STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165468	A. BUILDING _____ B. WING _____	C 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EASTERN STAR MASONIC HOME	715 WEST THIRD STREET BOONE, IA 50036

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F 000	INITIAL COMMENTS Investigation of facility-reported incident # 83444-I resulted in the following deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 760 SS=J	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, facility policy review and staff and physician interviews, the facility failed to ensure a resident (#1) did not experience a significant medication error out of six total residents reviewed. Resident #1's physician ordered staff to administer a diuretic medication (Bumex) and staff failed to implement the order until four days later resulting in a significant decline in the resident's condition and hospitalization. The facility identified a census of 67 current residents. Findings include: The Minimum Data Set assessment dated 3/6/19 documented Resident #1 had diagnoses that included heart failure and Alzheimer's disease. The assessment documented he had clear speech and the ability to express his ideas and wants. At the time of the assessment, he did not display shortness of breath of dehydration. The assessment also documented Resident #1 received a daily diuretic medication (to remove water from the body).	F 760	Past noncompliance: no plan of correction required.	

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

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The resident's care plan, initiated on 6/6/17, documented use of a diuretic under the focus area for elimination patterns.

The resident's Electronic Medical Record (EMR) contained the following information:

a. A Health Status Note dated 5/13/19 at 11:30 am recorded staff observed the resident sitting on a bench in the hall. He dry-heaved and coughed up some phlegm and was assisted to his room. Staff noted a five pound weight gain in one day and edema to both lower extremities. The resident's vital signs showed a pulse rate (P) of 94, a respiratory (R) rate of 40 and pulse oximetry (POx, or how well the blood carries oxygen) read 97% on room air (normal is 90% or above). Staff faxed the physician with an update and called the resident's daughter. At 5:48 p.m., the resident's physician ordered the resident to receive Bumex 2 milligrams (mg) by mouth every day for the next three days in addition to Lasix (diuretic) 20 mg. every morning.

Review of the Medication Administration Record (MAR) for 5/19 revealed the resident received the new order of Bumex 2 mg on 5/14 and 5/15/19.

b. A Health Status Note dated 5/15/19 at 10:15 am documented Resident #1 had an unsteady gait, pallor and swelling in his face, eyes and abdomen. The note documented he started to receive Bumex on 5/14/19. His weight measured 187.9 pounds on 5/11/19 and his weight measured 192.0 that day. His P measured 60, his R were at 22 and his POx measured 96% on room air. The assessing nurse, the Director of Nursing, spoke with the resident's daughter and

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updated her on Resident #1's health status. The daughter agreed with obtaining laboratory tests and the resident's physician ordered a complete blood count (CBC) and basic metabolic panel (BMP) to be drawn. At 2 pm, staff faxed the physician the results of the laboratory testing. At 8:44 pm, the physician ordered staff to hold Resident 1's Bumex.

Review of the laboratory results dated 5/15/19 revealed the resident had a blood urea nitrogen level of 29 (a reference range runs 8 - 21) and a Creatanine level of 1.99 (a reference range runs 0.44 - 1.21). Both tests measure the health of one's kidneys in filtering and removing bodily waste products and toxins.

c. An Order Note dated 5/17/19 at 5:11 pm revealed Staff A, RN (Registered Nurse) received and noted a physician's order to discontinue Lasix (a diuretic medication), to continue administration of Bumex 2 mg and to obtain a BMP in one week.

Review of the resident's MAR and physician's orders revealed the Lasix as discontinued but staff did not administer of the Bumex 2 mg ordered on 5/17/19 until 5/21/19.

d. A Health Status Note dated 5/20/19 at 10:42 pm documented Resident #1 as unable to feed himself very well. At times, he would bring the spoon to his mouth but other times he would miss. He said a few words and did not smile per his usual. At 3 am, staff documented the resident got up to the bathroom but was unable to eliminate. His speech became unintelligible and he could not clearly state his name. The resident's P measured 87, his R measured 31 and his POx measured 95% on room air.

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e. A Health Status Note dated 5/21/19 at 11:37 am recorded Staff A called the resident's family and informed them his Bumex had not been given for a few days. An assessment at 11:05 am revealed the resident as sleepy, restless and jerking in his sleep. He woke with verbal stimulations but his speech was garbled and unclear at times. The resident's skin appeared pale, warm and dry. He had pitting edema to both legs. His R measured 40 and heavy, his P at 80 and regular and POx measured 94% on room air. A note at 5:07 pm documented Resident #1 admitted to the hospital at that time.

The Hospital Course Summary dated 5/24/19 documented Resident #1 entered the hospital with an increasing cough and shortness of breath. Further investigation revealed he was seen in the physician's office on 5/16/19 and started on Bumex 2 mg daily. Unfortunately, this order was never carried out. Resident #1 started on intravenous Bumex every 8 hours and in three days, his weight dropped 19 pounds. The resident's admitting and discharge diagnoses documented he had congestive heart failure, a history of atrial fibrillation, dementia, hypotension, dyslipidemia, benign prostatic hypertrophy and chronic kidney disease. The summary documented he discharged from the hospital on 5/24/19 back to the facility.

During interview on 5/28/19 at 7:45 pm, Staff A remembered the Bumex did not get ordered correctly. Staff A stated she really did not know how that happened or what got missed. She felt sure she put it in the EMR (electronic medical record), but maybe it didn't save.

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During interview on 5/29/19 at 5:30 pm, the resident's physician stated the lack of Bumex implementation on 5/17/19 constituted a significant medication error for Resident #1. He talked with the facility's administration afterwards, telling them it was a major error and probably landed the patient in the hospital. He wanted to know how it happened and what was being done to prevent future occurrences. The physician stated he was satisfied with the facility's actions: they got back to him within 24 hours with the answer to the first question and called him back the next day with prevention of future occurrences.

The facility's Receiving Physician's Orders Policy revised on 5/10/18 documented that with phone or verbal orders, the nurse receiving the order shall transcribe the order(s) verbatim onto a verbal/telephone order slip, read back the order to the ordering practitioner, wait for acknowledgement, note the order, transcribe it to the EMAR (electronic medication administration record), fax a copy to pharmacy, notify family and any outside agencies and document in the Progress Notes/24-hour report sheet/PCC (point click care) Dashboard. A Quality Assurance (QA) procedure dated 5/23/19 documented the orders would also be reviewed by the night charge nurse for accuracy and would be triple checked by the Director of Nursing (DON) or her designee.

Interview on 5/30/19 at 10:30 with the DON revealed, that originally staff would copy a new order and put it in her folder for later review. The facility put this QA process in place after the annual health survey of 2/18/19. The DON looked at the copies of orders to make sure they

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F 760	Continued From page 5 were accurate. Since the error detailed above, the facility also had the night shift charge nurse check over new orders in addition to the DON. She stated she would not have known to look at health status notes for any new orders; the facility has used the EMR to record new orders since 2014. The deficient practice detailed above resulted in an immediate jeopardy situation for the facility. The facility abated the immediate jeopardy on 5/24/19 by re-training all nursing staff on the Receiving Physician Orders policy and on QA efforts related to medication administration. This abatement resulted in past noncompliance for the facility.	F 760		