DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165374	A. BUILDING ______ B. WING ______	C 04/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILL VALLEY CARE CENTER	1201 PARK STREET BELLEVUE, IA 52031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Correction Date: 4/15/21 BP The following deficiencies relate to the investigation of Complaints #96278 and #96286 on 3/10/21 - 4/14/21. Both Complaints were substantiated. (See Code of Federal Regulations (42CFR) Part 483, Subpart B-C).	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain the required written authorization from the physician for prescription medication orders, medication administration authorization, and authorization when the potential for a severe drug interaction was identified, as required by law, for 2 of 5 resident reviewed during a partial extended survey (Resident's #9 and #13). The facility reported a census of 30 residents. Findings include: 1. The 2/4/21 Minimum Data Set (MDS) Assessment Tool revealed Resident #9 with diagnoses that included congestive heart failure, anxiety non-Alzheimer's dementia and history of pulmonary embolism (blood clot in the lung), and scored 8 out of 15 points possible on the Brief	F 658		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brandi [illegible] RN LNHA
TITLE
(X6) DATE: 4/20/21

04/28/2021

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 658	Continued From page 1 Interview for Mental Status (BIMS) cognitive assessment that indicated moderate cognitive impairment. The resident identified to require extensive assistance of at least 1 staff for transfers to and from bed and chair, ambulation, bathing, toileting and personal hygiene, never incontinent of bowel and occasionally incontinent of urine (7 or fewer episodes in a week). A risk of skin breakdown related to incontinence problem initiated on the Nursing Care Plan on 9/5/14 directed staff: a. Monitor skin during care, report redness or breakdown. b. Report any signs of skin breakdown, such as sore, tender, red or broken areas. c. Skin treatments as ordered for any areas of impaired skin integrity. A Physician Order dated 4/2/21 directed staff to administer Coumadin (a blood thinning medication) 2 milligrams (mg) oral on Tuesday and Thursday, and 3 mg oral on Monday, Wednesday, Friday, Saturday and Sunday related to the resident's history of pulmonary embolism. A Physician Order dated 4/2/21, initiated and transcribed by Staff E, Licensed Practical Nurse (LPN), and transmitted electronically to the facility's Medical Director for authorization, directed staff to administer Nystatin powder (an anti-fungal medication) 100,000 units per Gram, applied to abdominal folds topical every day and evening shift for irritation for 14 days. When reviewed on 4/8/21, the medication was documented as administered on the evening shifts on 4/2/21 and 4/3/21, then twice daily through 4/8/21.	F 658		

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On 4/2/21, staff were alerted via the electronic record of a possible severe medication interaction between Nystatin and Coumadin, the hypoprothrombinemic effects of Coumadin may be increased by Nystatin Powder (the blood thinning effect of the Coumadin medication would be increased, the blood would be even thinner and less likely to clot).

The resident's record lacked any documentation or assessment of the resident's skin condition, reason the medication was required, or that the potential for severe medication interaction had been reviewed and approved by the physician.

2. The 2/18/21 MDS Assessment revealed Resident #13 with diagnoses that included atrial fibrillation (irregular heartbeat), peripheral vascular disease (poor circulation), non-Alzheimer's dementia and asthma, and scored 5 of 15 points on the BIMS cognitive assessment that indicated severe cognitive impairment. The resident identified to require extensive assistance of at least 1 staff for transfers to and from bed and chair, ambulation in room, dressing, bathing, toileting and personal hygiene, occasionally incontinent of urine and frequently incontinent of bowel (described as 2 or more episodes in a week).

A risk of skin breakdown related to impaired mobility and cognition problem initiated on the Nursing Care Plan on 10/14/19 directed staff:
a. Monitor skin during care, report redness or breakdown.
b. Report any signs of skin breakdown, such as sore, tender, red or broken areas.
c. Skin treatments as ordered for any areas of

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F 658	Continued From page 3	F 658		

impaired skin integrity.

A Physician Order dated 2/27/21 directed staff to administer Coumadin 5 mg oral daily related to atrial fibrillation.

A Physician Order dated 4/3/21, initiated and transcribed by Staff K, LPN, and transmitted electronically to the facility's Medical Director for authorization, directed staff to administer Nystatin powder 100,000 units per Gram, applied topical to groin every day and evening shift for redness for 14 days. When reviewed on 4/8/21, the medication was documented as administered twice daily from 4/4/21 through 4/8/21.

On 4/4/21, staff were alerted via the electronic record of a possible severe medication interaction between Nystatin and Coumadin, the hypoprothrombinemic effects of Coumadin may be increased by Nystatin Powder.

The resident's record lacked any documentation or assessment of the resident's skin condition, reason the medication was required, or that the potential for severe medication interaction had been reviewed and approved by the physician.

A document entitled "Standing Orders for 2020", transcribed and signed by the facility's Medical Director on 1/22/2020, directed staff could apply Nystatin powder 100,000 units per Gram to affected areas twice daily for 14 days or until healed, to use on irritated body folds.

Staff interviews revealed:

On 3/31/21 at 2:10 p.m., the Director of Nursing (DON), stated the facility didn't have a policy for

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F 658	Continued From page 4 Physician Orders, but expected staff to follow Physician Orders, administer medication as ordered unless contraindicated or clarification required, and seek further direction at that time. On 3/30/21 at 8:52 a.m., Staff X, Office Nurse for the facility's Medical Director, stated the physician was on vacation and out of the office from 3/27/21 until 4/12/21. On 4/7/21 at 8:33 a.m., Staff X stated the physician had not made any arrangements for order authorization in his absence, there was always a physician available (on-call) at their practice in another town, staff should contact the on-call physician if they needed orders for a resident, and any orders the facility sent to the Medical Director's office would not be approved or signed until after his return on 4/12/21. On 4/6/21 at 1:44 p.m., Staff H, Registered Nurse (RN), stated there were written standing orders from the facility Medical Director in the med room, staff wrote orders from it and sent them to the Medical Director for signature and authorization when needed. On 4/6/21 at 1:54 p.m., Staff Y, Registered Pharmacist (RPh) from the facility's Pharmacy, stated he was not aware of any standing orders from the facility's Medical Director, there was nothing on file or in the computer about such orders, he was not aware that facility staff had not obtained physician authorization for Resident's #9 and #13's Nystatin, and the Pharmacy could not dispense medication without written authorization from a physician, that was the law (the facility sent the request for Nystatin to the pharmacy and it was dispensed).	F 658		

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F 658	Continued From page 5 On 4/6/21 at 1:38 p.m., Staff Z, Corporate Nurse, stated she was not familiar with standing orders at the facility and had conferred with staff who reported Nystatin orders on Resident's #9 and #13 were from the standing orders. When asked to provide the physician's written authorization for the Nystatin prescriptions, Staff Z could not provide it. On 4/7/21 at 11:10 a.m., Staff Z stated the facility didn't have a policy for Standing Orders, and she, the acting Administrator, the DON and the Medical Director would meet after the physician returned from vacation and would address the Standing Order issue.	F 658		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, physician interview, Power of Attorney (POA) interview, professional drug reference, emergency services record review, and social media postings, the facility failed to provide comprehensive cardiac assessments for a resident with a recent history of heart surgery; failed to transcribe and clarify cardiac medication orders; and failed to notify the cardiologist of acute cardiac change of condition for 1 of 12 residents reviewed for assessment and	F 684		

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intervention (Resident #3). Resident #3 complained of indigestion over a span of several days, reached out to 911 on 3/3/21, and on 3/6/21 the resident found unresponsive and CPR (cardiopulmonary resuscitation) started. The resident transferred to the hospital where he later was pronounced deceased. The failures identified on 4/1/21 as an immediate jeopardy situation. The facility reported a census of 30 residents.

Findings include:

The 2/25/21 Minimum Data Set (MDS) Assessment Tool revealed Resident #3 admitted to the facility on 2/16/21 with diagnoses that included coronary artery disease, congestive heart failure, hypertension (high blood pressure), pneumonia, septicemia (severe infection that involves the blood system), and cellulitis of the left lower leg (swelling with infection). The resident scored 13 out of 15 points possible on the Brief Interview of Mental Status (BIMS) cognitive assessment, without symptoms of delirium, had verbal behaviors directed at others from 1 to 3 days of the 7 days that preceded the assessment, and required extensive assistance of at least 1 staff for transfers to and from bed and chair, ambulation, dressing, bathing, toileting and personal hygiene.

A History and Physical dated 2/8/21 transcribed by the resident's cardiologist described the resident had a myocardial infarction (heart attack) on 11/20/20 that required angioplasty with stent placement, and had significantly diminished ability for his heart to pump and circulate blood effectively.

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The Hospital Discharge and Facility Admission orders dated 2/16/21 directed the resident to follow up with the cardiologist at an appointment scheduled 2/22/21, and staff to administer medications and treatments that included:
a. Amiodarone (a strong antiarrhythmic heart medication) 200 milligrams (mg) oral once daily.
b. Amoxicillin-clavulanate 875-125 mg tablet (an antibiotic) oral 2 times daily for 2 days.
c. Apixaban 5 mg oral twice daily.
d. Ascorbic acid (vitamin C) 500 mg oral 3 times daily.
e. Atorvastatin (a statin used to lower cholesterol) 80 mg oral daily.
f. Clopidogrel (a blood thinning medication) 75 mg oral daily..
g. Doxycycline hyclate (an antibiotic) 100 mg oral every 12 hours for 5 days.
h. Lasix (a diuretic) 80 mg oral twice daily.
i. Gentamicin 0.1 percent ointment (antibiotic ointment) applied to affected area on left lower leg twice daily.
j. Levemir insulin 8 units injected subcutaneously daily.
k. Lisinopril (an ACE inhibitor anti-hypertension medication) 20 mg oral daily.
l. Metformin Extended Release (ER) (a diabetic medication) 1000 mg oral twice daily.
m. Metoprolol succinate (beta blocker medication used for hypertension and to prevent heart attacks) 25 mg 24 hour tablet oral twice daily.
n. Potassium Chloride ER (an electrolyte replacement supplement) 20 miliequivalents oral twice daily.
o. Spironolactone (a diuretic and anti-hypertension medication) 25 mg oral daily.
p. Albuterol (a bronchodilator medication used open airways) 2.5 mg in 3 milliliters (ml) solution

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administered via nebulizer every 4 to 6 hours as needed for wheezing.

Other Physician Orders at the time of admission included screen for fever and respiratory symptoms (new or changing cough, sore throat, new or worsening shortness of breath) twice daily on the day and evening shift, mandated by COVID-19 Corona virus infection control practices at long-term care facilities.

A Physician Order transcribed 2/18/21 by the facility's medical director directed staff to change the Metoprolol Succinate ER order to 50 mg tablet administered oral daily.

A Progress Note Summary of the resident's cardiologist appointment on 2/22/21 directed staff to continue the same medications, and return office appointment in 3 to 6 months or sooner as needed. Further directives on the visit summary listed "today's orders", that included a 12 lead electrocardiogram completed at the appointment, Amiodarone 100 mg tablet without further description of the amount or frequency, and Metoprolol succinate 50 mg 24 hour tablet, also without frequency. The last page of the summary described "medications stopped today", and listed Amiodarone 200 mg oral daily and Metoprolol succinate 24 hour tablet oral twice daily. There was a hand written notation by the Metoprolol by Staff G, Registered Nurse (RN) and Assistant Director of Nursing (ADON) that stated "was already discontinued, continue with 50 mg daily".

Staff G, RN transcribed a Physician Order on 2/23/20 that discontinued the Amiodarone, and sent the order to the facility's medical director for authorization.

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Pages 112 through 115 of the facility's Drug Reference "Nursing 2018 Drug Handbook", published by Wolters Kluwer, cautions that Amiodarone had a Black Box warning the medication only to be used for patients with life-threatening ventricular fibrillation (a fatal cardiac arrhythmia) or recurrent unstable ventricular tachycardia unresponsive to other medications (an arrhythmia when the heart ventricle beats at a fast rate and requires immediate treatment), and patient's should not stop taking the medication without consulting the prescriber.

An altered mood due to getting agitated at times problem initiated on the Nursing Care Plan on 2/22/21 directed staff:
a. Attempt to redirect resident's behavior If resistive to cares leave alone and try again in a few minutes.
b. Encourage resident to vent feelings and concerns.
c. Medicate as ordered, monitor and record response.
d. Refer to qualified professional as needed.
e. Reward verbally all positive behavior and compliance.

A verbal behavioral symptoms directed towards others problem initiated on the Nursing Care Plan on 3/3/21 directed staff:
a. Avoid over-stimulation.
b. Avoid power struggles with the resident.
c. Convey an attitude of acceptance towards the resident.
d. Explore with the resident, previous effective and ineffective coping mechanisms. Allow resident to call his family.

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e. If resident has delusions do not try to reason with or confront him, offer reassurance.
f. Maintain a calm environment and approach to the resident.
g. Praise resident when behavior is appropriate.
h. Refocus conversation when resident becomes verbally abusive.

Vital sign assessment related to COVID-19 screening, recorded on the March Medication Administration Record (MAR), the temperature recorded in Fahrenheit and blood pressure not assessed, revealed:

	Temperature	Pulse	Respiration	Oxygen Saturation
3/1/21				
Day shift	97.3	74	18	94 percent
Evening shift	97.2	76	18	95 percent
3/2/21				
Day shift	97.6	72	16	96 percent
Evening shift	98.7	65	18	97 percent
3/3/21				
Day shift	98.2	64	16	96 percent
Evening shift	96.8	83	18	94 percent
3/4/21				
Day shift	97.5	76	16	96 percent
Evening shift	97.3	64	18	96 percent

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3/5/21
Day shift 97.6 68 16
96 percent
Evening shift 97.8 79 18
95 percent

3/6/21
Day shift 98 80 18
96 percent
Evening shift 97 81 20
92 percent

The only blood Pressure (BP) assessments recorded in the resident's record revealed:
a. On 2/16/21 at 3:40 p.m. 118 over 73.
b. On 2/17/21 at 4:42 a.m. 126 over 68.
c. On 2/17/21 at 1:13 p.m. 122 over 72.
d. On 2/17/21 at 9:56 p.m. 110 over 66.
e. On 2/18/21 at 12:30 a.m. 116 over 62.
f. On 2/18/21 at 12:43 p.m. 110 over 68.
g. On 2/18/21 at 4:58 p.m. 144 over 92.
h. On 2/19/21 at 12:05 p.m. 138 over 80.
i. On 3/6/21 at 8:27 p.m. 88 over 57.

A Nurse's Progress Note transcribed by Staff K, Agency Licensed Practical Nurse (LPN) at 8:20 p.m. on 2/27/20 stated around 5:00 p.m., resident in bed, screaming for help continuously, she went to the room, the resident stated he slipped and fell on the floor, laid there for an hour, crawled back into bed because staff refused to help him and he broke his leg. The resident resisted Staff K's attempts to assess his leg for injury and told her to call the police. When asked why she needed to call the police, the resident stated it was because she wouldn't help him. Staff K documented a police officer came to the facility, stated he received a call and he spoke to the

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F 684	Continued From page 12 resident. Staff K notified the director of nursing (DON) and the resident's power of attorney (POA) of the events, asked the POA to speak to the resident to gain the resident's cooperation in order for the nurse to assess the resident, and the resident then allowed Staff K to assess his leg and she found no signs of injury. The written transcript of a 911 call to the County Emergency Dispatch Center revealed a call received from the resident at 5:49 p.m. on 2/27/21, the caller stated he had a possible broken leg, he fell and needed help, stated they knew he fell but were not helping him. The Dispatch Center attempted to make contact with the facility by phone at 5:51 p.m. and 5:56 p.m., unable to make contact with facility and dispatched the Bellevue police to see if medical support was needed. The written transcript of a 911 call to the County Emergency Dispatch Center revealed a call received from the resident at 5:11 p.m. on 3/3/21, the resident was asked for help and no one helped him. The Dispatch Center called the facility twice between 5:11 p.m. and 5/14 p.m., "let the phone ring and ring and ring" without answer. Bellevue police were dispatched to the facility. The audible recordings of the resident's 911 calls on 2/27/21 at 5:49 p.m. and 3/3/21 at 5:11 p.m. revealed an obvious decline in the resident's condition on 3/3/21, with shortness of breath and weakness evident by the resident's voice, and the resident's great difficulty expressing himself and what he needed help with. Screenshots of the resident's posts to his social media account revealed the following:	F 684		

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a. On 3/4/21 at 12:13 p.m. - Can't eat...can't poop...can't throw up... help me please.
b. On 3/4/21 at 12:31 p.m. - Can't eat, poop or breath. Help me. A contact responded "do you need to go to the hospital at 12:31 p.m.
c. On 3/4/21 at 1:02 p.m. - Called 911 twice, no Emergency Room in Bellevue. Called private ambulance service twice, help please.
d. On 3/4/21 between 1:02 p.m. and 1:17 p.m., a contact responded "Is there a nurse there who can help you? I called the care center, did someone come check with you?"
3/4/21 at 1:19 p.m. -A contact posted "What have you got?, the resident responded Don't know. Trying to get to Dubuque. No Emergency Room here.

An order transcribed by Staff C, RN at 2:00 a.m. on 3/2/21 directed staff to administer Mylanta (an antacid medication) 200-200-20 mg per 5 ml, 20 ml administered oral 1 time daily as needed for indigestion until 3/5/21. There was no documentation at the time in the resident's record of an assessment of the resident or need for the order.

The Medication Administration Record (MAR) revealed Mylanta was administered to the resident:
a. On 3/2/21 at 1:12 p.m. by Staff K, agency LPN.
b. On 3/4/21 at 12:30 a.m. by Staff J, agency RN.
c. On 3/5/21 at 11:07 p.m. by Staff C, RN.

Nurse's Progress Notes transcribed at times related to the Mylanta administration revealed:
a. On 3/2/21 at 12:03 p.m., Staff K wrote "Resistant with care this shift, on the phone after breakfast yelling, screaming and cursing at whomever was on the phone. This nurse went

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into room to answer call light, resident asked how long does it take to answer a call light? This nurse reminded the resident we are in the middle of breakfast and certain people have to be assisted and staff are getting to call lights as quick as possible. Asked what he needed, resident wanted breakfast tray off bedside table and lights turned off. When nurse went into room to administer the tuberculosis skin test, explained what the test was and how it was done, the resident refused the test and asked where his COVID-19 vaccine was as it was scheduled for 3 days prior. Nurse explained they awaited a call from the clinic to schedule a date for the vaccine for him and the resident not satisfied with the answer." A notation on the MAR described the Mylanta was effective. There was no documentation of any assessment of the resident's overall physical condition at any time on 3/2/21.
b. On 3/4/21 at 12:50 a.m., Staff J, Agency RN, stated Mylanta administered for resident complaints of indigestion.
c. On 3/4/21 at 4:33 a.m., Staff J wrote "Resident got up during the night and stated "I think I am having a heart attack I need Mylanta" resident received Mylanta and sleep through the night no complain of pain". Staff J noted at 4:45 a.m. on 3/4/21 that Mylanta was effective.

There was no documentation of any assessment of the resident's overall physical condition, or further assessment of the resident's statement he thought he was having a heart attack at any time on 3/4/21, and the physician was not notified of the statement or repeated Mylanta administrations.

d. On Friday, 3/5/21 at 11:07 p.m., Staff C, RN

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noted Mylanta administered, followed by an entry at 11:16 p.m. "Resident continues to report heartburn. He has been given medication, per standing orders, for 3 days. Physician notified, per standing order, if discomfort is not resolved."
e. On Saturday 3/6/21 at 1:24 a.m., Staff C noted Mylanta was effective.

Staff C documented "resident continues to complain of heartburn. He has taken Mylanta per standing orders. It relieves at the time and heartburn returns" on a form dated 3/5/21 and used for physician notification via facsimile (fax). There was no documentation or acknowledgement on the form that it was received or reviewed by the physician.

There was no documentation of any assessment of the resident's overall physical condition at any time on 3/5/21 or early hours of 3/6/21.

Other pertinent Nurse's progress note documentation between 3/2/21 and 3/6/21 revealed:
a. At 5:30 p.m. on 3/3/21, by Staff K, Agency LPN, stated "Incontinent care provided by Certified Nursing Assistant (CNA), resident on phone not even 15 minutes later saying "the nurse will not help me, I've been soiled for 2 hours. She said she will not help me because she does not like me". Family called facility asking for care to be provided. Staff went into room to address resident needs, states he needs Tylenol; given by med nurse per request. Law enforcement at facility said someone called stating they needed assistance, 2 CNA's went into room, resident said he did not need care at that time but wanted to know how to get someone to help him. Encouraged to use call light if he

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F 684	Continued From page 16 needed something". There was no documentation of any assessment of the resident's overall physical condition at any time on 3/3/21, and the physician was not notified that police were dispatched to the facility on behalf of the resident. b. On 3/6/21 at 9:43 p.m., Staff K, Agency LPN recorded "At approximately 8:00 p.m., blood sugar 152 (within normal range), resident not talkative or as responsive as usual, asked other nurse to lay eyes on resident, Staff J, RN went to the resident's room, stated oxygen saturation level was low and resident needed oxygen. Oxygen concentrator and nasal cannula taken to room and applied at 2 liters per minute. At approximately 8:20 p.m. while RN obtained vital signs, the resident's blood pressure (BP) dropped, this nurse checked code status and called 911. As this nurse walked down hall towards room at approximately 8:30 p.m., RN yelled out the resident was unresponsive, this nurse took the crash cart to the room where RN provided chest compressions (cardiopulmonary resuscitation CPR), this nurse assisted with CPR until ambulance arrived." c. On 3/6/21 at 9:49 p.m., Staff J, agency RN, recorded "this nurse check on resident at 8:10 p.m., resident lying in bed with eyes open, BP 104 over 58 (normal low range), pulse 57 (normal 60 to 80), oxygen saturation 89 percent (normal 97 to 100 percent). Oxygen applied at 8:15 p.m., at 8:20 p.m. BP 88 over 57 (low), oxygen saturation 88 percent, oxygen increased to 6 liters per minute, at 8:30 p.m. resident unresponsive, CPR started".	F 684		

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F 684	Continued From page 17 d. On 3/6/21 at 10:45 p.m., Staff K noted the resident's POA notified the facility the resident passed away. The ambulance report dated 3/6/21 described personnel were dispatched at 8:37 p.m. with all 5 crew-members at facility at 8:46 p.m., CPR in progress by facility staff. Ambulance staff took over CPR, attached a monitor with defibrillator that revealed ventricular fibrillation, followed established protocols and continued CPR, transported the resident and arrived at hospital Emergency Room (ER) at 9:44 p.m. The Hospital ER record revealed the resident arrived by ambulance in full cardiac arrest with CPR in process on 3/6/21 at 9:45 p.m., the heart monitor showed asystole (no heart rhythm), assessed for viable signs of life, all were negative and the resident pronounced dead at 9:51 p.m. by the ER physician. The undated facility's Physician Notification Policy directed staff to notify the physician of a resident's change in condition that included: a. Significant change in resident condition which is life threatening. b. A significant change in resident condition which has potential for clinical complication. c. A change in condition which requires a significant alteration in treatment. d. Any change in condition which may be life-threatening should be called and not faxed to the physician immediately. Staff interviews revealed: a. On 3/24/21 at 10:02 a.m. Staff G, ADON, stated she saw the order to discontinue the Amiodarone on page 6 of the progress note, did	F 684		

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F 684	Continued From page 18 not see the other pages of the note, did not call the cardiologist office to verify the order, wrote the order to discontinue Amiodarone and sent it to the medical director for signature and did not send it to the cardiologist. b. On 3/23/21 at 11:15 a.m., the resident's cardiologist stated the resident had heart conditions that required the Amiodarone medication, seen at the office on 2/22/21, the resident was to continue the medication regimen that included Amiodarone and it should not have been discontinued, the facility had not contacted their office to question the orders or asked if the medication could have been discontinued. In another interview on 4/6/21 at 1:54 p.m., the cardiologist stated it was difficult to say with any certainty, but the Amiodarone discontinuation could have contributed to the resident's death. c. On 3/23/21 at 11:47 a.m., the Advanced Practice Nurse Practitioner (ARNP) at the resident's cardiologist office stated she assessed the resident at the 2/22/21 appointment, ordered his medication regimen continued that included Amiodarone, and the medication should not have been discontinued. d. On 3/24/21 at 1:06 p.m., Staff L, CNA, stated they were in a different resident's room on 3/3/21 when a coworker (Staff O, CNA) said the police had just been in the building because of calls about the resident, they went to the resident's room, the resident stated he trusted the 2 of them, stated the nurse on duty said she wouldn't help him because he had an attitude and described the nurse on duty (Staff K) who said it. The resident asked this employee "how do I fix my attitude? and the employee didn't know what to say. The employee stated they had the impression that it was said that day/had recently occurred, assured the resident they would help	F 684		

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him and encouraged him to use his call light if he needed anything. The employee stated the resident would yell at staff, but it really wasn't at them, it was a condition, such as if he wanted chocolate milk and received regular milk, he would yell about that.

e. On 3/24/21 at 2:21 p.m., Staff O, CNA, stated police came into the facility on 3/3/21, spoke to the nurse (Staff K) who said there was a resident that calls 911 in his room down that hall (directed the officer), the officer said he didn't need to see him and left the building. The employee stated it never came out as to why the resident called 911, thought there was probably staff that didn't like him due to how he acted, but this employee never had any problems with him and they got along well.

f. On 3/22/21 at 3:04 p.m., Staff N, CNA, stated the resident used his call light a lot and thought it was downplayed, other staff comments "he's on his light all the time and what he wanted wasn't that important". Employees were told that he called 911 because he didn't feel like he was getting the help he needed, but thought it depended on who the staff on duty was. There were staff on both day and evening shifts that didn't want to deal with the resident or go into his room, management was aware of that and heard the administrator was fired because of the resident. The employee stated the resident was always on his call light and that annoyed the nurse, Staff K.

g. On 3/22/21 at 1:38 p.m., Staff M, CNA, stated the resident would get agitated fast, would say he wasn't getting the help he needed and at some point he thought a CNA needed to stay in the room with him. The employee said they never felt unsafe around the resident, he just said mean things once in a while. On the day the resident

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passed, he acted nice, sweet, wasn't acting like there was anything unusual, the employee thought maybe he had some medication changes that caused it.

h. On 3/17/21 at 2:18 p.m., Staff B, RN, stated the resident could be explosive, he wanted to be left alone if he was on the phone. The employee thought the resident called 911 to get out of the facility, he claimed he fell and hurt his leg but there were no obvious injuries. If the resident said he thought he was going to die or complained of chest pain, that was definitely an immediate need for assessment of the resident and determination of needs, call the physician if there were concerns and send the resident to the hospital when needed.

i. On 3/18/21 at 11:24 a.m., Staff E, LPN, stated the resident would be nice 1 day, and not the next, he screamed so loud he was heard at the opposite end of the building, staff were scared that he would become physical, the employee thought the resident needed a psychiatric consult. Staff had notified the Director of Nursing (DON) with concerns about the resident's actions and the response was to take a 2nd staff member to the room when care was provided. The resident complained of leg pain with dressing changes, had not complained of chest pain or shortness of breath, he said his stomach hurt and refused to eat, the employee offered warm packs for his stomach but the resident wanted to be left alone.

j. On 3/22/21 at 1:03 p.m., Staff H, RN, stated 1 time when she cared for the resident he yelled at her and said she talked too loud, she apologized and the resident was okay with her then and she hadn't had any problems when she worked with him. If a resident complained of heartburn or indigestion, she would check their vital signs, skin, respiratory effort, assess for diaphoresis,

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F 684	Continued From page 21 nausea or vomiting, or any radiation of pain symptoms and would notify the physician. If it was 1:00 a.m. and Mylanta resolved the issue, she would fax the physician about the event, wouldn't give the medication without an assessment and would always notify the physician. k. On 3/16/21 at 7:55 p.m., Staff C, RN, stated the resident had complaints of indigestion and there was a standing order for staff to administer Mylanta. Staff C stated she had worked as a nurse on a psychiatric unit, she felt the resident probably had some psychiatric issues so she had the aides check on him every 15 minutes, just like staff did in psychiatric units, and they never had problems with the resident on the night shift, but knew staff on other shifts did. During another interview on 3/30/21 at 1:27 a.m., Staff C stated the resident complained of indigestion one night, she wrote the order for the Mylanta from the physician's standing orders and administered it (2:00 a.m. on 3/2/21), it seemed to help at the time, but he continued to have indigestion, the Mylanta would help but only for a while, they could only give the medication for 3 days, so she wrote a fax to the physician when the order expired to let him know that. l. On 3/17/21 at 9:06 a.m., Staff K, Agency LPN, stated the resident complained of heartburn, took Mylanta and it helped but she didn't have to administer it to him. The resident complained of leg pain, Tylenol worked to relieve it, he wasn't short of breath. The 1st time he called 911 he said he fell and broke his leg, a police officer came into the facility and spoke to him. A few days later he called 911 again, police came but didn't talk to him, the resident said he didn't know how to get help and she told him to use his call light. On 3/6/21, she had seen the resident 4	F 684		

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F 684	Continued From page 22 times before he arrested, at the beginning of the shift his vital signs weren't unusual, he took his medication but didn't eat supper, had no complaints of pain. She took his blood sugar around 8:00 p.m., within normal range, normally he was very verbal, but he wasn't responding like he normally did, had the other nurse on duty Staff J, RN, look at the resident, and that's when everything started to crash. CPR was initiated and she called for an ambulance. During another interview on 3/29/21 at 3:18 p.m., Staff K stated on 3/3/21 the resident had leg pain or a headache earlier in the shift, the other nurse gave him Tylenol for it, he didn't tell her he had pain, he wanted help but couldn't say what he wanted help with. He didn't have indigestion or stomach upset, she didn't have to call the physician about him and she never gave him Mylanta. On 3/22/21 at 4:01 p.m., when asked what type of assessment was completed when she administered Mylanta to the resident, Staff J, Agency RN, stated all residents were assessed every shift because of COVID. Staff J stated the resident asked for Mylanta and she administered it, he didn't complain of anything like nausea or chest pain. During another interview on 3/29/21 at 7:17 a.m., Staff J stated the resident asked for Mylanta and she gave it, she would have remembered if he had chest pain or other symptoms that concerned her. When asked about her documentation, "the resident said he felt like he was having a heart attack", Staff J stated she didn't remember writing that, and when asked about the assessment completed when the Mylanta was administered, she said all residents were assessed every shift and all	F 684		

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documented in Point Click Care (PCC, the facility's electronic medical record system).

On 3/24/21 at 4:10 p.m., the DON stated she'd had several conversations with the resident's POA about his 911 calls, she hadn't spoken with the resident about the calls or why he called 911, but read his chart, staff said in the notes he called 911 because he wanted to get cleaned up and know how to get help. Staff reported they had problems with him, the resident called a nurse "brain-dead", refused medications and treatments and ordered staff out of his room. Some staff felt nervous to go in his room alone so she told them to go in pairs. The administrator told her that someone called the facility and said to check on the resident, she and the administrator spoke with the POA about the resident's social media account and the POA said they would turn it off. The DON stated if a resident complained of indigestion, the nurse should assess the resident, document the assessment in PCC, in this resident's situation, staff should have called the physician and sent him to the hospital.

On 3/22/21 at 4:06 p.m., Staff AA, Bellevue police officer, stated 911 dispatch notified him on 2/27/21 that a resident at the care center had fallen and needed help, the call center had tried to call the facility but couldn't get an answer and asked that he go to the center to check on the matter. He was able to get into the facility, staff directed him to the resident's room where he was in bed, the resident said he didn't need anything, the officer spoke to the nursing staff about the call and they assured the officer they would take care of the resident.

On 3/23/21 at 2:59 p.m., Staff BB, Bellevue police

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officer, stated on 3/3/21, dispatch notified him that a resident at the care center called for help, dispatch tried to call the care center and couldn't get an answer on the phone and dispatched him to the facility to see what was going on. He got into the facility and at first didn't see any staff, but then saw a staff member who helped him locate the nurse. When he told the nurse a resident there had called 911, the nurse said she knew who it was, said the resident was down a hall and pointed in the direction, staff were headed to the room, the nurse said they would take care of the resident and didn't need further assist from him so he left.

During an interview with the resident's POA, she stated the resident had a cell phone, frequently called and told the POA he'd activated his call light and staff hadn't responded, at times they remained on the phone with the resident until someone responded and it was more than 15 minutes, sometimes the POA called the facility to ask staff to provide assistance, 1 time she called and Staff K, LPN, stated "his light hasn't been on that long", other times no one answered the phone with multiple calls placed. The POA reported the resident had problems with Staff K, they didn't get along very well. On 3/2/21, the resident kept calling the POA and family members, said he was dying, the POA called facility staff who assured them he was fine. The resident really struggled with the isolation he was in because of COVID, he wanted a shower so badly but couldn't have one until out of isolation, scheduled for 3/8/21. Between 3/3/21 and 3/5/21, the resident complained of pain in his stomach and it hurt to swallow, couldn't swallow his pills or it hurt to swallow them and couldn't eat because his stomach hurt so bad. The POA tried

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to encourage the resident, the last time they talked to him on 3/5/21 they told him to hang in there, just a few more days and he would be out of isolation and get the shower he wanted so badly and the resident said "I don't think I can make it that long".

The POA stated on the morning of 3/5/21, they received a phone call from the Administrator and Nursing Director, they were on speaker phone, the Administrator asked them to disable his social media account and said the resident's cell phone caused problems and they might have to come and get it from the resident.

On 4/13/21 at 3:34 p.m., the facility's Medical Director physician stated it was hard to say whether staff should have notified him about the resident's complaints of indigestion, it would have depended on if he had other symptoms and what their assessment indicated, but they should have assessed the resident, and he should have been notified if he'd had indigestion several days in a row, or without resolve from the Mylanta. The physician expressed his concern about the competence of the facility's current nursing staff that didn't assess the resident.

The incident detailed above resulted in determination of an Immediate Jeopardy (IJ) for the facility and notified of such on 4/1/21 at 2:00 p.m. The Facility Staff removed the Immediate Jeopardy situation on 4/2/21 through the following actions:
a. All Nursing Staff educated on 4/1-2/21 on comprehensive cardiac assessments, clarification of orders and notification to the physician of any acute changes in condition for a resident.
b. All Nursing Staff educated on 4/1-2/21 on

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F 684	Continued From page 26 signs/symptoms to look for when a resident has a cardiac history with recent acute issues and to look for signs/symptoms of possible complications. c. All Nursing Staff educated on 4/1-2/21 on double noting all Physician Orders by the Director of Nursing or designee and to be monitored in monthly Quality Assurance and Performance Improvement (QAPI) meetings. Based on the results of the corrective measures taken by the facility lowered the scope and severity of the deficiency from a J level to a D level.	F 684		
F 760 SS=D	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 record review and staff interviews, the facility failed to ensure that staff maintained a supply of narcotic medications, administered the medications as ordered, and ensure that 3 of 12 resident records reviewed remained free from complications related to medication errors that included severe pain (Resident's #1, #9 and #10). The facility reported a census of 30 residents. Findings include: 1. The 11/12/20 MDS Assessment Tool revealed Resident #9 with diagnoses that included congestive heart failure, anxiety non-Alzheimer's dementia and osteoarthritis, scored 8 out of 15 points possible on the Brief Interview for Mental	F 760		

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Status (BIMS) cognitive assessment that indicated moderate cognitive impairment, always able to make self understood and able to understood others. The resident identified to require extensive assistance of at least 1 staff for transfers to and from bed and chair, ambulation, bathing, toileting and personal hygiene, had frequent pain rated at 5 on a 0 to 10 pain scale, with 10 assigned to the worst pain, the pain limited her day to day activities, and the resident received both scheduled and as-needed analgesic medication for pain management.

A pain related to osteoarthritis problem initiated 9/5/14 on the Nursing Care Plan directed staff:
a. Administer medications as ordered. Monitor effectiveness and any adverse side effects.
b. Assess effects of pain on the resident.
c. Evaluate effectiveness of ain management interventions.
d. Monitor for any complaints of pain, location, duration, quantity, quality, alleviating factors, aggravating factors.
e. Monitor for any non-verbal signs of pain such as guarding, moaning, restlessness, grimacing, diaphoresis or withdrawal.

Physician orders directed Nursing Staff on the following:
a. Administer Fentanyl 50 microgram (mcg) per hour patch (a very strong narcotic analgesic) topically to skin and change every 72 hours, prescribed 8/25/17.
b. Verify Fentanyl patch placement every 8 hour shift (ensure the patches were in place and not removed), prescribed 5/18/19.
c. Administer Lortab 5-325 milligram (mg) tablet (a strong synthetic narcotic analgesic) oral 1 time daily, prescribed 4/18/19.

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d. Administer Lortab 5-325 mg tablet oral every 8 hours as needed for pain, prescribed 8/18/15.

The December, 2020 Medication Administration Record (MAR) revealed Staff A, Agency Licensed Practical Nurse (LPN) administered the Fentanyl patch on 12/19/20 at 8:00 p.m. Staff H, Registered Nurse (RN), documented the medication was not administered when scheduled on 12/22/20. Staff A documented she administered Fentanyl on 12/23/20 at 8:00 p.m., and Staff B, RN documented she admonished the medication on 12/26/20.

The MAR revealed staff documented they verified the patch placement on the resident every 8 hour shift as follows:

a. On 12/23/20-
Day Shift - Staff E, LPN
Evening Shift - Staff A, LPN
Night Shift - Staff D, LPN

b. On 12/24/20-
Day Shift - Staff E, LPN
Evening Shift - Staff A, LPN
Night Shift - Staff C, RN

c. On 12/25/20-
Day Shift - Staff F, RN
Evening Shift - Staff A, LPN
Night Shift - Staff C, RN

d. On 12/26/20-
Day Shift - Staff E, LPN
Evening Shift - Staff B, RN

Narcotic Inventory Control Sheets revealed Staff A documented she administered the last Fentanyl

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patch in stock on 12/19/20 at 8:00 p.m. The inventory control sheets revealed the facility received 5 Fentanyl 50 mcg/hr patches for the resident on 12/23/20 at 6:00 p.m., Staff A recorded she administered a patch on 12/23/20 at 8:00 p.m. and Staff B recorded she administered a Fentanyl patch on 12/26/20, the patch removed from the resident was dated 12/19/20 (the patch was on the resident for 7 days, and not changed on 12/23/20 as documented by Staff A).

A Medication Error Report form dated 12/28/20 described when staff changed the resident's Fentanyl patch on 12/26/20, the patch removed from the resident was dated 12/19/20 (the patch on the resident for 7 days and not changed on 12/23/20 as documented by Staff A).

A facility document that documented destruction of Fentanyl patches did not reveal any Fentanyl patch destruction occurred on 12/23/20.

Narcotic Inventory Control Sheets also revealed Staff A administered the resident's scheduled 1 time daily Lortab on 12/19/20 at 7:00 a.m., 2 tablets remained in narcotic storage, then administered an as-needed Lortab on 12/19/20 at 7:22 p.m., and 1 tablet remained. Staff E, LPN, recorded she administered the last pill from the resident's Lortab supply on 12/20/20 at 7:00 a.m. The Narcotic Inventory Control Sheets revealed the facility received 30 Lortab 5-325 mg tablets at 10:00 p.m. on 12/21/20, and Staff E, LPN, documented she gave the 1st dose from the new supply at 7:00 a.m. on 12/22/20 (the resident went 48 hours without the prescribed medication). The resident's Lortab narcotic inventory control sheets revealed the resident usually received 2 tablets per day and sometimes as many as 4.

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Staff utilized the 0 to 10 pain scale assessment with 10 assigned to the highest level of pain , and recorded the following pain assessments on the resident:
a. On 12/18/20 at 6:09 p.m. level 5.
b. On 12/19/20 at 7:22 p.m. level 5.
c. On 12/22/20 at 2:49 p.m. level 7.
d. On 12/23/20 at 4:58 p.m. level 5.
e. On 12/24/20 at 6:22 p.m. level 5.
f. On 12/25/20 at 7:02 p.m. level 5.
g. On 12/26/20 at 6:33 p.m. level 8.

The Lortab Narcotic Inventory Control Sheet revealed Staff B, RN administered an as-needed Lortab on 12/26/20 at 6:33 p.m.

Staff interviews revealed:

On 3/17/21 at 2:19 p.m., Staff B, RN stated around Christmas time when she changed the resident's Fentanyl patch, the date on the patch she removed was 3 days past when it was last changed, the resident was crying, had facial grimacing and was in obvious pain. The Assistant Director of Nursing (ADON) was on duty at the time and reported it to her, and she wrote up a med error report. A couple days later, when she changed Resident #1's Fentanyl patches, they were also 3 days past when they were last changed and she notified both the ADON and the DON. There was a place on the MAR where staff documented patch placement every shift and since the incident, they have changed the documentation required to track the Fentanyl patches better.

On 3/18/21 at 11:24 a.m., Staff E, LPN, stated staff were required to date and sign a Fentanyl

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F 760	Continued From page 31 patch when they applied it, the Fentanyl patch removed was destroyed in the presence of another nurse who both witnessed the destruction, staff had to verify a Fentanyl patch was on the resident every shift and document that on the MAR. Before the incident, staff didn't have to verify the date on the patch when checked, now they had to document placement with date on the patch, the patches destroyed with the DON or ADON, and the date on the destroyed patch is also recorded on the destruction documents. On 3/25/21 at 4:00 p.m., Staff A, Agency LPN, stated she got a call from the DON about Fentanyl patches that were 6 days old on 2 residents, thought she must have removed the new patches after she applied them and then destroyed the new patches with another nurse, and didn't remove the old patches as she should have done. Staff A reported that she always dated and signed the new Fentanyl patch after she applied it to the resident. On 3/16/21 at 12:17 p.m., the DON stated on 12/26/20, the ADON notified her when Staff B, RN changed the resident's Fentanyl patch, the patch removed was dated 12/19/20 and the DON directed her to put the patch removed in an envelope and secure it in the narcotic compartment of the medication cart. Then on 12/27/20, Staff B found both Fentanyl patches on Resident #1 dated 12/21/20, notified the ADON who notified the DON on 12/27/20. The DON notified the administrator of the Fentanyl discrepancies on 12/28/20 and initiated an investigation. Since the incident, they have implemented some changes, now all Fentanyl patches are changed on the day shift, the destruction witnessed by either the DON or	F 760		

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F 760	Continued From page 32 ADON, staff have to document the date on the patch when checked for placement every shift, and the date on the patch destroyed is recorded on the destruction documents. The DON stated nursing staff were supposed to notify pharmacy by fax when the narcotic supply was getting low. On 3/23/21 at 11:53 a.m., Staff Y, Registered Pharmacist (RPh) from the facility's Pharmacy stated the facility should call or fax requests for narcotic refills when they remove the last Fentanyl patch from their supply, or when they are down to a 2 day supply on other narcotics, and they have tried to work with the facility to make sure they take inventory of their narcotic supplies on Friday so the Pharmacy has time to contact physicians before the weekend if prescription authorizations were required. Resident #9 had 30 Lortab 5-325 tablets left on a prescription that could have been dispensed immediately, but staff didn't contact the pharmacy for a refill until 9:48 a.m. on 12/21/20 when they were out of the medication. In reference to the resident's Fentanyl supply that was exhausted on 12/19/20, the facility didn't notify the pharmacy they needed more Fentanyl until 8:25 a.m. on 12/23/20, and the pharmacy had to obtain physician authorization for a new prescription. The facility's Controlled Medication Administration policy dated 2/22/18 directed staff to reorder controlled narcotic medications when needed. 2. The 4/15/20 Minimum Data Set (MDS) Assessment Tool revealed Resident #1 with diagnoses that included Peripheral vascular disease, diabetes, non-Alzheimer's dementia and	F 760		

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F 760	Continued From page 33 osteoarthritis, severe cognitive impairment, moderate hearing impairment, and sometimes understood others, rarely or never able to make self understood. The resident identified to require extensive assistance of at least 1 staff to turn and reposition in bed, transfer to and from bed and chair, dressing, eating, bathing, toileting and personal hygiene, unable to ambulate, had daily indicators of pain that included non-verbal sounds, facial expressions and protective movements, and received analgesic medications on a scheduled and as-needed basis. A pain problem related to osteoarthritis initiated on the Nursing Care Plan 6/4/13 directed staff to : a. Administer medications as ordered. Monitor effectiveness and any adverse side effects. b. Assess effects of pain on the resident. c. Evaluate effectiveness of ain management interventions. d. Monitor for non-verbal signs of pain such as guarding, moaning, restlessness, grimacing, diaphoresis or withdrawal. Physician Orders directed the following: a. Administer Morphine Sulfate (a strong narcotic analgesic) 5 mg) administered oral 3 times a day at 7:00 a.m., 1:00 p.m. and 7:00 p.m., and 5 mg oral every 1 hour as needed for pain or discomfort, prescribed 6/12/20. b. Administer Fentanyl 100 mcg/hour patch, apply 2 patches (200 mcg/hr) topically to skin and change every 72 hours, prescribed 6/18/20. c. Verify Fentanyl patch placement every 8 hour shift, prescribed 5/18/19. The MAR revealed Staff A, Agency LPN, documented she changed and applied new Fentanyl patches at 8:00 p.m. on 12/21/20 and	F 760		

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12/24/20, and documented the patches removed from narcotic storage on the narcotic inventory control sheets on those dates and times.

The MAR revealed staff documented they verified the patch placement on the resident every 8 hour shift as follows:

a. On 12/24/20-
Day Shift - Staff E, LPN
Evening Shift - Staff A, LPN
Night Shift - Staff C, RN

b. On 12/25/20-
Day Shift - Staff F, RN
Evening Shift - Staff A, LPN
Night Shift - Staff C, RN

c. On 12/26/20-
Day Shift - Staff E, LPN
Evening Shift - Staff B, RN
Night Shift - Staff C, RN

d. On 12/27/20-
Day Shift - Staff E, LPN
Evening Shift - Staff B, RN

A pain assessment completed on a PAINAD Assessment Tool (Pain Assessment for Advanced Dementia) on 12/27/20 at 8:13 p.m. revealed Resident #1 scored 8 out of 10 possible points, with 10 the highest score for pain symptoms; the resident demonstrated non-verbal signs of pain by negative vocalizations, facial expression, body language, and inconsolability.

The MAR revealed Staff B, RN, documented she changed and applied new Fentanyl patches on 12/27/20 at 8:00 p.m., and the narcotic inventory

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control sheet documented she removed 2 Fentanyl patches from narcotic storage on 12/27/20 at 8:22 p.m. Staff B documented she administered 5 mg Morphine on 12/27/20 at 8:13 p.m., and the narcotic inventory control sheet documented she removed the Morphine from narcotic storage on 12/27/20 at 8:13 p.m.

A facility document that described destruction of Fentanyl patches revealed Staff A, LPN, documented 2 Fentanyl 100 mcg/hour patches were destroyed on 12/24/20, witnessed by Staff C, RN.

A Medication Error Report dated 12/28/20 revealed on 12/27/20, when staff changed the resident's Fentanyl patches, the patches removed from the resident were dated 12/21/20 (the patches on the resident for 6 days and not changed on 12/24/20 as documented by Staff A).

A Controlled Medication Disposal policy dated 2/22/18 directed staff that used Fentanyl patches were to be disposed of in the Drug Buster Drug Disposal container, in the presence of 2 licensed nurses, and the disposal documented on the accountability record by both nurses.

3. The 11/12/20 MDS Assessment revealed Resident #10 with diagnoses that included coronary artery disease, diabetes, non-Alzheimer's dementia and osteoarthritis, had moderate cognitive impairment with short and long term memory deficits, and able to make self understood and understood others. The resident identified to require extensive assistance of at least 1 staff to transfer to and from bed and chair, dressing, bathing, toileting and personal hygiene,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 36	F 760		

the resident unable to ambulate, received scheduled and as-needed analgesic medications for pain management and without symptoms of pain at the time of assessment.

A pain related to osteoarthritis problem initiated on the Nursing Care Plan on 6/11/15 directed staff:
a. Administer medications as ordered. Monitor effectiveness and any adverse side effects.
b. Assess effects of pain on the resident.
c. Evaluate effectiveness of ain management interventions.
d. Monitor for any complaints of pain, location, duration, quantity, quality, alleviating factors, aggravating factors.
e. Monitor for any non-verbal signs of pain such as guarding, moaning, restlessness, grimacing, diaphoresis or withdrawal.

Physician orders directed Nursing Staff:
a. Administer Fentanyl 12 mcg/hr patch topically, change every 72 hours, prescribed 6/24/20.
b. Tramadol (a strong non-narcotic analgesic) 50 mg administered oral daily at bedtime, prescribed 9/3/20. The order was discontinued on 11/19/20.
c. Tramadol 50 mg administered oral twice daily at 7:00 a.m. and 8:00 p.m., prescribed 11/19/20.
d. Morphine Sulfate 5 mg administered oral every 20 minutes as needed for pain or dyspnea, prescribed 8/14/20.

The November 2020 MAR revealed Staff A, agency LPN, documented she administered the Fentanyl patch at 8:00 p.m. on 11/19/20 and 11/22/20. Staff B, RN, documented the Fentanyl was not administered on 11/25/20 as scheduled.

The Fentanyl Inventory Control Sheets revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165374	A. BUILDING ______ B. WING ______	C 04/14/2021

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F 760	Continued From page 37 Staff A administered the last Fentanyl patch from the resident's supply on 11/22/20. Inventory Control Sheets revealed the facility received 2 Fentanyl 12 mcg/hr patches on 11/26/20 (Thanksgiving Day) at 6:00 a.m., and Staff B documented she administered the medication at 2:45 p.m. on 11/26/20 (nearly 24 hours after the previous application expired). Staff did not complete regular or routine pain assessments on the resident. Documented pain assessments revealed: a. On 10/27/20 at 7:32 a.m., 4 assessed with a PAINAD pain assessment tool. b. On 12/1/20 at 7:50 p.m., 5 assessed on the verbal 0 to 10 pain scale. Nurse's Progress Notes revealed the following entries: a. On 11/25/2020 9:22 p.m., transcribed by Staff B, RN - Pharmacy did not deliver Fentanyl patches this evening, unable to apply new patch. b. On 11/25/2020 9:40 p.m., transcribed by Staff B - Called Pharmacy on call pharmacist to inquire about the missing Fentanyl patches. c. On 11/25/2020 10:33 p.m., transcribed by Staff B - On call Pharmacist called to state they will need a new Fentanyl prescription order from the physician but will send out 2 Fentanyl patches tonight for the resident. They will contact the physician on Monday (11/29/20) to obtain a new order for Fentanyl. Resident is on Hospice so they will honor this request and bring the patches out tonight. Resident does not appear to be in pain and is resting with eyes closed.	F 760		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IA0836	A. BUILDING: ______ B. WING ______	C 04/14/2021

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L 191	58.10(3)b General policies 481-58.10(135C) General policies. 58.10(3) There shall be written personnel policies for each facility. Personnel policies shall include the following requirements: b. Employees shall have a physical examination at least every four years. This Statute is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that each employee had physical examinations at least every four years as required by law for 4 of 5 employee records reviewed. The facility reported a census of 30 residents. Findings include: Review of the Employee Personnel Files revealed the following: a. Staff G, Registered Nurse (RN) and ADON, hired 8/4/15, a required pre-employment physical completed 7/30/15, and no physical examination completed since that date. Staff G terminated employment on 4/2/21. b. Staff P, Certified Nursing Assistant (CNA), hired 1/15/07, pre-employment physical completed 1/23/07, a physical completed on 3/8/11, 6/10/16, and no physical examination completed since then. c. Staff Q, Cook, hired 8/13/09, pre-employment physical completed 1/27/10, a physical completed 5/16/16, and no physical examination completed since then.	L 191		

DEPARTMENT OF INSPECTIONS AND APPEALS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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L 191	Continued From page 1 d. Staff V, CNA, hired 8/31/12, pre-employment physical completed 8/30/12, a physical completed in 2016, and no physical examination completed since then. During an interview 4/6/21 at 1:50 p.m., Staff W, Corporate Consultant Manager, stated the facility followed required rules, did not have a policy for employee health examinations and the Employee Handbook directs employees to have a physical every 4 years. The facility Employee Handbook directed that every employee must satisfactorily complete a physical examination every four years to continue employment, and the results must be available within 30 days after the fourth anniversary of the previous physical examination.	L 191		

Mill Valley Care Center
Complaint Survey March 10-April 14, 2021
Provider # 165374

Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

F658
On 4/15/21, the facility met with the Medical Director regarding the stoppage of using his standing orders at Mill Valley Care Center. All physician orders will be obtained through either written or verbal orders from the provider. Physician orders will be double noted by 2 licensed nurses and reviewed by the DON or designee. New orders for medications with drug interactions will be identified through PointClickCare with new order entry. Medication interactions will be directed to the prescriber for any changes. Any issues with medication orders or drug interactions will be addressed and reviewed through the QAPI process.
Completion Date: 4/15/21

F760
On 4/4/21, a nurse's meeting was held to re-educate nursing staff on the process for maintaining the medication supply of controlled substances at the facility. All residents' controlled substances have been inventoried for supply. Medication supply levels will be monitored by the night shift nurse and reordered in advance of medications running out. Any discrepancies will be reviewed through the QAPI process.
Completion Date: 4/15/21

F684
On 4/2/21, re-education was provided to nurses regarding comprehensive cardiac assessment, clarification of orders, and notification of a physician regarding a resident's change of condition. The DON or designee will monitor for condition changes and the notification of the physician. The DON will review new physician orders to ensure they are complete. Any issues will be reviewed through the QAPI process.
Completion date: 4/15/21

Mill Valley Care Center
Complaint Survey March 10-April 14, 2021
Provider # 165374
State Plan of Correction

Preparation and/or execution of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because the provisions of federal and state law require it.

L 191 58.10(3)b
All employee files have been reviewed to identify staff overdue for their 4-year employment physicals. DON or designee will complete all overdue physicals. Going forward, the DON or designee will complete the 4-year physical during employees' annual review period. Any discrepancies will be reviewed through the QAPI process.
Completion date: 05/03/2021