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F 000	INITIAL COMMENTS Correction date _____ The following deficiencies are the result of the facility's annual health survey and complaint #87656-C completed December 16-24, 2019. Investigation of complaints #86546-C and facility self-reported incident #87053-I did not result in deficiency. See the Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F 000		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires	F 645		

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

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the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as

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described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review and staff interview, the facility failed to ensure completion of a PASARR (preadmission screen and resident review) for one of five residents reviewed for PASRRs, (Resident #32). The facility identified a census of 66 current residents.

Findings include:

According to the admission Minimum Data Set (MDS) assessment dated 10/11/19, Resident #32 had diagnoses that included anxiety, depression, bipolar disease and schizophrenia. The assessment documented she had intact memory and cognition, as evidenced by a brief interview for mental status score of 14. The assessment documented she experienced the following mood indicators: little interest of pleasure in doing things, feeling down or hopeless, trouble with sleep, feeling tired or with little energy and trouble with concentration. The MDS also documented she displayed verbal and other behavioral symptoms during 1 - 3 days of the assessment period. The assessment documented Resident #32 admitted to the facility on 10/4/19.

The resident's Care Plan dated 10/4/19, did not contain documentation of PASARR directed services.

The resident's electronic health record (EHR) contained a PASARR dated 9/18/19 that allowed for 60 day placement without PASARR support/services. The EHR contained no additional PASARR evaluation.

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F 645	Continued From page 3 During interview on 12/19/19 at 8:46 AM, the Assistant Director of Nursing (ADON) stated it would be unlikely to find another PASARR in the resident's record as staff were all still learning the PASARR process. The ADON stated the resident's case manager visited the facility on 12/17/19 and she usually informed staff of the need for PASARR. During observation and interview on 12/19/19 at 9:17 AM, the DON and ADON worked in ADON's office. Observation revealed ASCEND (the state PASARR agency) consultation information on the ADON's computer screen. When asked if they were requesting a PASARR evaluation for resident, both stated yes. Review of the facility's ASCEND referral list dated 12/19/19 showed Resident #32 had no dates of referral. On 12/19/19 at 10:02 AM, the DON stated that no further PASARR evaluation could be found.	F 645		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident interview, staff interview, pharmacy record review and facility policy review, the facility failed to obtain narcotic pain medication within the first 48 hours of a resident's admission to the facility who	F 697		

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entered with a new abdominal surgical wound and failed to intervene with an effective pain intervention to minimize the pain experienced by the resident who described the pain as excruciating, suffering for the first 2 days of admit (Resident #167). The facility failed to provide non-pharmalogical pain interventions for a separate resident (Resident #62); out of 3 residents reviewed for pain management. The facility reported a census of 66 residents.

Findings include:

1. The Discharge Return Anticipated (DRA) Minimum Data Set (MDS) assessment dated 9/2/19 for Resident #167 identified the resident admitted to the facility on 8/29/19 then transferred to the hospital 9/2/19. The MDS revealed the resident required extensive physical assistance for bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS recorded the presence of a ostomy (a surgically created opening in the abdomen that allows waste or urine to leave the body). The MDS documented diagnoses that included: diabetes mellitus; chronic kidney disease; injury of sigmoid colon, initial encounter; major depressive disorder, recurrent, mild; gastro-esophageal reflux disease without esophagitis (acid reflux); chronic peptic ulcer, site unspecified, without hemorrhage or perforation (a break in the inner lining of the stomach, AKA stomach ulcer); hyperlipidemia (high cholesterol); headache; and morbid obesity. The MDS identified the resident received scheduled pain medication regimen and PRN (as needed) pain medications or offered PRN pain medication declined during the 5 day look back period. The medication section of the MDS recorded the resident received opioid medications

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on 4 out of 5 days.

The admission MDS assessment dated 9/23/19 identified the resident returned from the hospital on 9/16/19. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 13 without signs/symptoms of delirium. A score of 13 indicated intact cognition. The MDS documented additional diagnoses that included: heart failure, arthritis, chronic lung disease, and migraines. The MDS identified the resident did not receive scheduled pain medication regimen in the 5 day look back period but did receive PRN pain medications or PRN pain medication offered and declined. The MDS pain assessment recorded the resident reported the presence of frequent, severe pain. The MDS documented the presence of a surgical wound. The Care Area Assessment (CAA) Summary identified pain care area triggered.

On 8/29/19, the Care Plan identified the use of a colostomy (artificial opening in the abdominal wall so as to bypass a damaged part of the colon) and documented the presence of an ostomy due to perforation of intestine (a hole developed all the way through the intestines). The Care Plan documented the resident experienced acute pain related to surgical wound located midline abdomen and identified the resident used opioid (narcotic pain medication) oxycodone related to pain. The Care Plan informed staff the resident preferred to have pain controlled by medication and instructed staff to anticipate the resident's need for pain relief and respond immediately to any complaint of pain.

The hospital Discharge Orders printed, 8/29/19 at 12:38 p.m., documented the resident hospitalized

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8/16/19 thru 8/29/19 with primary diagnosis of superficial disruption of operational wound. The report documented an incision present on the mid-abdomen. The instructions included directives to call the provider for severe uncontrolled pain.
The Medication List included the following medicines to be started or continued:
a. baclofen (muscle relaxer) 5 mg (milligrams) by mouth 3 times a day at 12:00 p.m., 5:00 p.m., and 8:00 p.m. (last hospital dose at 12:34 p.m. on 8/29/19).
b. Imitrex (migraine medication also known as sumatriptan) 6 mg/0.5 ml (milliliter) injection; inject 0.5 ml subcutaneously as needed for migraine.
c. oxycodone/acetaminophen (narcotic pain medication combined with Tylenol) 7.5/325 mg tablet; 1 tablet by mouth 3 times a day as needed for pain (last hospital dose at 12:25 p.m. on 8/29/19).
d. pregabalin (nerve pain medication) 75 mg by mouth 3 times a day at 8:00 a.m., 12:00 p.m., and 8:00 p.m. (last hospital dose at 10:09 a.m. on 8/29/19).
The hospital orders contained a section on opioid pain medicine information. The report educated opioids helped to reduce or eliminate pain and when used for short periods of time, they helped a person to: sleep better; do better in physical or occupational therapy; feel better in the first few days after an injury; and recover from surgery.

The Progress Notes dated 8/29/19 at 3:41 p.m. recorded the resident admit nursing assessment. The entry documented responses to assessing the residents pain. The resident experienced pain which was worse in the afternoons, felt sharp, and located in the surgical wound on the

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abdomen. The pain documented as relieved by medication, deep relaxation, and frequent position changes. The assessment noted the resident received scheduled pain medication of oxycodone/acetaminophen 7.5 mg/325 mg tablet, 1 tablet by mouth every 8 hours as needed with pain medication effective within 45 minutes.

The Progress Notes dated 8/29/19 at 8:08 p.m. documented acetaminophen 650 mg PRN given for complaints of mid abdominal pain rated a 5 out of 10 on the pain scale of 0 to 10 (0 = no pain and 10 = worst pain imaginable).

On 8/30/19 at 4:56 a.m. the Progress Notes recorded the PRN acetaminophen effective with a follow-up pain rating of 3. At 5:31 a.m., the notes recorded acetaminophen 650 mg PRN again given to the resident.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 8/30/19 at 5:31 a.m. a pain level of 9 out of 10.

On 8/30/19 at 5:54 a.m. the Progress Notes recorded the resident alert and oriented with incision to mid abdomen, staples intact to the upper portion, and lower portion packed. The entry documented the dressing changed, incision cleaned, and new dressing applied. The entry recorded the resident's medications did not arrive from pharmacy and the nurse passed on to the day nurse to contact pharmacy first thing in the morning; acetaminophen PRN given twice that shift for pain and a temp of 99.9 degrees. At 9:24 a.m. thru 9:33 a.m., the notes contained multiple entries that recorded several medications not given to the resident as no supply available which included pregabalin.

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At 9:34 a.m., the notes documented PRN acetaminophen effective with some help and continued pain rating of 5 out of 10.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 8/30/19 at 10:39 a.m. a pain level of 8 out of 10.

On 8/30/19 at 10:42 p.m. the Progress Notes recorded a daily skilled comprehensive nursing assessment. The entry documented a surgical incision on the abdomen above and below the naval with redness, purulent drainage, foul odor present, and packing lower portion of incision covering with ABD pad (type of dressing). The resident reported experiencing pain with the additional symptoms of anxiety associated with the pain, worse in the morning. The resident reported: the pain located at the sacrum and abdomen; described as splitting, throbbing, and hurt a whole lot; pain relieved by medication, frequent position changes, and distraction; PRN pain medication received; and the pain medication NOT effective.

On 8/30/19 at 11:23 a.m. thru 11:24 a.m., the Progress Notes again contained multiple entries that recorded several mediations not given to the resident as no supply available which included baclofen and pregabalin. At 3:47 p.m. thru 3:49 p.m. the notes again contained multiple entries that recorded several mediations not given to the resident as no supply available which included baclofen.

The Consolidated Delivery Sheets dated 8/30/19 at 5:46 p.m. recorded the pharmacy delivery of medications to the facility. The delivery included baclofen 10 mg tablet; 33 tablets for Resident

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#167. The delivery did not contain the ordered medications of oxycodone/acetaminophen (combination narcotic pain medication) or pregabalin (the nerve pain medication).

The Progress Notes dated 8/31/19 at 3:49 a.m. recorded a daily skilled short note. The note documented an Observation, Evaluation, and Development of Plan of Care, Pain, that recorded the resident rated pain at an 8 and declined PRN Tylenol.

On 8/31/19 at 9:27 a.m. the Progress Notes documented pregabalin pain medication to be given 3 times a day not available to give, then at 11:41 a.m. again the notes documented the medication not available to give, and at 8:12 p.m. not available to give. At 8:14 p.m. the notes documented acetaminophen 650 mg PRN given for pain.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 8/31/19 at 8:14 p.m. a pain level of 9 out of 10.

On 8/31/19 at 9:19 p.m. the Progress Notes recorded the PRN acetaminophen ineffective with a follow-up pain scale of 7 and oxycodone/acetaminophen 7.5/325 mg tablet given PRN for severe pain. At 11:06 p.m. the notes recorded the PRN oxycodone/acetaminophen effective with a follow-up pain rating of 0.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 9/1/19 at 7:22 a.m. a pain level of 5 out of 10 and on 9/1/19 at 8:31 a.m. a 9 out of 10.

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On 9/1/19 at 7:57 a.m. the Progress Notes recorded the pregabalin medication not available to give the resident.
At 8:31 a.m. the notes documented oxycodone/acetaminophen 7.5/325 mg tablet PRN given for severe pain. The entry recorded medication brought in by the family due to pharmacy not filling prescription because no written script from the provider on file. The entry documented the resident had been suffering from severe pain since admission. The nurse wrote the clinic, on-call (physician), discharging hospital, facility pharmacy, and Rex Pharmacy all contacted the day before to try to resolve the issue but no resolution discovered. The entry documented the facility would use the personal supply of medications from the family until Tuesday (9/3/19) when the primary provider could be contacted.
At 12:02 p.m. the notes recorded the pregabalin pain medication not available to give.
At 2:07 p.m. the notes recorded a daily skilled comprehensive nursing assessment. The assessment documented the resident experienced abdominal pain increased by movement, worse in the morning, localized due to abdominal incision, felt sharp, and hurt a whole lot. The note recorded the pain relieved by medication, PRN pain med utilized, and PRN effective.
At 2:59 p.m. the notes recorded the PRN oxycodone/acetaminophen effective with a follow-up pain rating of 4.
At 7:07 p.m. the notes recorded acetaminophen 650 mg PRN given for a temperature of 100.3 degrees.
At 8:21 p.m. the notes recorded the pregabalin not available to give.
At 8:21 p.m. the notes recorded

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oxycodone/acetaminophen 7.5/325 mg tablet given PRN for severe pain.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 9/1/19 at 8:21 p.m. a pain level of 8 out of 10.

On 9/1/19 at 8:22 p.m. the Progress Notes recorded the PRN acetaminophen effective with a temperature of 99.6 degrees and follow-up pain rating of 6. At 10:52 p.m. the notes recorded the PRN oxycodone/acetaminophen effective with follow-up pain rating of 0.

On 9/2/19 at 2:01 a.m. the Progress Notes documented the resident's bandage came off and the wound to abdomen with thick purulent drainage with staple that had come loose opening up several dime size areas to the wound. A large red area surrounded the wound, warm to touch, and the resident more lethargic complaining of increased pain. The notes recorded the physician was contacted.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 9/2/19 at 7:20 a.m. a pain level of 6 out of 10.

On 9/2/19 at 8:16 a.m. the Progress Notes recorded the pregabalin not available to give. At 10:44 a.m. the notes recorded acetaminophen 650 mg PRN given for general discomfort.

The Weight and Vitals Summary printed 12/23/19 recorded the resident reported on 9/2/19 at 10:44 a.m. a pain level of 7 out of 10 and on 9/2/19 at 10:55 a.m. a 7 out of 10.

On 9/2/19 at 10:55 a.m. the Progress Notes

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recorded oxycodone/acetaminophen 7.5/325 mg tablet given for severe pain. The entry documented the pills brought in by family due to pharmacy not receiving a written script from the provider. At 11:51 a.m., the notes recorded the resident discharged to the hospital with family present at 11:40 a.m.

Review of the August 2019 Medication Administration Record (MAR) revealed Resident #167 did not receive any scheduled medications on the evening of 8/29/19. The MAR reflected Resident #167 missed baclofen 10 mg 2 different times and pregabalin 2 different times on 8/30/19. The MAR documented the resident received oxycodone/acetaminophen 7.5/325 mg 1 tablet only once from 8/29/19 to 8/31/19 on 8/31/19 at 9:19 p.m.

The September 2019 MAR documented Resident #167 did not receive pregabalin 75 mg 3 times a day for pain on 9/1 thru 9/3.

On 12/23/19 at 11:36 a.m. Resident # 167 confirmed she had to wait 2 days to get her medicines when she first arrived at the facility even though the hospital called early before she left the hospital. Resident #167 stated the facility did not have any of her medications that were ordered. Resident # 167 commented she had to suffer for 2 days without her medications that should have been available on the first day. Resident #167 expressed she suffered with a lot of pain from her wound and felt Tylenol alone did not cut it.

On 12/23/19 at 2:08 p.m. the Administrator responded she would need to check with the DON (Director of Nursing) as she thought

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Resident # 167 had a history of being non-complainant. The Administrator acknowledged arrangements should have been made to ensure the resident's medications on hand at the time of admit.

On 12/23/19 at 2:27 p.m. the DON responded she put new admit orders into the computer then Staff B, Registered Nurse (RN)/Unit Manager checked the orders the day of admit then the orders sent to pharmacy for them to go thru and look for allergies who then send back if good or changes needed. The DON commented the facility usually received pharmacy deliveries at night and she believed the cut off order time 4:00 p.m. for the facility pharmacy in order to receive medications the same day as ordered except on holidays. The DON reported the facility pharmacy delivered on Saturdays but not Sundays. The DON voiced Resident #167 skilled so she used the facility pharmacy as the facility responsible to provide medications when a resident skilled. The DON responded her expectation if a nurse got an order without a script would be usually make sure she got the orders before a resident arrived then if needed, call the on-call physician to get an order to send to pharmacy for the medication.
At 3:37 p.m., the DON responded to question of why she thought the medications did not come with she thought most meds came but things that needed scripts the pharmacy would not send.
The DON said she read from the clinical record other pharmacies not able to get the medications and staff not able to pull from the E-kit (Emergency Medication supply) as they couldn't get the narcotic medication out of the kit without prior authorization.

On 12/23/19 at 4:20 p.m., Staff C, Licensed

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Practical Nurse (LPN), reported she worked for 3 years at the facility and since July 2019 as an LPN. Staff C recalled Resident #167 and the resident had a lot of pain with the stomach area where the wound vac was. Did not recall caring for the resident when originally admitted 8/29/19 prior to the wound vac.

On 12/24/19 at 7:30 a.m. the DON acknowledged the medications not received timely for Resident # 167 upon her admission. The DON confirmed Resident # 167's medications not received until the next evening following admission, 8/30/19. The DON acknowledged the narcotic pain medication given to the resident on 8/31/19 should not have been given from the supply family brought in. The DON responded she agreed the resident may have needed something stronger than Tylenol medication for the abdominal surgical wound. The DON clarified the surgeon the original prescriber for the narcotic pain medication Percocet (oxycodone/acetaminophen) and thought that was part of the difficulties getting the written script for the pharmacy on that weekend. The DON commented part of the problem with getting the medication related to the county hospital unwilling to provide services for the resident, other pharmacies contacted who said no, and therefore she thought the facility had to wait on the surgeon.
The DON responded she thought the family brought the narcotic pain medication from home from Resident # 167's previous home order. The DON commented she had instructed the nurses to destroy some of the narcotic medication due to improper labeling or identification.

On 12/24/19 at 8:24 a.m. Staff D, Certified

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Medication Aide (CMA), recalled working as a med aide at the time Resident #167 resided in the facility. Staff D confirmed there was a medication the facility had difficulty acquiring and stated she just documented the medication not available. Staff D stated she did recall the resident having pain in the stomach area but she did not deal with the medication oxycodone.

On 12/24/19 at 9:26 a.m., Staff E, LPN, recalled working with Resident #167 during the resident's original admit. Staff E recalled the resident did not have her narcotic pain medication as they could not get a hand signed script from the prescribing doctor who was the surgeon. Staff E stated she called the resident's primary physician, the hospital where the surgery performed, that hospital attempted to track down the surgeon and was not able to get a signed script. Staff E responded she did not talk to the facility medical director as once she discovered it was the surgeon who ordered the medication, she knew she needed his signature to get the medication from pharmacy. Staff E stated yes the resident having pain and Resident #167's family member brought the pain med from home. Staff E explained Resident #167 took the medication previously at home on a routine basis as she had chronic pain and thought that medication was oxycodone. Staff E stated the usual facility process for obtaining narcotic medication for a newly admitted resident was a script received from the hospital discharge packet. Staff E said it was a blue script paper and it required a signature from a physician, then sent to pharmacy. Staff E commented it was nearly impossible to get the signed script for Resident #167's pain medication. Staff E said she did not know if the difficulties getting the narcotic pain

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medication related to Resident #167 having a previous home script. Staff E said it actually happened the first time the resident ever at the facility where the family member had to bring in pain medication for Resident #167. Staff E stated the family member reluctant to bring medication so only brought a few at a time. Staff E stated the nurses wrote down the number of pills brought in from the family on a count paper. Staff E responded the nurses verified the medication in the bottle with the resident's name listed on the bottle and thought pharmacy also verified the medication. Staff E stated Resident #167 definitely experienced pain and it was sad as she could see the resident in pain and just knew it by looking at her. Staff E said Resident #167 described her pain as excruciating. Staff E recalled Resident #167 gripped the rails of the bed during dressing changes as they were so painful. Staff E responded she did not feel Tylenol enough of a pain med to control the resident's pain. Staff E commented the resident's abdominal wound large and a person could see right down into the resident's stomach as the wound had dehisced (separation of the incision line prior to complete healing resulting in an open wound). Staff E said the wound dehiscing was the reason the resident originally admitted to the facility on 8/29/19 and then the resident rapidly became septic (infected) which lead to the resident going back to the hospital. Staff E said when Resident #167 returned from the hospital she re-entered the facility with a wound vac to the abdominal surgical wound site. Staff E commented Resident #167 never talked about not getting her pain medication but if Staff E were the resident, she would have been upset about not getting the pain medication as Staff E knew Resident #167 in a lot of pain.

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On 12/24/19 at 10:01 a.m. Staff F, CMA, recalled working with Resident #167. Staff F said she didn't deal with actual pain medications but knew pharmacy didn't send meds right away and they did take some medications out of the E-kit. Staff E couldn't recall if it were just the pain medications the facility didn't received.

On 12/24/19 at 10:18 a.m. Staff G, LPN, responded she vaguely recalled Resident #167 as she only worked with her 1 time. Staff G refreshed her memory by looking at the resident's progress note completed on 8/30/19 at 10:42 a.m. Staff G confirmed she did assess the resident had pain and believed she recalled the pain located in the abdomen. Staff G did not recall what she did for a pain intervention but stated if she had given a pain medication it would have been reflected in the progress notes. Staff G confirmed she could not find any other notes by her to reflect an intervention performed by her. Staff G stated she did find an entry by Staff F on 8/30/19 at 9:24 a.m. that showed Resident #167 received Tylenol at that time. Staff G could not recall if the Tylenol effective for the resident's pain. Staff G stated she believed the resident hurt the most when getting up. Staff G responded she would expect the CMA to report to her if a resident asked for pain medication but Staff G responsible for conducting pain assessments and interventions. Staff G did not recall if Staff F said anything about Resident #167's pain.

The pharmacy Request for Removal of a Controlled Substance From the E-Kit instructed the following process to obtain a narcotic:
- Attention: if faxing AFTER HOURS, please

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contact the pharmacy using emergency procedures (phone # given).
- Section to complete for demographics of resident and medication needed.
- Section to complete by facility: if a new Schedule 2-5 medication order, before faxing the request, contact the practitioner and request a prescription be faxed to the pharmacy OR a verbal order called to the pharmacy (fax and phone numbers provided); if existing Schedule 2-5 medication order fax the request directly to the pharmacy.
- Section for pharmacy to complete authorizing release of the E-Kit supply or not authorizing as pharmacy did not have a valid prescription and the practitioner had not contacted the pharmacy with a faxed or verbal authorization.

2. Resident #62's admission MDS assessment dated 11/29/19 documented he had intact memory and cognition as evidenced by a BIMS score of 15. The assessment documented diagnoses that included cancer, heart failure, anemia, kidney disease, diabetes, arthritis and gouty arthritis. The assessment documented he experienced frequent pain at an "8" of a zero to ten pain scale which did not impair his sleep or limit his daily activities. The MDS documented Resident #62 received as needed pain medications and non-medication interventions for pain. The Care Area Summary of the MDS documented pain as a triggered care area and included in care planning.

The resident's Care Plan focus area dated 11/25/19, documented he experienced pain related to a flare-up of gouty arthritis. The interventions instructed to anticipate his need for pain relief and respond immediately to any

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F 697	Continued From page 19 complaint of pain, to evaluate the effectiveness of pain interventions within one hour of administration and review for compliance, alleviating of symptoms, dosing schedules and his satisfaction with results and impacts on functional ability and cognition, to monitor and document for side effects of pain medication, to monitor, document, and report to nurse as needed any signs or symptoms of nonverbal pain and to notify physician if interventions are unsuccessful or if current complaint is a significant change from the resident's past experience of pain. The Care Plan contained no instructions and examples of non-medication interventions to alleviate Resident #62's pain. During interview on 12/16/19 at 3:36 PM, Resident #62 stated he could not remember staff offering non-medication interventions for his pain (like hot packs, ice packs or having his feet up); just medications. The resident stated he tried to keep his feet up and that hospital staff told him to do that. During interview on 12/19/19 at 10:48 AM, Staff A, RN stated the resident receives Tramadol (opiate medication) for pain. Staff A stated the Tramadol seemed to work, but she did not recall any non-medication interventions for his pain. On 12/19/19 at 11:50 AM, the DON stated she thought nurses try non-medication interventions for the resident's pain but they were not added to the care plan. The DON stated a general expectation would be to try position changes, to get a resident up, or use ice or heat before trying medications.	F 697		
F 755	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		

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§483.45 Pharmacy Services
The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

§483.45(a) Procedures. 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.

§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-

§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on clinical record review, resident interview, staff interview and pharmacy record review, the facility failed to acquire and administer medications for a new resident in a timely manner

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leading to the resident going without a majority of their scheduled medications for 24 hours (Resident #167); out of 3 residents reviewed for pain medications. The facility reported a census of 66 residents.

Findings include:

The Discharge Return Anticipated (DRA) Minimum Data Set (MDS) assessment dated 9/2/19 for Resident #167 identified the resident admitted to the facility on 8/29/19 then transferred to the hospital 9/2/19. The MDS documented diagnoses that included: diabetes mellitus; chronic kidney disease; injury of sigmoid colon, initial encounter; major depressive disorder, recurrent, mild; gastro-esophageal reflux disease without esophagitis (acid reflux); chronic peptic ulcer, site unspecified, without hemorrhage or perforation (a break in the inner lining of the stomach, AKA stomach ulcer); hyperlipidemia (high cholesterol); headache; and morbid obesity. The medication section of the MDS recorded the resident received antipsychotic, antidepressant, and diuretic medications on 5 out of 5 days of the look back period and hypnotic, and opioid medications on 4 out of 5 days.

The admission MDS assessment dated 9/23/19 identified the resident returned from the hospital on 9/16/19. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 13 without signs/symptoms of delirium. A score of 13 indicated intact cognition. The MDS documented additional diagnoses that included: heart failure, arthritis, chronic lung disease, and migraines.

On 8/29/19 the Care Plan identified the resident experienced acute pain related to surgical wound

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located midline abdomen and identified the resident used opioid (narcotic pain medication) oxycodone related to pain. The care plan informed staff the resident preferred to have pain controlled by medication. The Care Plan identified the use of antidepressant medication Bupropion 300 mg (milligrams) PO (by mouth) every AM related to depression and insulin/hypoglycemic (blood sugar lowering) medications related to diabetes.

The hospital Discharge Orders printed, 8/29/19 at 12:38 p.m., documented the resident hospitalized 8/16/19 thru 8/29/19 with primary diagnosis of superficial disruption of operational wound. The Medication List included the following medicines to be started or continued:
a. bumetanide (diuretic medication) 2 mg by mouth 2 times a day at 8:00 a.m. and 12:00 p.m.; start taking on Tuesday (9/3/19) only if Cr (creatine) better.
b. spironolactone (diuretic medication) 25 mg by mouth once daily; start taking on Tuesday (9/3/19) only if Cr better.
c. lactobacillus acidophilus (type of good bacteria found in the intestines; a probiotic) 1 capsule by mouth once daily.
d. aimovig autoinjector (migraine medication) 140 mg per ml (milliliter); inject 140 mg under the skin every 28 days.
e. aspirin 81 mg by mouth once daily (last hospital dose at 10:10 a.m. on 8/29/19).
f. baclofen (muscle relaxer) 5 mg by mouth 3 times a day at 12:00 p.m., 5:00 p.m., and 8:00 p.m. (last hospital dose at 12:34 p.m. on 8/29/19).
g. bupropion (antidepressant medication) 300 mg by mouth every morning at 8:00 a.m..
h. carbidopa ER (extended release)/levodopa (used to treat Parkinson's disease) 25-100 mg

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tablets, take 2 tablets by mouth daily every night at bedtime, 8:00 p.m..
i. carbidopa-levodopa 10-100 mg tablet; take 1 tablet by mouth 2 times a day at 8:00 a.m. and 5:00 p.m..
j. carbidopa-levodopa 25-100 mg tablet; take 1 tablet by mouth every morning; give with carbidopa-levodopa 10/100 mg at 8:00 a.m. only.
k. cholecalciferol (vitamin D3) 1,000 units by mouth daily with lunch at 12:00 p.m..
l. docusate sodium (stool softener) 100 mg by mouth 2 times a day, hold for loose stools (last hospital dose at 10:10 a.m. on 8/29/19).
m. ferrous sulfate (iron) 325 mg tablet by mouth daily with breakfast.
n. fexofenadine (antihistamine medication) 180 mg by mouth once daily.
o. folic acid (vitamin) 1 mg by mouth once daily (last hospital dose at 10:10 a.m. on 8/29/19).
p. Imitrex (migraine medication also known as sumatriptan) 6 mg/0.5 ml injection; inject 0.5 ml subcutaneously as needed for migraine.
q. ipratropium-albuterol (lung medication that helps open airways) 0.5-2.5 mg/3 ml nebulizer; inhale 3 ml into the lungs once every 4 hours as needed for wheezing or shortness of breath.
r. losartan (treats high blood pressure)100 mg by mouth daily every night (last hospital dose at 10:03 p.m. on 8/27/19).
s. magnesium oxide (element body needs to function properly) 400 mg by mouth once daily.
t. melatonin (hormone that regulates sleep) 5 mg capsule; take 3 capsules at bedtime, 8:00 p.m..
u. mometasone-formoterol (combination medication used to treat asthma also known as Dulera)100-5 mcg (micrograms) per actuation inhaler; inhale 2 puffs into the lungs 2 times a day.
v. nitrostat (medication used to treat chest pain)

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0.4 mg SL (sublingual) tablet; dissolve 1 tablet under the tongue may repeat every 5 minutes with maximum of 3 doses in 15 minutes.
w. omeprazole (medication used to treat gastric ulcers) 40 mg by mouth once daily in the morning at 8:00 a.m..
x. oxybutynin (medication used to treat overactive bladder) 5 mg by mouth 3 times a day at 8:00 a.m., 12:00 p.m., and 5:00 p.m. (last hospital dose at 12:34 p.m. on 8/29/19).
y. oxycodone/acetaminophen (narcotic pain medication combined with Tylenol) 7.5/325 mg tablet; 1 tablet by mouth 3 times a day as needed for pain (last hospital dose at 12:25 p.m. on 8/29/19).
z. pregabalin (nerve pain medication) 75 mg by mouth 3 times a day at 8:00 a.m., 12:00 p.m., and 8:00 p.m. (last hospital dose at 10:09 a.m. on 8/29/19).
aa. prenatal vitamin plus low iron 27 mg iron-1 mg tablet; take 1 tablet by mouth every morning at 8:00 a.m..
bb. propranolol (heart medication, beta blocker) 40 mg by mouth 2 times a day (last hospital dose at 10:09 a.m. on 8/29/19).
cc. ranitidine (antacid medication) 300 mg by mouth 2 times a day at 8:00 a.m. and 5:00 p.m..
dd. simvastatin (medication to treat high cholesterol) 20 mg by mouth daily every night.
ee. tradjenta (diabetic medication) 5 mg by mouth once daily.
ff. trazodone (antidepressant medication)150 mg by mouth daily every night at bedtime 8:00 p.m..
gg. Ventolin (lung medication that helps open airways) HFA 90 mcg/actuation inhaler; inhale 1 to 2 puffs into the lungs once every 4 hours as needed for wheezing.
hh. vitamin C 500 mg by mouth once daily.
ii. ziprasidone (antipsychotic medication used to

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treat bipolar disease or schizophrenia) 60 mg by mouth 2 times a day with meals (last hospital dose at 10:09 a.m. on 8/29/19).
The Discharge Orders gave instructions to pick up some medications at Rex Pharmacy in Atlantic, Iowa: bumetanide; propranolol; spironolactone.

The Progress Notes dated 8/29/19 at 3:41 p.m. recorded the resident admit nursing assessment.

On 8/30/19 at 5:54 a.m. the Progress Notes recorded the resident's medications did not arrive from pharmacy and the nurse passed on to the day nurse to contact pharmacy first thing in the morning. At 9:24 a.m. thru 9:33 a.m., the notes contained multiple entries that recorded several medications not given to the resident as no supply available: bupropion, carbidopa/levodopa, Dulera, fexofenadine, omeprazole, oxybutynin, folic acid, magnesium oxide, ranitidine, pregabalin, prenatal vitamin plus low iron, propranolol, tradjenta, and ziprasidone.

On 8/30/19 at 11:23 a.m. thru 11:24 a.m., the Progress Notes again contained multiple entries that recorded several mediations not give to the resident as no supply available: baclofen, pregabalin, oxybutynin, and cholecalciferol.
At 3:47 p.m. thru 3:49 p.m. the notes again contained multiple entries that recorded several mediations not given to the resident as no supply available: baclofen, Dulera, carbidopa/levodopa, propranolol, oxybutynin, ziprasidone, and ranitidine.

The Consolidated Delivery Sheets dated 8/30/19 at 5:46 p.m. recorded the pharmacy delivery of medications to the facility. The delivery included

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the following medications and amounts for Resident #167.
a. bumetanide 2 mg tablet; 22 tablets
b. spironolactone 25 mg tablet; 11 tablets
c. acidophilus capsule; 11 capsules
d. baclofen 10 mg tablet; 33 tablets
e. bupropion 150 mg tablet; 20 tablets
f. carpidopa/levodopa 25/100 mg tablets; 21 tablets
g. carpidopa/levodopa 10/100 mg tablets; 21 tablets
h. carpidopa/levodopa 25/100 mg tablets; 11 tablets
i. vitamin D3 1,000 IU (International Units) tablet; 11 tablets
j. fexofenadine 180 mg tablets; 11 tablets
k. folic acid 1 mg tablet; 11 tablets
l. sumatriptan 6 mg/0.5 ml; 2 mls
m. ipratropium/albuterol inhaler; 180 mls
n. losartan potassium 100 mg tablet; 11 tablets
o. magnesium oxide 400 mg tablets; 11 tablets
p. Dulera 100 mcg/5 mcg inhaler; 13 gm (grams)
q. nitroglycerin 0.4 mg tablet; 25 tablets
r. omeprazole 40 mg capsule; 11 capsules
s. oxybutynin 5 mg tablet; 33 tablets
t. prenatal plus tablet; 11 tablets
u. propranolol 40 mg tablet; 21 tablets
v. ranitidine 300 mg tablet; 21 tablets
w. simvastatin 20 mg tablet; 11 tablets
x. tradjenta 5 mg tablet; 11 tablets
y. trazodone 100 mg tablet; 16 tablet
z. albuterol sulfate HFA inhaler (also known as Ventolin) 90 mcg; 8.50 gm
aa. vitamin C 500 mg tablet; 11 tablets
bb. ziprasidone 60 mg capsule; 21 capsules
cc. melatonin 5 mg tablet; 32 tablets
The delivery did not contain the ordered medications of oxycodone/acetaminophen (combination narcotic pain medication) or

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pregabalin (the nerve pain medication).

On 8/31/19 at 9:27 a.m. the Progress Notes documented pregabalin pain medication to be given 3 times a day not available to give, then at 11:41 a.m. again the notes documented the medication not available to give, and at 8:12 p.m. not available to give.

On 9/1/19 at 7:57 a.m. the Progress Notes recorded the pregabalin medication not available to give the resident.
At 8:31 a.m. the notes documented oxycodone/acetaminophen 7.5/325 mg tablet PRN given for severe pain. The entry recorded medication brought in by the family due to pharmacy not filling prescription because no written script from the provider on file. The entry documented the resident had been suffering from severe pain since admission. The nurse wrote the clinic, on-call (physician), discharging hospital, facility pharmacy, and Rex Pharmacy all contacted the day before to try to resolve the issue but no resolution discovered. The entry documented the facility would use the personal supply of medications from the family until Tuesday (9/3/19) when the primary provider could be contacted. At 12:02 p.m. the notes recorded the pregabalin pain medication not available to give. At 8:21 p.m. the notes recorded the pregabalin not available to give.

On 9/2/19 at 8:16 a.m. the Progress Notes recorded the pregabalin not available to give.

On 9/2/19 at 10:55 a.m. the Progress Notes recorded oxycodone/acetaminophen 7.5/325 mg tablet given for severe pain. The entry documented the pills brought in by family due to

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pharmacy not receiving a written script from the provider. At 11:51 a.m., the notes recorded the resident discharged to the hospital with family present at 11:40 a.m.

Review of the August 2019 Medication Administration Record (MAR) revealed Resident #167 did not receive any scheduled medications on the evening of 8/29/19. On the morning of 8/30/19, Resident #167 received acidophilus 1 capsule, aspirin 81 mg, ferrous sulfate 325 mg, vitamin C 500 mg, and docusate sodium 1 capsule. The MAR reflected Resident #167 missed the following medications on 8/30/19: bupropion 300 mg, carbidopa/levodopa 25/100 mg tablet, cholecalciferol 1,000 units, fexofenadine 180 mg, folic acid 1 tablet, magnesium oxide 400 mg, omeprazole 40 mg, prenatal vitamin plus low iron tablet, tradjenta 5 mg, carbidopa/levodopa 10/100 mg tablet 2 different times, Dulera 100/5 mcg per actuation 2 puffs inhaled 2 different times, propranolol 40 mg 2 different times, ranitidine 300 mg 2 different times, ziprasidone 60 mg 2 different times, baclofen 10 mg 2 different times, oxybutynin 5 mg 3 different times, and pregabalin 2 different times. The MAR documented the resident received oxycodone/acetaminophen 7.5/325 mg 1 tablet only once from 8/29/19 to 8/31/19 on 8/31/19 at 9:19 p.m.

The September 2019 MAR documented Resident #167 did not receive pregabalin 75 mg 3 times a day for pain on 9/1 thru 9/3.

On 12/23/19 at 11:36 a.m. Resident # 167 confirmed she had to wait 2 days to get her medicines when she first arrived at the facility even though the hospital called early before she

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left the hospital. Resident #167 stated the facility did not have any of her medications that were ordered. Resident # 167 commented she had to suffer for 2 days without her medications that should have been available on the first day. Resident #167 expressed she suffered with a lot of pain from her wound and felt Tylenol alone did not cut it.

On 12/23/19 at 2:08 p.m. the Administrator responded she would need to check with the DON (Director of Nursing) as she thought Resident # 167 had a history of being non-complainant. The Administrator acknowledged arrangements should have been made to ensure the resident's medications on hand at the time of admit.

On 12/23/19 at 2:27 p.m. the DON responded she put new admit orders into the computer then Staff B, Registered Nurse (RN)/Unit Manager checked the orders the day of admit then the orders sent to pharmacy for them to go thru and look for allergies who then send back if good or changes needed. The DON commented the facility usually received pharmacy deliveries at night and she believed the cut off order time 4:00 p.m. for the facility pharmacy in order to receive medications the same day as ordered except on holidays. The DON reported the facility pharmacy delivered on Saturdays but not Sundays. The DON voiced Resident #167 skilled so she used the facility pharmacy as the facility responsible to provide medications when a resident skilled. The DON responded her expectation if a nurse got an order without a script would be usually make sure she got the orders before a resident arrived then if needed, call the on-call physician to get an order to send to pharmacy for the medication.

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At 3:37 p.m., the DON responded to question of why she thought the medications did not come with she thought most meds came but things that needed scripts the pharmacy would not send. The DON said she read from the clinical record other pharmacies not able to get the medications and staff not able to pull from the E-kit (Emergency Medication supply) as they couldn't get the narcotic medication out of the kit without prior authorization.

On 12/24/19 at 7:30 a.m. the DON acknowledged the medications not received timely for Resident # 167 upon her admission. The DON confirmed Resident # 167's medications not received until the next evening following admission, 8/30/19. The DON acknowledged the narcotic pain medication given to the resident on 8/31/19 should not have been given from the supply family brought in. The DON clarified the surgeon the original prescriber for the narcotic pain medication Percocet (oxycodone/acetaminophen) and thought that was part of the difficulties getting the written script for the pharmacy on that weekend. The DON commented part of the problem with getting the medication related to the county hospital unwilling to provide services for the resident, other pharmacies contacted who said no, and therefore she thought the facility had to wait on the surgeon. The DON responded she thought the family brought the narcotic pain medication from home from Resident #167's previous home order. The DON commented she had instructed the nurses to destroy some of the narcotic medication due to improper labeling or identification.

On 12/24/19 at 8:24 a.m. Staff D, Certified Medication Aide (CMA), recalled working as a

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med aide at the time Resident #167 resided in the facility. Staff D confirmed there was a medication the facility had difficulty acquiring and stated she just documented the medication not available.

On 12/24/19 at 9:26 a.m., Staff E, LPN, recalled working with Resident #167 during the resident's original admit. Staff E recalled the resident did not have her narcotic pain medication as they could not get a hand signed script from the prescribing doctor who was the surgeon. Staff E stated yes the resident having pain and Resident #167's family member brought the pain med from home. Staff E explained Resident #167 took the medication previously at home on a routine basis as she had chronic pain and thought that medication was oxycodone.

On 12/24/19 at 10:01 a.m. Staff F, CMA, recalled working with Resident #167. Staff F said she didn't deal with actual pain medications but knew pharmacy didn't send meds right away and they did take some medications out of the E-kit. Staff E couldn't recall if it were just the pain medications the facility didn't received. Staff F commented it was her opinion she didn't like late admissions as the facility did not get medications. Staff F stated she remembered ranting about that; that the resident did not have paperwork in time to send to the pharmacy to make sure she got the resident's medications. Staff F stated the facility accepted admits at all hours, but for her considered a late admit when they couldn't get papers to the pharmacy. Staff F thought they needed to fax pharmacy by 4 p.m. or 5 p.m. but she always aimed for 4 p.m. Staff F reported if they did not get medications, a nurse had to call the on-call pharmacy and it had to be deemed important for them to come to the facility a

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F 755	Continued From page 32 second time. Staff F commented the pharmacy fought them if order not correct or not have signature so they stonewalled the facility.	F 755		