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F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		3/5/18

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F 760	Continued From page 1 Based on staff interview, facility documentation review, and clinical record review, the facility staff failed to ensure five Residents were free from significant medication error (Residents #10, 29, 40, 83, and 47) in a survey sample of 21 Residents. 1. For Resident #10, the facility failed to administer anti seizure medication as ordered by a physician. 2. For Resident #29, the facility failed to administer insulin as ordered by a physician. 3. For Resident #40, the facility failed to administer anti seizure medication as ordered by a physician. 4. For Resident # 83, the facility staff failed to document the administration of Insulin for Diabetic Management and Anti-seizure medications. 5. For Resident # 47, the facility staff failed to document the administration of anti-seizure medications as ordered by the physician. The findings included: 1. Resident #10, was admitted to the facility on 5-20-17. Diagnoses included; left tibia fracture with surgical repair infection and revision of implanted device, hypertension, seizures, contractures, and congestive heart failure. Resident #10's most recent MDS (minimum data set) with an ARD (assessment reference date) of 1-17-18 was coded as an admission assessment. Resident #10 was coded as having a BIMS (brief	F 760	F 760 1.The physician & family for resident #10, #29, #40, #83, and #47 were made aware of the medication errors found in the medical record. Medication error reports were completed for each occurrence AND FILED IN DON OFFICE. 2.The facility has identified residents as having the potential to be affected by this alleged deficient practice. An audit of current Medication Administration and Treatment records were reviewed for errors and omissionS. Staff were educated as necessary and the physicians were made aware of the findings as needed. 3. Licensed staff were in-serviced by the Clinical Consultant on proper Medication Administration and the importance of appropriate documentation and (MAR) medication administration record accuracy. DON/designee will audit Medication Administration Records to ensure proper medication documentation for medications as ordered. 4. A weekly summary of audit results, will be reported to the Nursing Home Administrator by the DON Administrator will sign following the review.. DON to report a monthly summary to the QAPI committee for review until all medication administration thresholds are met.	

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F 760	Continued From page 2	F 760		

interview of mental status) score of "13" out of a possible 15, or, mild to no cognitive impairment. Resident #10 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #10's clinical record revealed no evidence the following medication was administered on the days and times indicated:

1. Levetiracetam 1000 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (anti-seizure): 1-1-18 (8 a.m.),
1-12-18 (8 a.m.), 1-21-18 (8 a.m.), 1-24-18 (8 a.m.), and 1-26-18 (8 a.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #10's clinical record, including nursing progress notes, revealed no evidence he was away from the facility, nor refused the medication in question.

Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following

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F 760	Continued From page 3 administration. The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility. 2. Resident #29, was admitted to the facility on 9-12-16. Diagnoses included; hypertension, vascular dementia, stroke, diabetes, glaucoma, depression, high cholesterol, sleep apnea, gout, and gastro-esophageal reflux disease. Resident #29's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-20-17 was coded as a quarterly assessment. Resident #29 was coded as having a BIMS (brief interview of mental status) score of "15" out of a possible 15, or, no cognitive impairment. Resident #29 was also coded as requiring extensive to total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting. Review of Resident #29's clinical record revealed no evidence the following insulin order was administered on the days and times indicated: Novolog 100 unit/ml (milliliters) per sliding scale sub cutaneous injection insulin at 6:30 a.m., and 4:30 p.m., (diabetes): 1-1-18 (6:30 a.m.), 1-10-18 (6:30 a.m.), 1-14-18 (6:30 a.m.), 1-19-18 (6:30 a.m.), 1-24-18 (6:30 a.m.).	F 760		

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F 760	Continued From page 4 Valid physician's orders were evident for the medications and treatment in question. A thorough review of Resident #29's clinical record, including nursing progress notes, revealed no evidence she was away from the facility, nor refused the medications and treatment in question. Review of the facility's policy entitled, "Medication Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given. When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications and treatments were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration. The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility. 3. For Resident #40, the facility failed to administer anti seizure medication as ordered by a physician.	F 760		

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Resident #40 was admitted to the facility on 12-09-16. Diagnoses included; Pneumonia, stroke, dysphagia, dementia, psychosis, gastrostomy.

Resident #40's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-17-17 was coded as a readmission assessment. Resident #40 was coded as having a BIMS (brief interview of mental status) score of "1" out of a possible 15, or, severe cognitive impairment. Resident #40 was also coded as requiring total assistance of staff to perform activities of daily living, such as bed mobility, transferring, eating, locomotion, and toileting.

Review of Resident #40's clinical record revealed no evidence the following two seizure medications were administered on the days and times indicated:

1. Levetiracetam 750 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

2. Valproic Acid 250 mg (milligram) twice daily at 8:00 a.m., and 8:00 p.m. (seizures): 1-3-18 (8 a.m.), 1-6-18
(8 p.m.), 1-7-18 (8 p.m.).

Valid physician's orders were evident for the medications in question. A thorough review of Resident #40's clinical record, including nursing progress notes, revealed no evidence he was away from the facility, nor refused the medications in question.

Review of the facility's policy entitled, "Medication

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Administration" revealed that all medications are to be given according to the prescriber's order and signed/documented by the administering individual as soon as the medication is given.

When interviewed on 1-26-18 at 4:00 p.m., the DON (director of nursing) stated that she had identified the failure of the staff to ensure medications were documented as being administered. The DON stated her expectation was for staff to administer medications and treatments per physician's orders and to document them as having been administered, immediately following administration.

The administrator and DON were informed of the failure of the staff to ensure significant medications were administered and documented, on 1-26-18 at 4:00 p.m. No further information was provided by the facility.

4. For Resident # 83, the facility staff failed to document the administration of Insulin for Diabetic Management and Anti-seizure medications as ordered by the physician.

Resident #83 was a 58 year old female admitted to the facility on 10/10/2017. Diagnosis included but were not limited to: Vascular Dementia with behavioral disturbances, Diabetes and Complete

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Traumatic Amputation of left lower leg.

The most recent Minimum Data Set (MDS) assessment, was an Admission Assessment with an Assessment Reference Date of 10/19/2018. The MDS coded Resident #83 as having a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment. Resident # 83 was also coded as requiring limited to total assistance of one staff member for Activities of Daily Living (ADLs). The only exception to this was eating, which the Resident was able to accomplish with only tray set up help. Resident # 83 was coded as always incontinent of bowel and bladder.

Review of Resident # 83's comprehensive admission care plan developed 10/20/2017, upon the Resident's admission revealed a Diabetic Management care plan which included interventions to Notify physician of unstable blood sugar levels and Administer medications as ordered by the physician, see MARs.

Review of the clinical record revealed that the Resident # 83's orders had commenced from admission on 10/10/2017. Review of the physician's order sheet, and Medication Administration Record (MAR) revealed the following orders for finger stick blood sugar (FSBS) checks, and Insulin which were not administered.

The following are the FSBS results and insulin omitted recorded on the MAR (Medication Administration Record) as documented by facility nursing staff:

1/11/18 at 4:30 p.m.- Blood sugar not

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documented.
1/15/18 at 4:30 p.m.- Blood sugar not documented.
1/16/18 at 6:30 a.m.- Blood sugar not documented.
1/24/18 at 6:30 a.m.- Blood sugar not documented .
1/24/18 at 4:30 p.m.- Blood sugar not documented.
1/25/18 at 6:30 a.m.- Blood sugar not documented.
1/25/18 at 4:30 p.m.- Blood sugar not documented.

1/24/18 at 5:00 p.m.- Humulin 70/30 Give 20 Units at Supper. Not documented.
1/25/18 at 5:00 p.m.- Humulin 70/30 Give 20 Units at Supper. Not documented.

Further review of the MAR revealed missing documentation of the anti-seizure medication Dilantin:

1/24/18 at 8:00 p.m.- Dilantin Extended CAP 100 milligrams by mouth every day. Not documented.
1/25/18 at 8:00 p.m.- Dilantin Extended CAP 100 milligrams by mouth every day. Not documented

Review of the nursing progress notes revealed no documentation of explanations for the omissions of documentation of insulin administration and no explanation as to why the FSBSs were not attempted. There was also no explanation about the omission of documentation of administration of Dilantin on those dates.

Medication Administration, and Diabetic Management policies were reviewed, and stated

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that all FSBS and insulin administration must be "Documented in the nursing notes and on the MAR."

Review of the facility policy on "Administering Medications" from Nursing Services Policy and Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: Timely Administration:
3. Medications must be administered in accordance with the orders, including any required time frame.
On Page 6,
18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose.
19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. "

Valid Physician's orders were evident for the medications and treatments not documented as having been administered.

An interview was conducted on 1/26/2018 with the Director of Nursing (DON) at approximately 1:00 p.m. The DON stated that if it was not documented, it was not done. She could not explain why they were omitted, as no progress notes described the reason for the omissions.

On 1/29/218 at 2:10 PM, the Director of Nursing stated she did not find any documentation regarding the omissions on the MAR.

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F 760	Continued From page 10 Administration was informed of the findings on 1/26/2018, and 1/29/2018 at the end of day debriefing each day, the facility presented no further evidence. 5. For Resident # 47, the facility staff failed to document the administration of anti-seizure medications as ordered by the physician. Resident # 47 was an 81 year old female admitted to the facility originally on 8/20/2016 with the diagnoses of, but not limited to, Seizure Disorder, Major Depressive disorder, Dysphagia , PEG tube (Percutaneous Endoscopic Gastrostomy), GERD (Gastroesophageal Reflux Disease) and Cerebrovascular Disease. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 12/5/2017. The MDS coded Resident # 47 with a BIMS (Brief Interview for Mental Status) of 1/15 indicating severe cognitive impairment; Resident # 47 required limited assistance of one staff person with activities of daily living for dressing, hygiene, bathing and toileting and required minimal assistance of one staff person for transfer, ambulation, and bed mobility; Resident # 47 required total assistance of one staff person for eating and was also coded as always continent of bowel and bladder. On 1/25/2018 at 9:30 AM, review of the clinical	F 760		

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F 760	Continued From page 11 record was conducted. Review of the Medication Administration Record (MAR) for December 2017 revealed missing documentation of medications: Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures, 12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube twice daily for seizures. 12/17/17 at 8 PM, 12/18/17 at 8 PM. 12/19/17 at 8 PM Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution 12/25/2017 at 2 PM Review of the Medication Administration Record (MAR) for January 2018 revealed missing documentation of medications: Keppra 100 milligrams per milliliter oral solution , give 7.5 milliliters (750 milligrams) per PEG tube twice daily for seizures, 1/11/18 at 8 PM Increase Depakote dose to 250 milligrams per 5 milliliters three times a day-Valproic Acid 250 milligrams per 5 milliliters solution (Depakene) give 10 milliliters (500 milligrams) per PEG tube three times per day for seizures. 1/11/18 at 8 PM	F 760		

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On 1/25/2018 at 1:45 PM, an interview was conducted with LPN E (Licensed Practical Nurse A) who stated that nurses were expected to administer medications and treatments as ordered by the physician and document on the MAR and TAR at the time of administration.

On 1/26/2018 at approximately 1:20 PM during the end of day debriefing, the Administrator and Director of Nursing (DON) were informed of the missing documentation of administration of medications for Resident # 47. The DON stated she had identified problems with documentation of medications as an issue at the facility. The DON stated she had been working with the facility staff on improving the documentation of medications and treatments. The DON stated the since facility used several Agency nurses who sometimes had difficulty with the electronic program to document on the MAR. The DON stated the expectation was for nurses to administer medications and treatments as ordered by the physician and to sign the MAR immediately after administering the medications.

On 1/26/2018 at approximately 1:30 PM, the DON stated the facility used "Med-Pass" for professional nursing guidance. The DON presented a copy of the Medication Administration Policy.

Review of the facility policy on "Administering Medications" from Nursing Services Policy and Procedure Manual for Long-Term Care Revised December 2012 revealed on Page 5, Under Policy Interpretation and Implementation, under the Highlights: "Timely Administration:
3. Medications must be administered in accordance with the orders, including any

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F 760	Continued From page 13 required time frame." On Page 6, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. 19. The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones. " Valid Physician's orders were evident for the medications and treatments not documented as having been administered. During the end of day debriefing on 1/29/2018, the DON and Administrator again were informed of the findings. No further information was provided.	F 760		