5:00pm, "Temp checked 99.3". "At 10:20PM returned to reassess resident and noted blood pressure 140/90, pulse 140, Temperature 107.0 F. Cold sponge applied, Tylenol suppository given." R3's nursing note documents that at 10:20pm the physician was "made aware". At 10:45pm 911 was called, and a report was given to the emergency room nurse at the community hospital.
A review of R3's MAR and Nurse's Notes showed no documentation of vital signs on 7/5/13 for days, evening, and night shift. There were no vital signs documented for 7/6/13 for the day and night shift. On 7/7/13 no vital signs were documented until 5:00pm. At 10:20 pm R3 was noted to have temperature of 107 degrees F. R3 was given cold sponge and Tylenol suppository. At 10:45 pm 911 was called. The assessment record from the Emergency Room (ER) of the local/community hospital dated 7/7/13 showed R3 arrived in the ER at 11:48 pm. R3's initial temperature was 108.5 degrees F. R3 was admitted to the Intensive Care Unit (ICU) where R3 required artificial ventilation. R3's admitting progress note also showed that R3 had labored respirations and

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F9999	Continued From page 22 required non-rebreather mask. On 7/22/13 at 3:30pm, E6 (Registered Nurse RN, who worked 3-11 shift on 7/5/13) stated, "It was around 10:00pm when I called the physician to report a high white blood count. The doctor wanted to know what the vital signs were. I went to take the vitals and R3's temperature was 107 axillary. At 10:20 pm I called the doctor and he ordered to send R3 to the emergency room. I went and cooled him off with a sponge bath, gave Tylenol, and started R3's Meropenem. At 10:45pm, I called 911. I was able to get his temperature down to 100.6 axillary but it came back up to 106.0 axillary. I was afraid R3 would have convulsions". The facility ' s policy and procedure titled "Fever/Infection" dated October 2010 does not provide any guidance regarding the frequency of monitoring and assessing residents admitted with infection and fever. The policy and procedure does provide any guidance when the physician should be notified and what to do with a febrile resident. (B)	F9999		