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	175303	A. BUILDING _____ B. WING _____	06/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARSONS PRESBYTERIAN MANOR	3501 DIRR AVENUE PARSONS, KS 67357

(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 The following citations represent the findings of a Health Resurvey and Complaint Investigations #KS00157544 and #KS00155794. The 2567 was electronically sent to the facility on 06/29/21.	F 000		
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: The facility reported a census of 28 residents. The sample of 15 residents included one resident reviewed for pain management. Based on observation, interview, and record review the facility failed to provide adequate pain management for the Resident (R) 26, when staff failed to administer scheduled pain medication on four occasions due to the unavailability of the physician ordered medication when staff failed to reorder the medication from the pharmacy. The resident stated she had pain at a level "worse than a 10" (out of a scale of 0-10, with 10 being the worst) over the weekend due to the lack of scheduled pain medication. Findings included: - Review of R26's "Physician Orders," dated 06/01/21, revealed diagnoses which included	F 697		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), osteoarthritis (OA degenerative changes to one or many joints characterized by swelling and pain), and age related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).

The "Annual Minimum Data Set" (MDS), dated 11/28/20, documentation included a "Brief Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. She required extensive staff assistance with activities of daily living (ADLs). She received scheduled and as needed (PRN) pain medication and reported almost constant pain rated as 10/10 during the lookback period. She reported the pain made sleeping difficult. She received opioids for seven days of the look back period. She did not receive non-medication pain interventions.

The "Quarterly MDS," dated 05/29/21, documented the following changes, which included she did not receive prn pain medication, while she continued to receive scheduled pain medication. She reported almost constant pain rated at 10/10, which interfered with her day to day activities and sleep. She received opioids for seven days of the look back period.

The "Pain Care Area Assessment" (CAA) and "ADL Functional/Rehabilitation Potential CAA," dated 12/03/20, respectively documented during the resident's pain assessment she stated she had constant pain which interfered with her sleep and kept her awake. She rated her worse pain at a10 out of10. She reported she had pain at her

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toes, joints, and left shoulder. She received scheduled and prn pain medications including Tramadol 50 milligrams (mg) scheduled three times a day and Tylenol/Acetaminophen 325 mg PRN, which she received three days within a seven-day period. Additionally, she received a scheduled pain medication, Hydrocodone 5mg /Acetaminophen 325 mg at 02:00 AM, per her request. She stated the narcotic analgesic was effective when given in conjunction with the acetaminophen. Her diagnoses included OA, osteoporosis, anxiety, depression, edema (swelling) and pain. She required extensive assistance of staff for bed mobility, transfers, grooming, dressing, and toileting. She maintained mobility through the use of a wheelchair within her room. The resident had a self-care deficit due to decreased physical functioning, limited mobility, knee weakness/pain, limitation of range of motion (ROM) to her left shoulder, and chronic pain.

Review of the most recent "Pain Screen," dated 03/31/21 at 09:39 AM, documentation revealed the resident reported daily pain located at bilateral legs, hips, and her head. She reported her pain was relieved by Tramadol, Tylenol, and Hydrocodone.

The "Care Plan" (CP), dated 03/05/21, directed staff the resident experienced impaired memory recall with a BIMS of 12, which indicated moderate cognitive impairment. She was able to still make decisions about her care. The resident required extensive assistance of staff with her ADLs due to weakness, decreased physical functioning, impaired mobility, chronic arthritic joint pain at her knees, right shoulder, and

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chronic toe pain rated on a scale of 8 to10 out of10. The resident reported her tolerable pain level as a 6 out of10. She preferred not to be awakened during the night, because it was hard for her to get back to sleep. She requested staff only wake her through the night to give her 02:00 AM pain medication (hydrocodone 5/325). The resident reported 02:00 AM as the time she experienced the most pain. She used lamb's wool between her left first and second toes. She reported frequent to constant arthritic joint pain for which medication treatment included Tylenol, Tramadol, and Hydrocodone. She preferred to rest in the bed when experiencing pain and reported she had frequent to constant pain in her back, joints, toes, right shoulder, and left knee. The CP directed staff that she always experienced pain and staff should offer non-pharmacological interventions such as exercise, listening to audio books (Bible), and/or warm towels to the affected areas.

Review of the "Interdisciplinary Notes," (IDN) dated 06/15/21 at 11:09 AM, documented the resident returned from a doctor's appointment with new orders, which included anulcer (an open sore on an external or internal surface of the body, caused by a break in the skin that fails to heal) with tophaceous gout (a chronic form of gout whereby nodular masses of uric acid crystals are deposited in the soft tissues f the body), extruding (forced out) from a bunion (deformity of the joint) on the left foot. Staff were to administer daily dressings with Bactroban (antibiotic ointment) and gauze. Keep her in socks and prevent pressure from the bed as sheets or shoe on the foot. Follow-up appointment in one week.

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The "IDN," dated 06/17/21 at 06:46 PM, documented the resident continued to complain of pain related to the wound on the left side of her foot. The staff notified the physician of the pain and of a new rash going up the left leg. The leg was warm to touch and had two to three plus pitting edema.

The "Physician Orders," dated 06/01/21, documented the following medication orders for treatment of pain:

1. Tramadol 50 mg by mouth, three times a day with food, for pain, start date 09/17/19, scheduled for administration at 08:00 AM, 04:00 PM, and 08:00 PM.

2. Hydrocodone 5 mg/acetaminophen 325 mg, one tablet at hour of sleep for pain, start date 05/20/20, scheduled at 02:00 AM.

3. Hydrocodone 5 mg/acetaminophen 325 mg, one tablet every six hours as needed (PRN) for pain, start date11/26/19.

4. Tylenol 325 mg, give two tablets PRN for pain, start date 04/13/20.

The "Medication Administration Record" (MAR), dated 06/01/21 through 06/22/21, documentation revealed the following concerns:
1. Tramadol 50 mg, by mouth, three times a day scheduled for 08:00PM, was not administered on 6/19/21 and 6/20/21, due to not being available from the pharmacy.

2. Tramadol 50 mg, by mouth, three times a day

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scheduled for 04:00PM, was not administered on 06/20/21, due to not being available from the pharmacy.

3. Tramadol 50 mg, by mouth, three times a day scheduled for 08:00 AM, was not administered on 06/20/21, due to not being available from the pharmacy.

4. Tramadol 50 mg, by mouth, three times a day scheduled for 08:00 AM dose was not administered on 06/21/21 until11:00 AM, after staff contacted the pharmacy and made them aware of the unavailability of the resident's scheduled Tramadol medication since the last dose Saturday on 06/19/2021 at 04:10 PM.

Further review of the "MAR" from 06/01/21 through 06/22/21 revealed the resident received Hydrocodone 5 mg/acetaminophen 325 mg, on 06/19/21 at 07:57 PM and 06/21/21 at 10:10 AM. The resident did not receive her PRN Tylenol 325 mg from 06/19/21 through 06/21/2021.

The "Individual Narcotic Record," for Tramadol, revealed staff administered the last dose of scheduled Tramadol on 06/19/21 at 04:10 PM. The resident did not receive her scheduled Tramadol from the 06/19/21 08:00 PM dose, until the 06/21/21 10:10 AM dose, which resulted in 4 missed doses of her pain medication over a 36-hour period.

The IDN, dated 06/21/21 at 05:30 PM revealed a fax communication to the physician that documented the resident was currently out of Tramadol. The pharmacy was waiting on the physician approval for refill of the medication.

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Received a new order from the physician to continue current medication regimen until follow-up visit on 06/29/21. The pharmacy delivered the Tramadol medication to the facility at approximately11:00 AM on 06/21/21. The scheduled 08:00 AM dose of Tramadol was then given to the resident. The IDN lacked evidence staff monitored the resident's level of pain during this time period.

On 06/16/21 at 08:37 AM, the resident sat in the chair with a bandage to her left foot. The resident reported her foot hurt bad since her appointment with the foot doctor (06/15/21). She stated the doctor "dug" around in her foot to get the infection out and it still hurt badly. Additionally, she stated her right knee was crippled from walking to compensate for her other knee hurting, her back, and her shoulder hurt. The resident stated, "the only joints that don't hurt when I move are my neck and right hip." She stated she took medication for pain, but the Tylenol does not help. She reported she received some pain medication earlier. The resident stated she was supposed to receive scheduled pain medication at 08:00 AM, 04:00PM, and 08:00PM and she received hydrocodone at 02:00 AM. She explained she did not get her 08:00AM pain medication until 10:00 AM this day.

On 06/16/21 at 04:07 PM, Certified Nurse Aide (CNA) N stated the staff did not put a shoe on the resident's foot and used a foot cradle to keep the covers off of her left foot. She occasionally complained about pain. When she complained they reported to the Certified Medication Aide (CMA) or the nurse. CNA N stated she assumed

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the CMA or nurse went back to see if the pain medication was effective.

On 6/17/21 at 10:58 AM, Licensed Nurse (LN) F reported the resident had a skin condition related to sebaceous (relating to oil or fat) gout and had a bunion on her left foot for 30 years.

On 06/17/21 at 02:05 PM, LN E, removed the dressing on the resident's left foot and revealed an open wound at the junction of the left great toe to the foot. The resident refused measurements of the wound; however, the open area appeared approximately 2.0 centimeters (cm) in length by 2.0 cm width by 0.2 cm deep. Her left lower leg was edematous. The open area was red and edematous with white tissue present (slough). LN H reported the resident was diagnosed with some type of gout resulting in the wound.

On 06/21/21 at 09:02 AM the resident sat in her wheelchair with her bandaged foot on the floor. She tearfully reported, "the bunion on her left foot hurt terrible." She stated she told the staff she was in pain, but they had not brought her 08:00 AM pain medication yet. The resident stated she had a new diagnosis of gout and they had not given her anything for it.

On 06/21/21 at 09:15 AM, the resident made CMA S aware of her pain. CMA S informed the resident she would give her the scheduled (for 08:00 AM) Tramadol, pain medication.

On 06/21/21 at 09:31 AM, CMA S stated the resident received Tramadol 50 mg three times daily for pain as well as a Hydrocodone 5/325 mg

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at 02:15 AM. While preparing the medications in applesauce, CMA S noted the resident did not have any Tramadol. She checked the overflow and there was not any Tramadol in the overflow stock. She explained the emergency kit did not have pain medications available. CMA S checked the MAR and reported the resident had not received her scheduled Tramadol since her 04:00 PM dose on Saturday 06/19/21. She explained the resident had orders for Tylenol that could be given between her routine medication and she had an order for Hydrocodone PRN as well. CMA S stated she would check with the nurse to see what she wanted her to do. CMA S proceeded to administer the other scheduled medications to the resident stating "Here are your morning medications." She did not inform the resident that her medications did not include her scheduled Tramadol, nor did she ask the resident about her pain. CMA S documented Tramadol as not available.

On 06/21/21 at 09:57 AM, CMA S informed LN E the resident was out of Tramadol since Saturday. LN H instructed CMA S to call the pharmacy. CMA S informed LN E the resident complained of pain. LN H instructed CMA S to give the resident her PRN Hydrocodone. LN E did not go and assess the resident's pain level.

On 06/21/21 at 12:53 PM, LN I stated she just learned of the resident's bunion and associated open area today. She reported the resident was diagnosed with gout. Upon review of the resident's clinical record, LN I verified the wound at the left great toe and foot measurements dated 06/18/21 as 1.3 cm x 1.0 depth of 0.2 cm. The resident reported pain and received a scheduled

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and PRN pain medication, which included Tramadol three times a day, Hydrocodone 5/325 mg PRN (last dose 01:10 AM 06/21/21 and 06/19/21 at 7:57 PM), and Tylenol 325 mg, 2 tabs PRN (last administered on 06/17/21). LN I stated The resident did not receive her Tramadol on Saturday at 08:00PM, and on Sunday at 08:00AM, 04:00PM or 08:00 PM. LN I verified the documentation noted the resident requested Hydrocodone for painon 6/19/21 at 07:57AM.

On 06/21/21 at 04:53 PM, the resident stated "the new physician diagnosed me with gout, but I have not received any new medications for gout". On inquiry, she tearfully stated, "My pain last night and this morning was worse than a ten. It was the worst pain I have ever had. I have been in so much pain I am confused for the first time this morning. When I woke up, I did not know if it was day or night. I don't get my medicine like I am supposed to. I try not to complain to anyone. I am in here to be taken care of. I am 94 and I cannot take care of myself." She stated "my pain, right now is not more than a three since they gave me two medications for pain."

On 06/22/21 at 11:57 AM, Administrative Nurse D, stated she expected staff to document the reason for administering a PRN medication and to document the effectiveness within an hour of administration. She expected the CMAs to report to the charge nurse if the resident's medication was not available and to notify the on-call nurse if staff could not provide the medication. There was a pharmacist on call 24/7. Pain medications were not available in the emergency kit. She stated she would expect the pharmacy to deliver medications within the day of notification of the

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need. Administrative Nurse D reported she was not made aware of the concerns regarding the unavailability of pain medication for this resident prior to the survey. She stated the staff should complete a pain assessment/pain scale for a resident who received PRN pain medication, but not with scheduled pain medications.

On 06/23/21 at 12:02 PM, Consultant Physician HH, stated he had just taken over the care of the resident and he was not informed the resident did not receive her prescribed pain medications during the time frame as noted above. He stated the staff should notify him of the lack of medication administration and the need for a refill. Consultant HH verified he did not get a refill request or notification of unmanaged pain over the weekend of 06/19/21 through 06/21/21. Additionally, he stated he would expect staff to provide PRN medication as ordered to control pain and assess for effectiveness of the medication.

The facility policy for "Pain Management," dated 06/10/2019, documentation included each resident would be screened at regular intervals to determine whether symptoms of pain or discomfort were present and to clarify the cause(s), severity, and location of the pain. Residents experiencing pain would be monitored for effectiveness of treatment. Staff would review the "Matrix Care Pain Screen" quarterly, with any significant change or more often if necessary and consider the resident's tolerance for pain and resident's beliefs related to pain.

The facility failed to provide adequate pain management, as prescribed by the physician,

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F 697	Continued From page 11 when facility staff failed to ensure the availability of scheduled pain medication. The resident went for at least 36 hours without administration of her scheduled pain medication. The resident experienced severe pain, "worse than a 10," during this time.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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	F 755		

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§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:

The facility reported a census of 28 residents. The sample of 15 residents included six residents reviewed for unnecessary medications. Based on observations, interviews, and record review, the facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications as ordered by the physician for four of the six residents reviewed, Resident (R) 8, R26, R10, and R12.

Findings included:

- "Physician Orders," dated 05/04/21, for Resident (R)8, included a diagnosis of dementia.

The "Admission Minimum Data Set" (MDS), dated 07/18/20, assessed R8 with short and long term memory problems and severely impaired decision making. She required extensive assistance of two or more staff for toilet use, was frequently incontinent of bowel, and constipation was not present.

The "Quarterly MDS," dated 04/17/21, revealed no changes from the admission assessment except R8 was always continent of bowels.

The "Care Plan," dated 04/29/21, indicated that R20 received Lactulose (medication used to treat constipation), bisacodyl (medication used to treat constipation), and Miralax (medication used to treat constipation) to treat her constipation. The staff were to monitor for side effects such as

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nausea, vomiting, anorexia, abdominal cramps, diarrhea, flatulence, abdominal distention, and belching.

The "Physician Orders," dated 05/04/21, included the following orders:

1. On 07/10/20, Lactulose, 10 grams per 15 milliliters (mL), by mouth, administer 15mL, twice daily for constipation.

2. On 07/30/20, bisacodyl, five milligrams (mg), by mouth, every day, for constipation, for no bowel movement (BM) in three days.

3. On 12/28/20, Miralax, 17 grams, powder, by mouth, every three days, as needed for constipation.

The daily charting in the electronic medical record, for bowel functioning, for 04/10-04/14/21, revealed R8 lacked having a BM (five days). On 04/15/21, R8 had a medium hard BM on the evening shift. There were no further BM's documented until 04/18/21 which was an extra-large, hard BM. Furthermore, the record revealed that every BM R8 had on the day shift during the month of April (eight total) were documented as having a hard consistency. She had no BM's on the night shift, and her only BM on evening shift was the one that occurred on 04/18/21. R8 lacked a BM from 04/27-04/30/21 (five days).

The "Medication Administration Record" (MAR), dated 04/2021, revealed that the facility administered bisacodyl as needed on 04/13/21, the facility failed to follow-up on effectiveness. On

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04/14/21, the facility administered bisacodyl as needed for no BM for nine days. The facility failed to document effectiveness. The MAR, for 04/2021, lacked documentation that the staff administered the as needed Miralax for constipation every three days. The facility failed to provide medication as ordered when R8 did not have a BM for three days.

The daily charting, in the electronic medical record, for bowel functioning, for 05/13-05/18/21, revealed R8 lacked having a BM (six days). On 05/31-06/04/21, she lacked having a BM (five days) and again on 06/08-06/13/21 (six days).

The MAR, dated 05/2021, revealed that the facility failed to administer bisacodyl as needed for constipation for the month of May. The MAR, dated 06/2021, revealed that the failed to administer bisacodyl when R8 lacked having a BM from 05/21-06/04/21. The staff administered bisacodyl on 06/13/21, the sixth day that R8 went without having a BM. The facility failed to administer the bisacodyl when R8 went 3 days without having a BM.

On 06/21/21 at 01:16 PM, Certified Nurse Aide (CNA) M stated she was not aware of R8 having any constipation problems.

On 06/21/21 at 03:03 PM, Certified Medication Aide (CMA) R, stated that the nurse gives the day shift a bowel sheet that lists residents that have not had a BM for three days. The day shift will go thru and see if they have a laxative on their list of medications. Usually, bisacodyl was given first, if they did not have an order for that, then the doctor would be notified to get a

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standing order if they did not have one. CMA R reported that on her shift, she would ask the residents if they had a BM for the day and put the effectiveness of the medication in the MAR. At the end of the shift, CMA R would check for residents with no BM's again, and then pass that on to the night nurse. CMA R was not aware of R8 having any constipation problems, she took her Lactulose, and did not refuse it.

On 06/21/21 at 03:41 PM, Licensed Nurse (LN) G stated that the day shift passes on to her if someone is on the bowel list, which includes residents that have not had a BM in three days. The day shift informs of what they gave the resident and it is monitored to see if it was effective. If the resident has no effect from what was given for their constipation, then that would be passed on to the night shift. LN G was not aware of R8 having any constipation problems.

On 06/21/21 at 04:12 PM, Administrative Nurse D stated that there was a report that the staff printed from the electronic medical record system that listed residents without a medium or large BM for the past three days. The day shift nurse prints out the report and gives it to the day shift CMA, and after discussion, the CMA would administer any necessary interventions, depending on the resident, such as prune juice, a bisacodyl tab, or a bisacodyl suppository, depending on the resident's orders. The staff would document in the MAR when the medication was given. If after the third day without a BM and interventions were unsuccessful, a bowel assessment would be done and documented in the interdisciplinary notes, and if needed would discuss with the

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doctor the next intervention.

The facility policy, "Bowel Elimination," revised 05/2019, revealed if the resident has physician orders in regard to bowel elimination concerns, the licensed nurse will implement these orders. If there is no response to this treatment within the time frame identified, a follow up assessment would be completed prior to notifying the physician. The licensed nurse would complete documentation of all assessments or evaluations, treatments, response to treatment, and communication with the physician.

The facility failed to administer medication as ordered by the physician for the resident's constipation.

- Review of resident's (R)'26's "Physician Orders," dated 06/01/21, revealed diagnoses which included type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), osteoarthritis (OA, degenerative changes to one or many joints characterized by swelling and pain), and age related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).
The care plan (CP), dated 03/05/21, directed staff to give medications as ordered.

The "Physician Orders", dated 06/1/21, documented medications orders which included the following:

1. Spironolactone, 25 milligram (mg) tablet, by mouth, once daily, for peripheral edema, ordered

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10/20/15.

2. Tramadol 50 mg tablet, one tablet by mouth three times daily for pain, ordered 11/30/18.

The resident's "Medication Administration Records" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications were not administered as ordered. The MAR documentation revealed the medications were not available as follows:

1. Spironolactone, 25 milligram (mg) tablet, by mouth, once daily, for peripheral edema, on 05/07/21 and 06/01/21.

2. Tramadol 50 mg tablet, one tablet by mouth three times daily for pain, on 06/19/21 at 08:00 PM, 6/20/21 three doses, at 08:00 AM, 04:00PM, and 08:00 PM. On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported

On 06/21/21 at 12:33 AM, Licensed Nurse (LN) E stated. The CMAs who give medication to the resident should notify the nurse if medications are not available. The nurse should notify the pharmacy and/or the doctor to make sure the residents get the medication they need. The pharmacy delivers medications daily and for emergencies if needed.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated she expected the CMAs report to the charge nurse if the resident's medication is not available and to notify the on call nurse if cannot provide the medication There is a pharmacist on call 24/7 We have an emergency box. She expected the pharmacy to deliver

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medications the same day they are notified of the unavailability of medication. I would expect the turnaround in receiving medications to be the same day. She stated she was not made aware of the concern with medications not being administered due to not being available.

The facility policy for "Medication Administration," dated 04/27/21, documentation included If medications is ordered but not present staff should notify the charge nurse, check pharmacy delivery sheet for listing, notify pharmacy to request emergency dose, notify the physician, and retrieve the dose immediately
The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident.

The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident.

- Review of resident's (R)'10's "Physician Orders," dated 01/23/2021, revealed diagnoses which included Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) , syncope (dizziness) and collapse, hypertension (high blood pressure), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness and/or

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weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), gastroesophageal reflux disease , hypothyroidism (condition characterized by decreased activity of the thyroid gland).

The care plan (CP), dated 5/10/21, directed staff to give medications as ordered.

The "Physician Orders", dated 06/1/21, documented medications orders which included the following:
1. Levemir Flex Touch U-100 insulin 100unit/milliliters (ml), give 17 units, subcutaneous, at bedtime, for DM, ordered 10/07/2020.

2. Levothyroxine, 50 micrograms (mcg) tablet, by mouth, daily, for hypothyroidism. Ordered 01/17/20.

3. Carbidopa 25 milligram (mg.) tablet, by mouth, four times a day, for Parkinson's disease, ordered 01/17/20.

4. Pantoprazole 40 mg. tablet, delayed release tablet, daily, by mouth, for gastroesophageal reflux, ordered 01/17/20.

5. Memantine 10 mg, twice daily, by mouth for Alzheimer's disease, ordered 01/17/21.

6. Folic Acid, 1 mg, by mouth, daily, for vitamin replacement, ordered 01/17/20.

7. Vitamin D3, 5000unit tablet, daily, by mouth for vitamin replacement, ordered 01/17/20.

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The resident's "Medication Administration Records" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications were not administered as ordered. The MAR documentation revealed the medications were not available as follows:

1. Levemir Flex Touch U-100 insulin 100unit/ml give 17 units subcutaneous at bedtime for diabetes mellitus , on 04/04/21.

2. Levothyroxine 50 mcg tablet by mouth daily for hypothyroidism on 05/11/21.

3. Carbidopa 25 mg tablet by mouth four times a day for Parkinson's disease, on 5/8/21, and 05/24/21 at the noon dose (2 doses).

4. Pantoprazole 40 mg. tablet delayed release daily for gastroesophageal reflux, on 06/2/21 through 06/07/21 (six doses).

5. Memantine 10 mg. twice daily for Alzheimer's disease, on 06/02/21 through 06/08/21 (seven doses).

6. Folic Acid 1 mg. by mouth daily for vitamin replacement, on 06/2/21 through 06/07/21 (six doses).

7. Vitamin D3 5,000unit tablet daily for vitamin replacement, not available 06/14/21.

On 06/17/21 at 04:02 PM, the resident sat in her recliner reading the paper and having an appropriate conversation with her daughter. The resident was alert and oriented. She had some tremors of her hands and arm, consistent with

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Parkinson's disease. She stated she went through an adjustment period when she first admitted to the facility.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T reported CMAs should let the nurse know if medications are not available and the nurse will follow-up. If meds are not administered the CMA should document the reason on the MAR.

On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported the resident occasionally reported anxiety and pain. She shakes because of her Parkinson's, and she gets scared. The staff sit with her and she calms down. She will tell me to tell the med aide she is ready for her pills. She will turn her light on and tell you she needs the nurse the nurse will assess and may give her medication

On 06/21/21 at 12:33 AM, Licensed Nurse (LN) E stated the resident takes a lot of medications due to multiple comorbidities. The CMAs who give medication to the resident should notify the nurse if medications are not available. The nurse should notify the pharmacy and/or the doctor to make sure the residents get the medication they need. The pharmacy delivers medications daily and for emergencies if needed.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated she CMAs are to report to the charge nurse if the resident's medication is not available and to notify the on call nurse if cannot provide the medication There is a pharmacist on call 24/7 We have an emergency box. She expected the pharmacy to deliver medications

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the same day they are notified of the unavailability of medication. I would expect the turnaround in receiving medications to be the same day. She stated she was not made aware of the concern with medications not being administered due to not being available.

The facility policy for "Medication Administration," dated 04/27/21, documentation included If medications is ordered but not present staff should notify the charge nurse, check pharmacy delivery sheetfor listing, notify pharmacy to request emergency dose, notify the physician, and retrieve the dose immediately
The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident.

The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident.

- Review of Resident (R)12's "Physician Orders," dated 06/01/21, documentation revealed diagnoses which included anemia (low blood iron content, hypertension (high blood pressure), and, pain,

The care plan (CP), dated 05/14/21, directed staff to administer medications as ordered.

The resident's "Physician Orders," dated 06/01/21 Revealed the following orders:
1. Hydrocodone 5 mg-acetaminophen 325 milligrams (mg.), one tablet, by mouth, twice

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daily, before a meal and at bedtime, for pain, ordered 03/14/19.

2. Ferrous Sulfate 325 mg, one table, by mouth, daily for anemia, ordered 03/14/19.

3. Diltiazem capsule, 240 mg. delayed release (CD), one capsule, by mouth, daily, for hypertension, ordered 03/14/19.

The resident's "Medication Administration Records" (MAR), dated 05/01/2021 through 06/21/21, documentation revealed the following medications were not administered as ordered. The MAR documentation revealed the medications were not available as follows:

1. Hydrocodone 5 mg-acetaminophen 325 milligrams (mg), one tablet, by mouth, twice daily, before a meal and at bedtime, for pain, on 05/05/21, 05/06/21, and 05/07/21. (four doses)

2. Ferrous Sulfate 325 mg, one tablet, by mouth, daily for anemia, on 05/30/21 and 06/05/21.

3. Diltiazem capsule, 240 mg. delayed release (CD), one capsule, by mouth, daily, for hypertension, 05/20/21, 06/10/21, 6/12/21, and 06/13/21. (4 doses)

On 06/16/21 at 11:09 AM, the resident sat in the chair watching television. On inquiry she stated She was not aware of any problems with her medications or not receiving her medications. The staff give me my medication And she relyed on staff for medication accuracy.

On 06/21/21 at 09:04 AM, Certified medication

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Aide S, administered the resident's morning medications which included Hydrocodone 5 mg. 1 tablet, Ferrous Sulfate 325 mg. 1 tablet, and Diltiazem 240 mg. The resident took the medications without questions.

On 06/17/21 at 09:04 AM, Certified Medication Aide (CMA) S verified the medications were administered in accordance with the physician orders. She reported the CMA should let the nurse know if medications are not available and the nurse will follow-up. If meds are not administered the CMA should document the reason on the MAR.

On 06/21/21 at 12:33 AM, Licensed Nurse (LN) E stated the CMAs give medication to the resident. The CMA should notify the nurse if medications are not available. The nurse should notify the pharmacy and/or the doctor to make sure the residents get the medication as ordered. The pharmacy delivers meds daily and for emergencies if needed.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated she expected CMAs to report to the charge nurse if the resident's medication was not available and to notify the on call nurse if staff cannot provide the medication There is a pharmacist on call 24/7 and the facility has an emergency box. She expected the pharmacy to deliver medications the same day they are notified of the unavailability of medication. She would expect the turnaround in receiving medications to be the same day. She stated she was not made aware of the concern with medications not being administered due to not being available.

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F 755	Continued From page 25 The facility policy for "Medication Administration," dated 04/27/21, documentation included If medications is ordered but not present staff should notify the charge nurse, check pharmacy delivery sheetfor listing, notify pharmacy to request emergency dose, notify the physician, and retrieve the dose immediately The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident. The facility failed to ensure the accurate acquiring, receiving, dispensing, and administering of multiple medications over several days for the resident.	F 755		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		

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separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 28 residents with 15 residents included in the sample, including six residents reviewed for unnecessary medications. Based on record review and interviews, the facility failed to ensure the consultant pharmacist identified irregularities during completion of the monthly drug regimen reviews including unavailability of medications for administration and lack of monitoring the effectiveness after administration of as needed medications for four of the six residents reviewed, Resident (R) 10, R12, R26, and R20.

Findings included:

- Review of resident (R) 10's "Physician Orders,"

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dated 01/23/2021, revealed diagnoses which included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) , syncope (dizziness) and collapse, hypertension (high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness and/or weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), gastroesophageal reflux disease , hypothyroidism (condition characterized by decreased activity of the thyroid gland),

The care plan (CP), dated 5/10/21, directed staff to administer medications as ordered and monitor for medication effectiveness and side effects.

The "Physician Orders", dated 06/1/21, documented medications orders which included the following:

1. Levemir Flex Touch U-100 insulin 100unit/milliliters (ml), give 17 units, subcutaneous, at bedtime, for diabetes mellitus (DM), ordered 10/07/2020.

2. Levothyroxine, 50 micrograms (mcg) tablet, by mouth, daily, for hypothyroidism. Ordered 01/17/20.

3. Carbidopa 25 milligram (mg.) tablet, by mouth, four times a day, for Parkinson's disease,

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ordered 01/17/20.

4. Pantoprazole 40 mg. tablet, delayed release tablet, daily, by mouth, for gastroesophageal reflux, ordered 01/17/20.

5. Memantine 10 mg. twice daily, by mouth for Alzheimer's disease, ordered 01/17/21.

6. Folic Acid, 1 mg. by mouth, daily, for vitamin replacement, ordered 01/17/20.

7. Vitamin D3, 5000 units tablet, daily, by mouth for vitamin replacement, ordered 01/17/20.

8. Tylenol Extra Strength 50milligrms (mg.) tablet, give one tablet by mouth every four hours as needed for pain, ordered 04/08/20.

9. Bisacodyl 5 mg tablet delayed release one tablet by mouth every three days as needed for constipation, ordered 04/08/20.

10. Tylenol 325 mg tablets give two tablets by mouth every six hours as needed for pain, ordered 01/26/20.

11. Tramadol 50 mg tablet give ½ tablet by mouth every 12 hours as needed for pain, ordered 03/31/21.

The resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed staff failed to administer the following medications as ordered. The MAR documentation revealed the medications were not available as follows:

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1. Levemir Flex Touch U-100 insulin 100unit/ml give 17 units subcutaneous at bedtime for diabetes mellitu, on 04/04/21.

2. Levothyroxine 50 mcg tablet by mouth daily for hypothyroidism on 05/11/21.

3. Carbidopa 25 mg tablet by mouth four times a day for Parkinson's disease, on 5/8/21, and 05/24/21 at the noon dose (2 doses).

4. Pantoprazole 40 mg. tablet delayed release daily for gastroesophageal reflux, on 06/2/21 through 06/07/21 (six doses).

5. Memantine 10 mg. twice daily for Alzheimer's disease, on 06/02/21 through 06/08/21 (seven doses).

6. Folic Acid 1 mg. by mouth daily for vitamin replacement, on 06/2/21 through 06/07/21 (six doses).

7. Vitamin D3 5,000unit tablet daily for vitamin replacement, not available 06/14/21.

Additionally, the resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications lacked follow-up for effectiveness following administration of the as needed medications:
1. Tylenol Extra Strength 50milligrms (mg) tablet, give one tablet by mouth every four hours as needed for pain, 04/21/21, 04/24/21, and 05/24/21.

2. Bisacodyl 5 mg tablet delayed release one

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tablet by mouth every three days as needed for constipation, 4/21/21.

3. Tylenol 325 mg tablets give two tablets by mouth every six hours as needed for pain, on 04/10/21 for two doses, 04/21/21, 04/29/21, 05/21/21, 05/23/1, 05/28/21, 05/30/21, 06/4/21, and 06/14/21,

4. Tramadol 50 mg tablet give ½ tablet by mouth every 12 hours as needed for pain, 4/01/21, 04/3/21, 04/26/21, 05/06/21, 05/16/21 for three doses,0 5/17/21, 06/03/21, 06/09/21, and 06/11/21.

Review of the pharmacist's monthly medication regiment reviews for the time frame of 04/1/21 through 06/21/21, revealed the pharmacist failed to identify and/or address the facility's failure to administer medications, due to the unavailability of medications, and the facility's failure to monitor medications for their side effects and/or effectiveness of multiple medications.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T reported the resident took a lot of medications throughout the day. CMA T reported the CMA should notify the nurse if medications were not available for administration and should document the medication as unavailable on the MAR. When the Staff administered PRN medications the effectiveness and/or side effects should be checked and documented within the hour of administration. The CMA should let the nurse know if the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of medications and document on the MAR.

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On 06/21/21 at 12:33 PM, Licensed Nurse (LN) E stated CMAs should notify the nurse if prescribed medications were not available. the CMA should notify the nurse of the need for PRN medications and the nurse and/or CMA should assess the resident for the effectiveness of the medication within an hour of administration

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated CMAs are to report to the charge nurse if the resident's medication are not available and to notify the on call nurse if the CMA cannot provide the medication There is a pharmacist on call 24/7. We have an emergency box. She expected the pharmacy to deliver medications the same day they are notified of the unavailability of medication. She would expect the turnaround in receiving medications to be the same day. She stated she was not made aware of the concern with medications not being administered due to not being available.

Attempts to reach pharmacy consultant staff GG by e-mail on 06/21/21 and 06/22/21 and by phone on 06/22/21, resulted in the pharmacist not available for interview.

The facility policy "Drug Regimen Review," revised 06/10/19, indicated that a drug regimen review is completed monthly by a licensed pharmacist. The consultant pharmacist will conduct DRR's to identify irregularities and to identify clinically significant risks and/or actual potential adverse consequences which may result from or be associated with medications. Any irregularities, significant risks or actual/potential adverse consequences should be

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identified in the report.

The pharmacist's monthly drug regimen reviews for R 10 failed to identify irregularities in the resident's monthly regimen reviews which included the lack of available medications which resulted in multiple prescribed medications not administered and the lack of monitoring of effectiveness of PRN medications for the resident.

- Review of Resident (R)12's "Physician Orders," dated 06/01/21, documentation revealed diagnoses which included anemia (low blood iron content, hypertension (high blood pressure), and, pain.

The care plan (CP), dated 05/14/21, directed staff to administer medications as ordered and monitor for effectiveness and side effects of medications.

The "Physician Orders," dated 06/1/21, documented medications orders which included the following:
1. Hydrocodone 5 mg-acetaminophen 325 milligrams (mg.), one tablet, by mouth, twice daily, before a meal and at bedtime, for pain, ordered 03/14/19.

2. Ferrous Sulfate 325 mg, one table, by mouth, daily for anemia, ordered 03/14/19.

3. Diltiazem capsule, 240 mg. delayed release (CD), one capsule, by mouth, daily, for hypertension, ordered 03/14/19.

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4. Loratadine 10 mg. one tablet by mouth once daily as needed (prn) for seasonal allergies, ordered 03/14/19.

5. Bisacodyl 5 mg tablet, delayed release, by mouth, once daily prn, for constipation, ordered 03/14/19.

6. MiraLAX 17 grams/dose of oral powder, by mouth, once daily, prn

7. Tylenol Extra Strength 500 mg tablet, one tablet by mouth every eight hours, prn for pain, ordered 04/15/21.

The resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed staff failed to administer the following medications as ordered. The MAR documentation revealed the medications were not available as follows:

1. Hydrocodone 5 mg-acetaminophen 325 milligrams (mg), one tablet, by mouth, twice daily, before a meal and at bedtime, for pain, on 05/05/21, 05/06/21, and 05/07/21. (four doses).

2. Ferrous Sulfate 325 mg, one tablet, by mouth, daily for anemia, on 05/30/21 and 06/05/21.

3. Diltiazem capsule, 240 mg. delayed release (CD), one capsule, by mouth, daily, for hypertension, 05/20/21, 06/10/21, 6/12/21, and 06/13/21. (4 doses).

Additionally, the resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the

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following medications lacked follow-up for effectiveness of the administered as needed medication:

1. Loratadine 10 milligrams (mg) tablet by mouth once daily as needed (prn) for seasonal allergies, on 05/03/21 for two doses.

2. Bisacodyl 5 mg tablet, delayed release, by mouth, daily, for constipation on 04/16/21.

3. MiraLAX 17 grams/dose of oral powder, by mouth, once daily, prn on 04/22/21, and 06/15/21.

Review of the pharmacist's monthly medication regiment reviews for the time frame of 04/1/21 through 06/21/21, revealed the pharmacist failed to identify and/or address the facility's failure to administer medications, due to the unavailability of medications, or the facility's failure to monitor medications for their side effects and/or effectiveness of multiple medications.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T reported the resident took a lot of medications throughout the day. CMA T reported the CMA should notify the nurse if medications were not available for administration and should document the medication as unavailable on the MAR. When the Staff administered PRN medications the effectiveness and/or side effects should be checked and documented within the hour of administration. The CMA should let the nurse know of the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of

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medications and document on the MAR.

On 06/21/21 at 12:33 PM, Licensed Nurse (LN) E stated the CMA should notify the nurse if prescribed medications were not available. The CMA should notify the nurse of the need for PRN medications and the nurse and/or CMA should assess the resident for the effectiveness of the medication within an hour of administration.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated CMAs are to report to the charge nurse if the resident's medication is not available and to notify the on call nurse if cannot provide the medication There is a pharmacist on call 24/7 We have an emergency box. She expected the pharmacy to deliver medications the same day they are notified of the unavailability of medication. She would expect the turnaround in receiving medications to be the same day. She stated she was not made aware of the concern with medications not being administered due to not being available.

Attempts to reach pharmacy consultant staff GG by e-mail on 06/21/21 and 06/22/21 and by phone on 06/22/21, resulted in the pharmacist not available for interview.

The facility policy "Drug Regimen Review," revised 06/10/19, indicated that a drug regimen review is completed monthly by a licensed pharmacist. The consultant pharmacist will conduct DRR's to identify irregularities and to identify clinically significant risks and/or actual potential adverse consequences which may result from or be associated with medications. Any irregularities, significant risks or

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actual/potential adverse consequences should be identified in the report.

The pharmacist's monthly drug regimen reviews for R 12 failed to identify irregularities in the resident's monthly regimen reviews which included the lack of available medications which resulted in multiple prescribed medications not administered and the lack of monitoring of effectiveness of PRN medications for the resident.

- Review of Resident (R) 26's "Physician Orders," dated 06/01/21, revealed diagnoses which included type 2 diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), osteoarthritis (OA, degenerative changes to one or many joints characterized by swelling and pain), and age related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).

The care plan (CP), dated 03/05/21, directed staff to administer medications as ordered, monitor for medication effectiveness and side effects. The pharmacist was to review the resident's medications for irregularities, report irregularities, and make recommendations and the facility was to follow-up on the monthly medication regimen review and recommendations made by the pharmacist.

The "Physician Orders," dated 06/01/21, documented medications orders which included the following:
1. Spironolactone, 25 milligram (mg) tablet, by

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mouth, once daily, for peripheral edema, ordered 10/20/15.

2. Tramadol 50 mg tablet, one tablet by mouth three times daily for pain, ordered 11/30/18.

3. Hydrocodone 5 mg-acetaminophen 325 mg, give one tab, by mouth, every six hours, as needed for breakthrough pain, ordered 05/28/21.

The resident's "Medication Administration Records" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications were not administered as ordered. The MAR documentation revealed the medications were not available as follows:

1. Spironolactone, 25 milligram (mg) tablet, by mouth, once daily, for peripheral edema, on 05/07/21 and 06/01/21.

2. Tramadol 50 mg tablet, one tablet by mouth three times daily for pain, on 06/19/21 at 08:00 PM, 6/20/21 three doses, at 08:00 AM, 04:00PM, and 08:00 PM. On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported

Additionally, the resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications lacked follow-up for effectiveness of the administered as needed medication:

1. Tramadol 50 mg tablet, one tablet by mouth three times daily for pain, on 06/19 for two doses, 06/20/21 for three doses,

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2. Hydrocodone 5 mg with acetaminophen 325 mg give one tab by mouth every six hours as needed for breakthrough pain, on 4/16/21 for 2 doses, and on 06/22/21.

Review of the pharmacist's monthly medication regiment reviews for the time frame of 04/1/21 through 06/21/21, revealed the pharmacist failed to identify and/or address the facility's failure to administer medications, due to the unavailability of medications, nor the facility's failure to monitor medications for their side effects and/or effectiveness of multiple medications.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T stated the CMA should notify the nurse if medications were not available for administration and should document the medication as unavailable on the MAR. When the Staff administered PRN medications the effectiveness and/or side effects should be checked and documented within the hour of administration. The CMA should let the nurse know of the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of medications and document on the MAR.

On 06/21/21 at 12:33 AM, Licensed Nurse (LN) E stated the CMA who give medications to the resident should notify the nurse if medications are not available. The nurse should notify the pharmacy and/or the doctor to make sure the residents get the medication they need. The pharmacy delivers medications daily and for emergencies if needed. She stated the CMA should notify the nurse of the need for PRN medications and the nurse and/or CMA should

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assess the resident for the effectiveness of the medication within an hour of administration

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated she CMAs should report to the charge nurse if the resident's medication is not available. The facility has an emergency box with some stock medications. The nurse should notify the on-call nurse if she cannot provide the medication. There is a pharmacist on call 24/7. She expected the pharmacy to deliver medications the same day they are notified of the unavailability of medication. She stated she was not made aware of the concern with medications not being administered due to not being available nor was she made aware of the lack of monitoring and documentation of effectiveness of medications by the pharmacist.

Attempted to reach pharmacy consultant staff GG by e-mail on 06/21/21 and 06/22/21 and by phone on 06/22/21, resulted in the pharmacist not available for interview.

The facility policy "Drug Regimen Review," revised 06/10/19, indicated that a drug regimen review is completed monthly by a licensed pharmacist. The consultant pharmacist will conduct DRR's to identify irregularities and to identify clinically significant risks and/or actual potential adverse consequences which may result from or be associated with medications. Any irregularities, significant risks or actual/potential adverse consequences should be identified in the report.

The pharmacist's monthly drug regimen reviews for R 26 failed to identify irregularities in the

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resident's monthly regimen reviews which included the lack of available medications which resulted in multiple prescribed medications not administered and the lack of monitoring of effectiveness of PRN medications for the resident.

- The "Physician Orders," dated 05/04/21, for Resident (R)20, included diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) disorder.

The "Care Plan," dated 05/18/21, revealed that R20 took multiple medications and was at risk for side effects including Ativan (antianxiety medication), and when combined with the antidepressant medication she takes it placed her at risk for falls. The antianxiety medication had a black box warning (a medication that can have serious side effects such as injury or death).

A physician order, dated 08/16/20, included Ativan, 0.5 milligrams (mg), by mouth, twice daily, for anxiety and Ativan, 0.5 mg, by mouth every day, as needed for anxiety. The as needed order for Ativan lacked a stop date.

The pharmacy reviewed R20's medication regimen on these dates and had no recommendations: 09/15/20, 10/09/20, 11/17/20, 12/11/20, 01/15/21, 03/11/21, 04/09/21, 05/14/21, and 06/11/21. On 02/11/21, the pharmacist recommended to consider if a gradual dose

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reduction was appropriate for Ativan, Celexa (antidepressant medication), and Seroquel (antipsychotic medication). The note failed to address the lack of a stop date for the Ativan ordered as needed.

The "Interdisciplinary Note," dated 02/26/21, revealed a facility nurse assisted R20 with a telehealth appointment, discussed pending pharmacy recommendations, and received orders to discontinue the Seroquel and continue with the Ativan and Celexa as R20 remained stable with no adverse reaction.

The "Medication Administration Record" (MAR), dated 05/2021 and 06/2021, revealed R20 received an as needed dose of Ativan on these dates:

1. On 05/02/21, for restlessness and documented the medication was ineffective.

2. On 05/03/21, documentation lacked reason for giving and if effective.

3. On 05/27/21, documentation indicated the medication was given per the nurse and lacked reason administered and the effectiveness of the medication.

4. On 05/30/21, documentation lacked reason for giving and if effective.

5. On 06/12/21, documentation lacked reason for giving and if effective.

The pharmacist failed to identify the lack of monitoring for the effectiveness of the as needed

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administration of Ativan to R20.

On 06/21/21 at 08:39 AM, R20 stood from a chair in the room where others were dining for breakfast, staff offered to get her coffee, R20 then sat back down.

On 06/21/21 at 01:03 PM, Certified Nurse Aide (CNA) M stated that she gets anxious and staff approach her later if she was resisting cares. The staff offer snacks, she liked sweets, and coffee, and that was effective when she had anxiety.

On 06/21/21 at 03:03 PM, Certified Medication Aide (CMA) R stated that when administering an as needed antianxiety medication, the staff are to document the reason why it was given and document later the effectiveness.

On 06/21/21 at 03:41 PM, Licensed Nurse (LN) R stated that she did not know if as needed antianxiety medications required a stop date, she does not have a role in regards to the pharmacy reviews, the CMA's document on effectiveness of as needed medications, and the CMA's would pass on to the nurse if an as needed medication was ineffective.

On 06/21/21 at 04:22 PM, Administrative Nurse G stated that the pharmacist reviews the medication regimen at the beginning of every month and when there was an irregularity, she does a pharmacy recommendation. Administrative Nurse G sends the recommendations to the physician to review, sign, and return.

Attempted to reach pharmacy consultant staff GG

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F 756	Continued From page 43 by email on 06/21/21 and 06/22/21 and by phone on 06/22/21 for interview. Pharmacy staff on duty reported the pharmacist was not available for interview. The facility policy "Drug Regimen Review," (DRR) revised 06/10/19, indicated that a drug regimen review was completed monthly by a licensed pharmacist. The consultant pharmacist will conduct DRR's to identify irregularities and to identify clinically significant risks and/or actual potential adverse consequences which may result from or be associated with medications. The pharmacist then documents any irregularities, significant risks or actual/potential adverse consequences in the report. The facility failed to ensure the pharmacist's monthly drug regimen reviews identified irregularities including the lack of a stop date for the as needed antianxiety medication and also the lack of documentation for the reason staff administered the medication and the follow up of the ffectiveness of the medicaiton.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or	F 757		

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F 757	Continued From page 44 §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: The facility reported a census of 28 residents with 15 selected for review including six residents reviewed for unnecessary medications. Based on record review and interview, the facility failed to ensure two of the six residents reviewed remained free of necessary medications when the facility staff failed to follow up on effectiveness of as needed medications for Resident (R)10 and R12. Findings included: - Review of resident's (R)10's "Physician Orders," dated 01/23/2021, revealed diagnoses which included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) , syncope (dizziness) and collapse, hypertension (high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness and/or weakness),	F 757		

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Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), gastroesophageal reflux disease , hypothyroidism (condition characterized by decreased activity of the thyroid gland), The care plan (CP), dated 5/10/21, directed staff to monitor for medication effectiveness and document.

The "Physician Orders," dated 06/1/21, documented medication orders which included the following:

1. Tylenol Extra Strength 50milligrms (mg.) tablet, give one tablet by mouth every four hours as needed for pain, ordered 04/08/20.

2. Bisacodyl 5 mg tablet delayed release one tablet by mouth every three days as needed for constipation, ordered 04/08/20.

3. Tylenol 325 mg tablets give two tablets by mouth every six hours as needed for pain, ordered 01/26/20.

4. Tramadol 50 mg tablet give ½ tablet by mouth every 12 hours as needed for pain, ordered 03/31/21.

The resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications lacked follow-up for effectiveness of the administered as needed medication:

1. Tylenol Extra Strength 50milligrms (mg) tablet, give one tablet by mouth every four hours as needed for pain, 04/21/21, 04/24/21, 05/24/21

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2. Bisacodyl 5 mg tablet delayed release one tablet by mouth every three days as needed for constipation, 4/21/21.

3. Tylenol 325 mg tablets give two tablets by mouth every six hours as needed for pain, on 04/10/21 for two doses, 04/21/21, 04/29/21, 05/21/21, 05/23/1, 05/28/21, 05/30/21, 06/4/21, and 06/14/21,

4. Tramadol 50 mg tablet give ½ tablet by mouth every 12 hours as needed for pain, 4/01/21, 04/3/21, 04/26/21, 05/06/21, 05/16/21 for three doses,0 5/17/21, 06/03/21, 06/09/21, 06/11/21

On 06/17/21 at 04:02 PM, the resident sat in her recliner reading the paper and having an appropriate conversation with her daughter. The resident was alert and oriented. She had some tremors of her hands and arm, consistent with Parkinson's disease.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T the CMA should document the effectiveness on the MAR within an hour of giving prn medications. The CMA should let the nurse know if the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of medications and document on the MAR.

On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported the resident occasionally reported anxiety and pain. She shakes because of her Parkinson's, and she gets scared. The staff sit with her and she calms down. She will tell the CMA when she is ready for her pills. The

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resident turns her call light on and ask for the nurse. The nurse will assess the resident and may give her medication. CNA N stated, "I assume the CMA or Nurse comes back and checks on the resident when they get something for pain or anxiety. We let the CMA or nurse know If the resident reports pain, anxiety, or constipation.

On 06/21/21 at 12:33 PM, Licensed Nurse (LN) E stated the resident the CMAs who give medication to the resident should notify the nurse if the resident needs a prn medication. The nurse will direct the CMA what to give and then the effectiveness should be monitored within the hour. The CMAs and/ or the nurse should document the effectiveness of prn medications in the MAR.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated the CMAs are to report to the charge nurse the resident's request or need for a prn medication. Then she expected the nurse to assess the resident and direct the CMA on the administration of medication. In follow-up to the administration of the medication she expected the CMA and/or the nurse to document the effectiveness of the medication on the MAR.

The facility policy "Medication Administration," dated 04/27/21, documentation included the authorized staff administering medications are required to document in the electronic medication administration record (EMAR) results achieved and any situation that requires monitoring.

The facility failed to provide adequate monitoring of the effectiveness of prn medications to ensure

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the resident was free from unnecessary drugs.

- Review of resident (R)12's "Physician Orders," dated 06/01/21, revealed diagnoses which included anemia (low blood iron content, hypertension (high blood pressure), constipation, seasonal allergies, and, pain,

The "Physician Orders," dated 06/1/21, documented medication orders which included the following:

1. Loratadine 10 milligrams (mg.) one tablet, by mouth, once daily, as needed (prn) for seasonal allergies, ordered 03/14/19.

2. Bisacodyl 5 mg tablet, delayed release, by mouth, once daily prn, for constipation, ordered 03/14/19.

3. MiraLAX 17 grams/dose of oral powder, by mouth, once daily, prn

4. Tylenol Extra Strength 500 mg tablet, one tablet by mouth every eight hours, prn for pain, ordered 04/15/21

The resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the following medications lacked follow-up for effectiveness of the administered as needed medication:

1. Loratadine 10 milligrams (mg) tablet by mouth once daily as needed (prn) for seasonal allergies, on 05/03/21 for two doses.

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2.Bisac odyl 5 mg tablet, delayed release, by mouth, daily, for constipation on 04/16/21,

3. MiraLAX 17 grams/dose of oral powder, by mouth, once daily, prn on 04/22/21, and 06/15/21
4. Tylenol Extra Strength 500 mg tablet, one tablet by mouth every eight hours, prn for pain, on 04/15/21,

On 06/16/21 at 11:09 AM, the resident sat in the chair watching television. On inquiry she stated she was not aware of any problems with her medications or not receiving her medications. The staff give me my medication and she relied on staff for medication accuracy.

On 06/21/21 at 09:04 AM, Certified medication Aide S, administered the resident's morning medications and the resident took the medications without questions.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T reported the CMA should document the effectiveness on the MAR within an hour of giving prn medications. The CMA should let the nurse know if the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of medications and document on the MAR.

On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported the resident occasionally reported pain. The nurse will assess the resident and may give her medication. CNA N stated, "I assume the CMA or Nurse comes back and checks on the resident when they get something for pain. We let the CMA or nurse know If the resident reports painor constipation.

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F 757	Continued From page 50 On 06/21/21 at 12:33 PM, Licensed Nurse (LN) E stated CMAs who give medication to the resident should notify the nurse if the resident needs a prn medication. The nurse will direct the CMA what to give and then the effectiveness should be monitored within the hour. The CMAs and/ or the nurse should document the effectiveness of prn medications in the MAR. On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated the CMAs are to report to the charge nurse the resident's request or need for a prn medication. Then she expected the nurse to assess the resident and direct the CMA on the administration of medication. In follow-up to the administration of the medication she expected the CMA and/or the nurse to document the effectiveness of the medication on the MAR. The facility policy "Medication Administration," dated 04/27/21, documentation included the authorized staff administering medications are required to document in the electronic medication administration record (EMAR) results achieved and any situation that requires monitoring. The facility failed to provide adequate monitoring of the effectiveness of prn medications to ensure the resident was free from unnecessary drugs.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following	F 758		

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categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be

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renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 28 residents with 15 selected for review including six residents reviewed for medications. Based on observation, record review, and interview, the facility failed to monitor the reason for administration and the effectiveness of Resident (R)20 and R10's antianxiety medication.

Findings included:

- The "Physician Orders," dated 05/04/21, for Resident (R)20, included diagnoses of dementia (memory loss) and anxiety disorder.

The "Significant Change Minimum Data Set" (MDS), assessed her with having short and long term memory problems, severely impaired decision making, and no behaviors, wandering, or rejection of care. She received an antianxiety medication for seven days.

The "Quarterly MDS," dated 04/10/21, revealed no changes in her cognition or antianxiety use, but had physical and verbal behaviors for one to three days and wandered four to six days.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 10/15/20, revealed R20 had diagnoses of dementia and anxiety and received an antianxiety medication for seven days of the lookback period.

The "Behavioral Symptoms CAA," dated

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10/15/20, revealed R20 had severe dementia, occasionally wanders in her wheelchair, and redirect her with conversation, snack, or activity.

The "Care Plan," dated 05/18/21, revealed that R20 took multiple medications and was at risk for side effects including Ativan (antianxiety medication), and when combined with the antidepressant medication she takes it places her at risk for falls. The antianxiety medication had a black box warning (a medication that can have serious side effects such as injury or death).

A "Physician Order," dated 08/16/20 included Ativan, 0.5 milligrams (mg), by mouth, twice daily, for anxiety and Ativan, 0.5 mg, by mouth every day, as needed for anxiety.

The pharmacy reviewed R20's medication regimen on these dates and had no recommendations: 09/15/20, 10/09/20, 11/17/20, 12/11/20, 01/15/21, 03/11/21, 04/09/21, 05/14/21, and 06/11/21. On 02/11/21, the pharmacist recommended to consider if a gradual dose reduction was appropriate for Ativan, Celexa (antidepressant medication), and Seroquel (antipsychotic medication). The note failed to address the lack of monitoring of effectiveness of the as needed Ativan.

The "Interdisciplinary Note," dated 02/26/21, revealed a facility nurse assisted R20 with a telehealth appointment, discussed pending pharmacy recommendations, and received orders to discontinue the Seroquel and continue with the Ativan and Celexa as R20 remained stable with no adverse reaction.

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The "Medication Administration Record" (MAR), dated 05/2021 and 06/2021, revealed R20 received an as needed dose of Ativan on these dates:

1. On 05/02/21, for restlessness and documented the medication was ineffective.

2. On 05/03/21, documentation lacked reason for giving and if effective.

3. On 05/27/21, documentation indicated the medication was given per the nurse and lacked reason administered and the effectiveness of the medication.

4. On 05/30/21, documentation lacked reason for giving and if effective.

5. On 06/12/21, documentation lacked reason for giving and if effective.

On 06/21/21 at 08:39AM, R20 stood from a chair in the room where others were dining for breakfast, staff offered to get her coffee, R20 then sat back down.

On 06/21/21 at 01:03 PM, Certified Nurse Aide (CNA) M stated that she gets anxious and staff approach her later if she was resisting cares. The staff offer snacks, she liked sweets, and coffee, and that was effective when she had anxiety.

On 06/21/21 at 03:03 PM, Certified Medication Aide (CMA) R stated that when administering an as needed antianxiety, the staff are to document the reason why it was given and document later

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the effectiveness.

On 06/21/21 at 03:41 PM, Licensed Nurse (LN) R stated that the CMA's document on effectiveness of as needed medications, and the CMA's would pass on to the nurse if an as needed medication was ineffective.

On 06/21/21 at 04:22 PM, Administrative Nurse G stated that the pharmacist reviews the medication regimen at the beginning of every month and when there was an irregularity, she does a pharmacy recommendation. Administrative Nurse G sends the recommendations to the physician to review, sign, and return.

The facility policy "Medication Administration," dated 04/27/21, documentation included the authorized staff administering medications are required to document in the electronic medication administration record (EMAR) results achieved and any situation that requires monitoring.

The facility failed to ensure staff monitored the behaviors associated with the administration of the antianxiety medication and staff followed up on the effectiveness of the administered medications.

- Review of resident's (R)10's "Physician Orders," dated 01/23/2021, revealed diagnoses which included Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and

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weakness) , syncope (dizziness) and collapse, hypertension (high blood pressure), diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with diabetic neuropathy (disease or dysfunction of one or more peripheral nerves, typically causing numbness and/or weakness), Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), gastroesophageal reflux disease, hypothyroidism (condition characterized by decreased activity of the thyroid gland).

The care plan (CP), dated 5/10/21, directed staff to monitor for medication effectiveness and document.

The "Physician Orders," dated 06/1/21, documented medication orders for Alprazolam (an antianxiety medication) 0.25, milligram (mg) tablet by mouth, daily for anxiety as needed, ordered 12/20/20.

The resident's "Medication Administration Record" (MAR), dated 04/01/2021 through 06/21/21, documentation revealed the medications lacked monitoring and follow-up for effectiveness of the administered prn for anxiety medication on the following dates: 04/02/21, 04/05/21, 04/10/21, 04/15/21, 04/16/21, 04/21/21, 04/23/21 for two doses, 04/30/21, 05/03/21,05/04/21, 05/06/21, 05/09/21, 05/17/21, 05/22/21, 05/23/21, 06/06/21, 06/09/21, and 06/11/21 (19 doses).

On 06/17/21 at 04:02 PM, the resident sat in her recliner reading the paper and having an appropriate conversation with her daughter. The

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resident was alert and oriented. She had some tremors of her hands and arm, consistent with Parkinson's disease.

On 06/17/21 at 12:53 PM, Certified Medication Aide (CMA) T reported the resident took a lot of medications throughout the day. CMA T reported the CMA should document the effectiveness on the MAR within an hour of giving prn medications. The CMA should let the nurse know if the resident has not had any relief when giving prn medications as well as the nurse should assess for the effectiveness of medications and document on the MAR.

On 06/17/21 at 03:35 PM, Certified Nurse Aide (CNA) N, reported the resident occasionally reported anxiety and pain. She shakes because of her Parkinson's, and she gets scared. The staff sit with her and she calms down. She will tell the CMA when she is ready for her pills. The resident turns her call light on and ask for the nurse. The nurse will assess the resident and may give her medication. CNA N stated, "I assume the CMA or Nurse comes back and checks on the resident when they get something for pain or anxiety. We let the CMA or nurse know If the resident reports pain, anxiety, or constipation.

On 06/21/21 at 12:33 PM, Licensed Nurse (LN) E stated the resident takes a lot of medications due to multiple comorbidities. The CMAs who give medication to the resident should notify the nurse if the resident needs a prn medication. The nurse will direct the CMA what to give and then the effectiveness should be monitored within the hour. The CMAs and/ or the nurse should

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document the effectiveness of prn medications in the MAR.

On 06/22/2021 at 11: 57 AM, Administrative Nurse D stated the CMAs are to report to the charge nurse the resident's request or need for a prn medication. Then she expected the nurse to assess the resident and direct the CMA on the administration of medication. In follow-up to the administration of the medication she expected the CMA and/or the nurse to document the effectiveness of the medication on the MAR.

The facility policy "Medication Administration," dated 04/27/21, documentation included the authorized staff administering medications are required to document in the electronic medication administration record (EMAR) results achieved and any situation that requires monitoring.

The facility failed to provide adequate monitoring of the effectiveness of prn psychotropic medications to ensure the resident was free from unnecessary drugs.