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	165146	A. BUILDING _____ B. WING _____	C 02/18/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KAHL HOME FOR THE AGED & INFIRMED	6701 JERSEY RIDGE ROAD DAVENPORT, IA 52807

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F 000	INITIAL COMMENTS HEALTH FACILITIES Correction date 3/4/19 MAR 11 2019 Complaint #80909-C was substantiated. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C	F 000	March 8, 2019 Kahl Home acknowledges receipt of this notice. Preparation and/or execution of this document and Plan of Correction does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth in the Statement of Deficiencies. These documents and Plan of Correction are prepared and/or executed solely because they are required by provisions of Federal and State Law and is not an admission of any wrong doing or the existence of any deficiency under the Medicare or Medicaid Programs, nor an admission that there are measures or steps that the facility could or should have taken to address the alleged deficiency in the past. Let these documents and Plan of Correction serve as this facility's credible allegation of compliance.	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756	The Consultant Pharmacist has reviewed and reported any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports have been acted upon, and has verified potential and actual medication allergies when identified for 4 of 6 residents reviewed. (Residents #1, #2, #4 and #5). The Consultant Pharmacist has reviewed and reported any irregularities not already addressed and resolved to the attending physician and the facility's medical director and director of nursing, and these reports have been acted upon, and has verified potential and actual medication allergies when identified for all current residents.	

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 756	Continued From page 1 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and resident, family member, staff, pharmacist and physician interviews, the facility failed to verify potential and actual medication allergies when identified upon resident admission for 4 of 6 residents reviewed (Residents #1, #2, #4 and #5). The facility reported a census of 119 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated 2/1/19 recorded Resident #1 had diagnoses that included hypertension (high blood pressure), peripheral vascular disease and a cerebrovascular accident (stroke). The resident scored 15 out of 15 points possible on the Brief Interview for Mental Status (BIMS) test, indicating intact memory and cognition. She required assistance of at least 1 staff for transfers to and from bed and chair, dressing, toilet use, bathing and personal hygiene. A physician order summary report dated 12/7/18 directed the resident's admission to the facility and listed allergies that included Codeine and Morphine (strong opioid narcotic analgesics). The physician ordered administration of Tramadol Hydrochloride (an opioid narcotic-like analgesic)	F 756	The Director of Nursing (designee) will audit 5 residents each week to ensure all medication alerts have been identified and followed up on according to policy. The Director of Nursing (designee) will Audit and reconcile all Pharmacy Recommendations submitted monthly to ensure each has been acted on and results/recommendations included in the resident's medical record. Results will be reviewed in the Kahl Home's QAA Meeting monthly for 6 months and then re-assessed.	

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50 milligrams (mg) by mouth every 4 hours as needed for pain. The orders were signed by the resident's physician on 12/12/18.

Allergies listed in the electronic record on 12/7/18 included codeine and morphine without listed reactions. On 2/7/19, Staff G, LPN and Unit Manager changed the record to reflect intolerance of unknown severity as the reaction to codeine.

A warning/alert message at 5:47 p.m. on 12/7/18 in the electronic record, addressed to Staff F, licensed practical nurse (LPN) and author of the order entry documented the system identified a possible drug allergy for the following order: Tramadol HCl tablet 50 mg, give 50 mg by mouth every 4 hours as needed for pain. The Nurse's Notes (NN) contained no documentation that addressed the identified medication allergy.

During an interview on 2/5/19 at 12:25 p.m., Staff F stated when a potential medication allergy is noted in the electronic record she usually clarified it with the provider, sometimes she made a note in the record, and she couldn't remember what she did in reference to the medication allergy notification that she received on 12/7/18. Staff F stated the facility's nurse practitioner (NP) verified medication orders. On 2/5/19 at 12:32 p.m., Staff F stated the NP signed all the physician order summaries and her training made her responsible for the final check for drug safety/potential allergic reaction. Staff F acknowledged the NP may not have received the medication allergy notifications that she had on 12/7/18.

During an interview on 2/6/19 at 10:55 a.m., Resident #1 stated she had problems with other

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pain medication and narcotics, but could take the Tramadol.

2. The MDS assessment dated 1/25/19 recorded Resident #2 had diagnoses that included chronic osteomyelitis (bone infection), infection of hip prosthesis (replaced joint) and arthritis. The assessment documented a score of 15 on BIMS test. Resident #2 required assistance of 1 staff for dressing, toilet use bathing and personal hygiene.

A physician order summary report dated 1/18/19 directed the resident's admission to the facility and listed no known allergies. Resident #2's medication orders included Hydromorphone hydrochloride (Dilaudid, a strong opioid narcotic analgesic) 2 or 4 milligrams (mg) administered oral every 4 hours as needed for pain. The orders were signed by a nurse practitioner (NP) from the infectious disease specialist physicians office on 1/21/19.

Staff F changed the listed allergies in the resident's record on 2/7/19 to reflect intolerance and constipation of unknown severity were the reactions to to both Hydrocodone and Oxycodone.

During and interview on 2/13/19 at 11:03 a.m., Resident #2 stated he didn't like Oxycodone or Vicodin (hydrocone) because they caused constipation and did better with Dilaudid.

3. The MDS assessment dated 12/9/18 recorded Resident #4 had diagnoses that included congestive heart failure, pneumonia and asthma. The resident scored 15 on the BIMS test and required assistance of 1 staff for dressing, toilet

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F 756	Continued From page 4	F 756		

use, bathing and personal hygiene.

A physician order summary report dated 12/4/18 directed the resident's admission to the facility and listed allergies that included Morphine (a strong opioid narcotic analgesic). The medication orders included administration of Hydrocodone-Acetaminophen (Vicodin, a synthetic narcotic analgesic) 7.5 mg - 325 mg, 1 tablet administered oral every 4 hours as needed for pain. The order summary was signed by the resident's physician on 12/5/18. Allergies listed in the electronic record on 12/4/18 by Staff A, registered nurse (RN), included Morphine, without reaction type or severity identified.

A warning/alert message at 5:14 p.m. on 12/5/18 addressed to Staff A and author of the order entry recorded the system identified a possible drug allergy for Hydrocodone-Acetaminophen 7.5-325 mg *Controlled Drug*, give 1 tablet by mouth every 6 hours as needed for pain. The Nurse's Notes (NN) contained no documentation that addressed the identified medication allergy.

During an interview on 2/5/19 at 12:10 p.m., Staff I, LPN, stated if the nurse received a notification in the electronic record about a potential medication allergy the nurse should review it with the physician for clarification, it would be in the NN if it was documented, sometimes the notification occurred because the resident was allergic to other narcotics and not necessarily the one ordered. Staff I stated she asked Resident #4 about the medication, the resident had taken the medication without difficulty before her admission and she should have documented that in the NN and didn't.

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4. The MDS assessment dated 1/16/19 recorded Resident #5 had diagnoses that included atrial fibrillation (irregular heart rate), anxiety, asthma, chronic obstructive pulmonary disease (COPD/emphysema) and cachexia (wasting of body due to severe illness). The assessment documented she scored 3 out 15 on the BIMS test, indicating severe cognitive impairment. Resident #5 required the assistance of at least 1 staff to reposition in bed, dressing, bathing, personal hygiene and toilet use and did not stand or walk during the assessment period.

A hospital history and physical note dated 1/1/19 listed medication allergies that included Albuterol (a beta-adrenergic agonist used for bronchiodialation) with disorder of implantable cardiac defibrillator listed for reaction.

A physician order summary report dated 1/4/19 directed the resident's admission to the facility and listed medication allergies that included Albuterol. The summary report directed administration of Xopenex (a beta-adrenergic agonist medication that contained Albuterol) 0.63 mg per milliliter (ml), 3 ml inhaled via nebulizer 3 times a day for shortness of breath. The order summary was signed by the resident's physician on 1/919.

Allergies listed in the electronic record on 1/4/19 by Staff G included Albuterol without a reaction type or severity identified. A warning/alert message on 1/4/19 at 4:37 p.m. and addressed to Staff G recorded the system identified a possible drug allergy for Xopenex Nebulization Solution 0.63 mg/3 ml, 3 ml inhaled orally via nebulizer 3 times a day for shortness of breath. The NN contained no documentation that

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F 756	Continued From page 6 addressed the identified medication allergy. The resident died at the facility on 1/31/19 while receiving Hospice services and the record contained no medication regimen review by the consultant pharmacist.	F 756		
F 760 SS=G	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: Based on clinical record review and resident, family member, staff, pharmacist and physician interviews, the facility failed to ensure that each resident remained free from undesired side effects from medications identified as allergens that resulted in pain, nausea, weight loss, overall decline and hospitalization for one of six residents reviewed (Resident #3). The facility reported a census of 119 residents. Findings include: The Minimum Data Set (MDS) assessment tool dated 12/28/18 recorded Resident #3 had diagnoses that included anemia, congestive heart failure, diabetes and asthma, a score of 15 out of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment, without deficits or symptoms of delirium,. Resident #3 required the assistance of one to two staff for transfers to and from bed, dressing, toilet use, bathing and personal hygiene. The resident did not walk during the assessment lookback period. A hospital discharge summary dated 11/30/18	F 760	Resident #3 was discharged from the facility on 1/3/2019. A review of all current resident's allergies, intolerances, and side effects was completed with any inconsistencies clarified with the resident and provider and included in the medical record. Medication Regimen and Review Policy and Medication Administration Policy were reviewed with applicable changes made as necessary. All new admissions/re-admissions will be reviewed according to policy and procedure and any identified concerns regarding possible allergen, potential overdose or dose outside the therapeutic range will be held until the order is clarified by the provider. All licensed nursing staff will be in-serviced regarding these policies and procedures.	

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F 760	Continued From page 7 detailed the resident's hospitalization and treatment for syncope (fainting), head injury, left leg injury, diabetes, chronic atrial fibrillation (irregular heart beat), severe persistent orthostatic hypotension (blood pressure drop upon standing), generalized weakness and anemia. Chronic medical conditions included gastric cancer with surgical correction in 2012, and ulcerative colitis. A hospital universal transfer form dated 11/30/18 directed to transfer Resident #3 to the facility and medication administration that included sulfasalazine (a combination of salicylate and Sulfa antibiotic medication, labeled as an anti-inflammatory medication for ulcerative colitis) 1000 milligrams (mg) administered orally three times daily. The 11/30/18 universal transfer form also listed the following medication allergies and reactions: a. Salicylates (a component of aspirin) - abdominal pain. b. Bactrim (a sulfa-based antibiotic) - rash. c. Sulfa drugs - nausea. d. Aspirin - no reaction listed. A warning/alert message on 11/30/18 at 7:40 p.m. in the electronic record, addressed to Staff A, registered nurse (RN) and author of the order entry the system identified a possible drug allergy for the following order: Sulfasalazine 500 mg tablet, give 2 tablets by mouth 3 times a day for bowel health. The resident's Medication Administration Record, (MAR) listed allergies that included Sulfa antibiotics, salicylates and aspirin and documented Resident #3 received Sulfasalazine 3 times a day as ordered from 11/30/18 through	F 760	All new admissions/re-admission medical records will be reviewed in IDT the day following admission, or by the Supervisor if that day falls on the weekend. The Director of Nursing (designee) will audit all new medication orders weekly for potential allergies and dose irregularities. Results of these audits will be reviewed in QAA monthly for 6 months and then re-evaluated.	

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12/31/18 with the following omissions:
a. 12/5/18 refused at 8:00 a.m.
b. 12/6/18 refused at 8:00 a.m.
c. 12/7/18 at 12:00 p.m. when hospitalized.
d. 12/23/18 at 8:00 p.m. through 12/27/18 at 8:00 p.m., when a physician ordered staff to withhold the medication pending review by the primary care physician.
e. 12/28/18 refused at 8:00 a.m.
f. 12/28/18 out of facility at 12:00 p.m.
g. 12/30/18 refused all doses.
h. 12/31/18 refused at 8:00 p.m.

A Nurse's Note (NN) transcribed by Staff B, RN (Registered Nurse) on 12/2/18 at 6:35 p.m. recorded Resident #3 stated he had not felt good since the day before, with nausea, upset stomach, loose stools, and felt like he had the flu.

A physician order on 12/3/18 at 11:45 a.m. directed staff to administer Zofran (an antiemetic medication) 4 mg orally every 6 hours as needed for nausea or vomiting. The MAR recorded staff administered Zofran on 12/4/18 at 4:04 p.m., 12/5/18 at 10:55 a.m. and 12/6/18 at 9:02 a.m.

On 12/7/18 at 11:40 a.m., a nurse practitioner assessed the resident, concerned about continued nausea, dizziness and headaches with movement, and ordered the resident's transfer to the Emergency Room (ER).

The 12/7/18 ER record described the resident treated for conditions that included recurrent nausea, general stomach ache and abdominal pain. Abdominal X-rays obtained then did not reveal any gastric or abdominal abnormalities.

A 12/10/18 NN transcribed at 6:06 p.m. by Staff

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C, licensed practical nurse (LPN), documented Resident #3 had continued nausea with poor appetite.

On 12/11/18 at 11:45 a.m., the Zofran order was increased to 8 mg administered orally every 6 hours as needed for nausea or vomiting. The MAR recorded staff administered Zofran 8 mg on 12/11/18 at 12:32 p.m., 12/12/18 at 8:49 p.m. and 12/24/18 at 10:59 a.m.

A 12/13/18 visit note transcribed by the NP recorded the resident had continued bouts of nausea, directed staff to continue to administer Zofran as needed and added an order for Compazine (an antiemetic medication) 10 mg orally every 6 hours as needed for nausea or dizziness and staff instruction to monitor the resident's condition.

A NN transcribed on 12/15/18 at 6:45 p.m. by Staff B reported the resident's stomach upset and poor appetite.

A NN transcribed on 12/19/18 at 3:44 p.m. by Staff C documented continued nausea with a poor appetite.

A visit note transcribed by the NP on 12/19/18 described continued nausea with temporary relief from Zofran, his oral intake impacted by nausea, the resident had continued loose stools without abdominal pain, and directed staff to schedule an appointment with the resident's gastroenterologist for follow-up.

A NN transcribed by Staff C on 12/20/18 at 3:49 p.m. described the resident's continued nausea with poor appetite.

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A NN transcribed by Staff D, LPN, on 12/23/18 at 1:36 p.m., documented Resident #3 had continued nausea. When she administered his noon medications she noticed the resident's listed Sulfa allergy on the MAR and his prescribed Sulfasalazine. The resident reported stomach upset was one of the symptoms of the allergy and he had been nauseated for a few weeks. She contacted the on-call physician and obtained an order to hold the Sulfasalazine until his primary care physician could evaluate the resident.

A visit note transcribed by the NP on 12/27/18 recorded Resident #3 stated he felt a little bit better that day, with a continued poor appetite but food intake slightly increased, no complaints of abdominal pain, and directed staff to resume administration of Sulfasalazine.

A computed tomography (CT) scan of the abdomen performed 12/28/18 revealed the test ordered for the resident's abdominal pain with diarrhea and bloating symptoms for about a month. The scan did not reveal any current abnormalities of concern related to the abdomen or stomach.

A facsimile (fax) document addressed to the physician on 1/1/19 requested discontinuation of Sulfasalazine due to constant daily refusals, and listed allergies that included Sulfa antibiotics, salicylates and aspirin. The returned fax on 1/2/19 ordered the medication discontinued.

A NN transcribed on 1/3/19 at 7:10 p.m., described the resident as pulseless, breathless, cardiopulmonary resuscitation (CPR) initiated, 911 activated and the resident transferred to the

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F 760	Continued From page 11 ER. Recorded resident weights included: 12/1/18 227.0 pounds (#) 12/2/18 227.7# 12/3/18 227.5# 12/4/18 226.8# 12/5/18 210.6# 12/10/18 210.4# 12/11/18 214.0# 12/13/18 214.8# 12/14/18 213.0# 12/15/18 213.8# 12/16/18 213.0# 12/17/18 213.8# 12/18/18 211.9# 12/19/18 212.0# 12/20/18 213.0# 12/21/18 213.6# 12/23/18 214.2# 12/24/18 213.8# 12/25/18 213.5# 12/26/18 213.5# 12/27/18 210.8# 12/28/18 211.6# 12/29/18 211.0# 12/30/18 211.9# 12/31/18 210.6# 1/1/19 207.4# 1/2/19 208.0# 1/3/19 208.0# On 2/12/19 at 1:01 p.m., the resident's gastroenterologist stated in the past, he prescribed Sulfasalazine but discontinued the medication due to the resident's Sulfa allergy. Resident #3 complained of abdominal pain and nausea, had been prescribed Apriso then (an anti-inflammatory medication for the treatment of	F 760		

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	165146	A. BUILDING _____ B. WING _____	C 02/18/2019

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ulcerative colitis), he had not been consulted about the resident's conditions while at the facility, and Sulfasalazine and Apriso medications should not be administered concurrently. One or the other medication should be prescribed to treat the targeted symptoms, but not both.

On 2/4/19 at 1:46 p.m., a pharmacist at the resident's retail pharmacy (utilized before hospitalization and admission to the facility) stated Resident #3 had not refilled the Sulfasalazine medication since March, 2018 and Sulfa was not listed as an allergy. During a second interview on 2/5/19 at 8:55 a.m., a pharmacist confirmed a Sulfa allergy was not listed and stated someone allergic to Sulfa should not take Sulfasalazine.

On 2/7/19 at 12:44 p.m., the facility's NP stated she reviewed admission referrals with medication orders for residents admitted to the facility's Medical Director. She could make changes to the medication regimen, meet with the resident and/or family, clarify conditions and allergies at that time, but Resident #3 was under the care of a different physician group who would have had that responsibility.

Upon request on 2/4/19, staff could not locate the resident's admission orders with physician signature. On 2/11/19, Staff G, LPN and unit manager, stated they were not able to locate the document. The document would list allergies, medical conditions, medications, treatments ordered, and physician signature mandated for admissions to facilities for skilled level of care.

On 2/4/19 at 2:31 p.m., Staff A, RN and evening supervisor, stated when pharmacy identified a

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medication conflict or allergy, the nurse or pharmacy could resolve that with the provider. He had not contacted the provider when he was alerted of the potential Sulfasalazine allergy on 11/30/18, the pharmacy took care of it and if the nurse clarified the order they would document that in the NN.

On 2/5/19 at 12:10 p.m., Staff I, LPN, stated if a nurse received notice of potential medication allergies in the resident's electronic record, they should review and clarify it with the provider, then document the action in the NN.

On 2/5/19 at 12:25 p.m., Staff F, LPN and unit manager, stated the nurse was notified of a potential medication allergy in the electronic record. She normally clarified it with the provider, sometimes made a note about it, and the facility NP verified orders. In a subsequent interview on 2/5/19 at 12:32 p.m., Staff F stated their NP signed all physician order sets (POS's) and her training made her responsible for the final check for drug safety or potential allergic reaction.

On 2/4/19 at 2:10 p.m., Staff C, LPN, stated the nurse should contact the provider to clarify if alerted of a medication allergy by the pharmacy, and document that in the NN. Resident #3 had a lot of gastrointestinal issues, lots of nausea, went to the ER a few times and always came back with nothing; the Zofran didn't help, nothing helped. Staff C stated she went through his medication list with his spouse, she said he was allergic to the Sulfasalazine so they discontinued it.

On 2/4/19 at 1:58 p.m., the Director of Nursing (DON) stated she wasn't sure what staff did to clarify orders if there was a conflict or potential

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drug allergy. The DON expected staff to clarify it with the provider but didn't think they wrote an order about it. At 2:44 p.m. the DON stated she spoke with the nurses and if they identified an allergy, they consulted with the provider and documented in the NN, they would write an order only if it changed the original order.

On 2/4/19 at 1:32 p.m., the facility's consultant pharmacist stated staff are alerted of potential medication allergies through the electronic record after medication orders were entered, nursing staff were supposed to clarify the matter with the physician and the pharmacy was not involved in that process.

The Medication Regimen & Review policy, dated 1/31/18 and without approval signatures, recorded a drug regimen review is conducted upon admission and throughout the stay. When potential clinically significant medication issues are identified the facility will address the issue in a timely manner. The admission nurse was responsible for medication reconciliation and identification of potential clinically significant medication issues upon the resident's admission.

The Medication Allergy Identification and Procedure policy, without signatures, dated 2/6/19 and provided on 2/7/19 at 12:40 p.m., recorded that a drug regimen review is conducted upon admission and throughout the resident's stay. Potential drug allergies will be addressed with the physician/NP. Orders will be obtained if it is determined the medication has potential risks and should be discontinued. The initial time the allergy warning appears on the MAR the nurse administering will consult with the physician/NP, if not done before. The nurse will document the

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results of the conversation in the medical record.

The facility's policy and procedure manuals provided on 2/7/19 at 1:11 p.m., contained the following documents:
a. A nursing Administering Medications policy, dated and signed by the previous administrator on 6/11/08, which directed nursing staff to verify medication allergies prior to medication administration, and if a medication was withheld, staff were to document the event with rationale in the NN and notify physician.
b. A Nursing Service: Medication Reconciliation policy, dated and signed by the previous administrator and current DON on 3/20/17, directed that each resident's drug regimen was free from unnecessary drugs that included the presence of adverse consequences which indicated the dose should be reduced or discontinued, clinically significant adverse consequences would be minimized, and the potential contribution of the medication regimen to an unanticipated decline or newly emerged or worsened symptom would be recognized and evaluated, and the regimen modified when appropriate. Nurses were to document physician notification and verification of admission orders and clarification of all discrepancies in the NN.
b. A nursing Medication Regimen & Review policy, dated and signed by the current administrator and DON 8/14/17, directed the consultant pharmacist's monthly review of resident medication regimens that included the medical record, and written reports required and directed to the physician, facility medical director and DON, for any irregularity that required action. The written report was to detail the relevant medication irregularity. If the identified irregularity required urgent action, the consultant pharmacist