STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175525	A. BUILDING _____ B. WING _____	07/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

(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.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 157		

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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(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 11 residents, of which 5 were reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to notify 1 of 5 sampled residents' physician regarding missed doses of medication. (#1)

Findings included:

- Resident #1's (POS) Physician Order Sheet, dated 6/11/17, documented diagnoses of myasthenia gravis (an autoimmune disease in which the immune system attacks the body's own tissues), and hypertension (elevated blood pressure).

The significant change (MDS) Minimum Data Set assessment, dated 3/20/17, documented the resident cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15. The mood score of 11 indicated moderate depression. The MDS documented no behaviors, and the

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resident required supervision with eating and extensive staff assistance for all other (ADL) activities of daily living. The resident received scheduled pain medications, reported almost constant, moderate pain, shortness of breath, and difficulty with choking/swallowing.

The quarterly MDS, dated 6/14/17, documented the same except the resident was independent with eating, and reported no pain.

The 3/20/17 (CAA) Care Area Assessment summary for (ADLs) activities of daily living stated the resident had limited functional (ROM) Range of Motion in both shoulders and lower extremities related to myasthenia gravis.

The 3/31/17 (reviewed 6/28/17) care plan for medication stated the resident had pain and numbness related to myasthenia gravis. The care plan directed staff to monitor the resident for signs and symptoms of respiratory distress, circulation and numbness in fingers and toes, cool skin to touch, pain, change in skin color from pale to blue to red, restlessness, impaired judgment, dizziness, unresolved rapid heartbeat, excessive agitation, nervousness, insomnia, tremors, change in vision, and report to the physician. The care plan indicated Bumex was a potent diuretic (medication to promote the formation and excretion of urine) which required careful medical supervision, and dosage amount and a medication schedule have to be adjusted to the individual patient's needs.

The 6/11/17, signed physician's medication orders, directed staff to administer: Pyridostigmine bromide (used to improve muscle strength in patients with myasthenia gravis, 60

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(mg) milligrams, three times daily, initiated 2/7/17. Bumex (diuretic), 1 mg, (prn) as needed, for weight gain, initiated 5/25/17. Give 1 tablet, as needed, if the resident's weight increased greater than or equal to 3 # (pounds) in a day.

The 6/1/17 physician's order directed staff to ensure staff collect the resident's daily weight.

Review of the medical record revealed the following one day weight gains:

06/08/2017 - 212
06/09/2017 - 215 3# gain
06/16/2017 - 209
06/17/2017 - 213 4# gain
06/30/2017 - 208.4
07/03/2017 - 213.3 4.9# gain
07/04/2017 - 213.4
07/05/2017 - 217 3.6# gain
07/06/2017 - 207.5
07/07/2017 - 219 12.5# gain
07/10/2017 - 212.6
07/11/2017 - 217.2 4.7# gain
07/13/2017 - 195.5
07/14/2017 - 201.5 6# gain
07/15/2017 - 209.5 8# gain
07/16/2017 - 213.4 3.9# gain
07/18/2017 - 218 4.6# gain
07/19/2017 - 222.5 4.5# gain

The 6/15/17 at 4:54 PM, progress note documented the nurse called the physician's clinic last week, requesting a Pyridostigmine prescription be faxed to the resident's assigned medication provider, in order to be refilled. The note documented the facility ran out of this medication, and the nurse called requesting the

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prescription be re-sent to the assigned medication provider, as well as to the local pharmacy.

The June 2017 (MAR) Medication Administration Record documented nursing staff had not administered Pyridostigmine from 8:00 PM on 6/11/17 through 12:00 PM on 6/15/17 (11 missed doses).

The June and July 2017 MARs lacked documentation the staff administered prn Bumex, per physician orders, for a weight gain of 3# or more in one day.

The 6/18/17 at 7:49 PM, progress note documented the resident complained of feeling poor today, reported he/she had no appetite, and felt lethargic. The resident stated he/she just doesn't feel right, and agreed to notify staff immediately if he/she began to feel worse this evening.

The 6/19/17 at 2:21 PM, progress note documented the resident exhibited intermittent confusion and did not appear to be feeling well. The nurse notified the physician's office nurse and awaited a call back.

The 6/19/17 at 5:18 PM, progress note documented the resident was admitted to the hospital with diagnoses of weakness, tremors, and possible sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion).

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The 7/19/17 pharmacist consultant review lacked documentation regarding the missed administration of 11 doses of Pyridostigmine and prn Bumex.

On 7/19/17 at 8:45 AM, observation revealed the resident sat in a wheelchair, at the dining table, while Medication Aide B administered medications to the resident.

On 7/19/17 at 9:23 AM, observation revealed the physician visited with the resident in his/her room.

On 7/19/17 at 12:50 PM, Medication Aide B stated the resident's medications come from the assigned medication provider, and he/she received a 3 month supply. Medication Aide B stated it took 10 days to get new medication from the assigned medication provider, but the facility usually does not run out, because we get 14 day supply from the local pharmacy. Medication Aide B stated staff contact the local pharmacy for more medications as needed, and if the resident did not have a medication, he/she notified the nurse. Medication Aide B stated staff usually contact the physician if the resident had not received his/her medications for a few days.

On 7/19/17 at 12:55 PM, Nurse C stated he/she had not notified the physician of the lack of administration of Pyridostigmine and prn Bumex, and verified the resident's medical record lacked documentation staff notified the physician regarding the resident not receiving the physician ordered medications.

On 7/19/17 at 2:00 PM, Administrative Nurse D verified the staff had not administered the resident's Pyridostigmine and prn Bumex

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medication, or notified the physician.

On 7/20/17 at 9:30 AM, pharmacist consultant E verified he/she had not identified the lack of administration of the physician ordered Pyridostigmine for several doses in June. Pharmacist consultant E stated the effects of not receiving the Pyridostigmine for several doses would include muscle rigidity, and increased salivation/secretions. Pharmacist consultant E verified he/she had not addressed the lack of administration of prn Bumex for a 3# weight gain in one day, or notified the director of nursing or the physician of the lack of administration of Pyridostigmine and prn Bumex.

On 7/20/17 at 9:45 AM, Administrative Nurse F verified staff should have notified the resident's physician of the missed doses of Pyridostigmine, and staff should have contacted the local pharmacy for the medication as soon as possible. Administrative Nurse F stated the pharmacist had not notified him/her of the lack of documentation regarding administration of Pyridostigmine for 11 doses or the lack of administration of prn Bumex for a weight gain of 3# or more in a day.

The facility's 7/2017 policy for Administration of Medication instructed staff to use the (EMAR) Electronic Administration Record to administer medications. The policy instructed staff to carefully check the EMAR for instructions on each medication. When staff are unable to administer a medication, document on the EMAR with the reason, and write a progress note. The policy stated if a medication is ordered, but not present, staff are to check other locations for the medication, confirm the medication was ordered, and if not, order the medication immediately. The

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F 157	Continued From page 7 policy instructed staff to notify the resident's physician, the director of nursing, or designee, and the resident's representative, for each day the medication is not given. The policy stated if the medication are to come from a pharmacy other than the local pharmacy, and was still not available on day three, the charge nurse would notify the resident's representative and inform them the medication would be ordered through our local pharmacy and staff were to submit a faxed medication order to the pharmacy. The monthly Medication Review policy stated the pharmacist would review all drugs currently ordered and assure that all diagnostic and monitoring information was available in the resident's EMAR. The facility failed to notify Resident #1's physician of the 11 missed doses of Pyridostigmine and the lack of administration of prn Bumex, which placed the resident at risk for health complications without physician guidance.	F 157		
F 371 SS=F	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.	F 371		

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F 371	Continued From page 8 (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: The facility had a census of 59 residents. The sample included 11 residents. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner to the 59 residents who reside in the facility and received meals for the facility kitchen. The facility failed to label and date food items when placed in the facility's refrigerator, monitor and record dishwasher temperatures daily, and use appropriate method for thawing meat. Findings included: - On 7/18/17 at 8:05 AM, observation in the facility kitchen revealed the following: 1 large bag with sliced mild cheddar cheese slices opened and not dated 1 large canister of shredded cheese not dated 1 bag of cooked chicken wings not dated 1 bag of oven roasted turkey breast slices not dated 1 quart carton of heavy cream, dated 7/7/17, and manufacturer expiration date 7/10/17 1 gallon jug of BBQ sauce opened without a lid or	F 371		

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F 371	Continued From page 9 cover, dated 4/18/17, when received 8 pound carton of Resers Deserts (fruit salad), dated 7/12/17, when opened 1 bowl with individual egg salad mixture, undated 1 undated chocolate meringue pie (half gone) 17 ounce Lyons Desert Sauce, dated 3/23/17, with a gray fuzzy substance on the spout lid Plastic bottle of Caramel, dated 5/16/17, with a gray fuzzy substance on the spout lid Individual salad plate, undated On 7/19/17 at 10:35 AM, an additional tour of the facility kitchen also revealed the following: The facility microwave revealed numerous dried-on food particles inside the microwave, with the plastic cover, on the inside roof of the microwave, partially falling off. Several sealed packages of frozen meat, in a water bath, without running water. The dishwasher temperature log lacked daily documentation of water temperatures. On 7/18/17 at 8:10 AM, all the above items were verified by Dietary Staff A. Dietary Staff A stated the dietary staff were to date the food items when opened and to discard any outdated food. On 7/19/17 at 10:35 AM, Dietary Staff A stated frozen meat could be thawed for 3 days in the refrigerator or in a kitchen sink with cold water, not running constantly. Dietary Staff A stated the meat in the sink was approximately 25 pounds and he/she had left the meat in the kitchen sink, without running water. Dietary Staff A verified the dietary staff were not documenting the dishwasher temperatures daily.	F 371		

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F 371	Continued From page 10 The facility's 3/2013 guideline for food safety policy directed staff to thaw meat, fish, or poultry in a refrigerator, in a drip proof container, and in a way that prevents cross contamination, by completely submerging the item in clean running water (<70 degrees) that was running fast enough to agitate and float off loose ice particles. The policy further stated if thawing meat in bulk quantities, staff were directed to submerge the meat in water, and continuously change the water, to keep below 70 Fahrenheit. The guideline directed staff to document dishwasher temperatures regularly, on a temperature log. The facility's undated dietary policy instructed staff to monitor and record dishwasher temperatures 3 times daily. The policy also instructed the dietary staff the food must be covered, labeled and dated when stored, and left over foods were to be discarded after 72 hours. The facility failed to monitor or record the dishwasher temperatures in the facility's kitchen, ensure the food was labeled and dated when placed in the refrigerator, discard outdated food, and use proper thawing techniques, which placed the 59 residents who receive meals from the facility kitchen, at risk for food borne illness.	F 371		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (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.	F 425		

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

(1) Provides consultation on all aspects of the provision of pharmacy services in the facility;
This REQUIREMENT is not met as evidenced by:
The facility had a census of 59 residents. The sample included 11 residents, of which 5 were reviewed for unnecessary medications. Based on observation, interview and record review, the facility failed to provide medication, per physician orders, for 1 of 5 residents sampled for medication review. (#1)

Findings included:

- Resident #1's (POS) Physician Order Sheet, dated 6/11/17, documented diagnoses of myasthenia gravis (an autoimmune disease in which the immune system attacks the body's own tissues), and hypertension (elevated blood pressure).

The significant change (MDS) Minimum Data Set assessment, dated 3/20/17, documented the resident cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15. The mood score of 11 indicated moderate depression. The MDS documented no behaviors, and the resident required supervision with eating and extensive staff assistance for all other (ADL) activities of daily living. The resident received scheduled pain medications, reported almost constant, moderate pain, shortness of breath, and difficulty with choking/swallowing.

The quarterly MDS, dated 6/14/17, documented

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F 425	Continued From page 12	F 425		

the same except the resident was independent with eating, and reported no pain.

The 3/20/17 (CAA) Care Area Assessment summary for (ADLs) activities of daily living stated the resident had limited functional (ROM) Range of Motion in both shoulders and lower extremities related to myasthenia gravis.

The 3/31/17 (reviewed 6/28/17) care plan for medication stated the resident had pain and numbness related to myasthenia gravis. The care plan directed staff to monitor the resident for signs and symptoms of respiratory distress, circulation and numbness in fingers and toes, cool skin to touch, pain, change in skin color from pale to blue to red, restlessness, impaired judgment, dizziness, unresolved rapid heartbeat, excessive agitation, nervousness, insomnia, tremors, change in vision, and report to the physician. The care plan indicated Bumex was a potent diuretic (medication to promote the formation and excretion of urine) which required careful medical supervision, and dosage amount and a medication schedule have to be adjusted to the individual patient's needs.

The 6/11/17, signed physician's medication orders, directed staff to administer: Pyridostigmine bromide (used to improve muscle strength in patients with myasthenia gravis, 60 (mg) milligrams, three times daily, initiated 2/7/17. Bumex (diuretic), 1 mg, (prn) as needed, for weight gain, initiated 5/25/17. Give 1 tablet, as needed, if the resident's weight increased greater than or equal to 3 # (pounds) in a day.

The 6/1/17 physician's order directed staff to ensure staff collect the resident's daily weight.

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Review of the medical record revealed the following one day weight gains:

06/08/2017 - 212
06/09/2017 - 215 3# gain
06/16/2017 - 209
06/17/2017 - 213 4# gain
06/30/2017 - 208.4
07/03/2017 - 213.3 4.9# gain
07/04/2017 - 213.4
07/05/2017 - 217 3.6# gain
07/06/2017 - 207.5
07/07/2017 - 219 12.5# gain
07/10/2017 - 212.6
07/11/2017 - 217.2 4.7# gain
07/13/2017 - 195.5
07/14/2017 - 201.5 6# gain
07/15/2017 - 209.5 8# gain
07/16/2017 - 213.4 3.9# gain
07/18/2017 - 218 4.6# gain
07/19/2017 - 222.5 4.5# gain

The 6/15/17 at 4:54 PM, progress note documented the nurse called the physician's clinic last week, requesting a Pyridostigmine prescription be faxed to the resident's assigned medication provider, in order to be refilled. The note documented the facility ran out of this medication, and the nurse called requesting the prescription be re-sent to the assigned medication provider, as well as to the local pharmacy.

The June 2017 (MAR) Medication Administration Record documented nursing staff had not administered Pyridostigmine from 8:00 PM on 6/11/17 through 12:00 PM on 6/15/17 (11 missed

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK LANE NURSING HOME	210 E PARK LANE SCOTT CITY, KS 67871

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doses).

The June and July 2017 MARs lacked documentation the staff administered prn Bumex, per physician orders, for a weight gain of 3# or more in one day.

The 6/18/17 at 7:49 PM, progress note documented the resident complained of feeling poor today, reported he/she had no appetite, and felt lethargic. The resident stated he/she just doesn't feel right, and agreed to notify staff immediately if he/she began to feel worse this evening.

The 6/19/17 at 2:21 PM, progress note documented the resident exhibited intermittent confusion and did not appear to be feeling well. The nurse notified the physician's office nurse and awaited a call back.

The 6/19/17 at 5:18 PM, progress note documented the resident was admitted to the hospital with diagnoses of weakness, tremors, and possible sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion).

The 7/19/17 pharmacist consultant review lacked documentation regarding the missed administration of 11 doses of Pyridostigmine and prn Bumex.

On 7/19/17 at 8:45 AM, observation revealed the resident sat in a wheelchair, at the dining table, while Medication Aide B administered

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medications to the resident.

On 7/19/17 at 9:23 AM, observation revealed the physician visited with the resident in his/her room.

On 7/19/17 at 12:50 PM, Medication Aide B stated the resident's medications come from the assigned medication provider, and he/she received a 3 month supply. Medication Aide B stated it took 10 days to get new medication from the assigned medication provider, but the facility usually does not run out, because we get 14 day supply from the local pharmacy. Medication Aide B stated staff contact the local pharmacy for more medications as needed, and if the resident did not have a medication, he/she notified the nurse. Medication Aide B stated staff usually contact the physician if the resident had not received his/her medications for a few days.

On 7/19/17 at 12:55 PM, Nurse C stated he/she had not notified the physician of the lack of administration of Pyridostigmine and prn Bumex, and verified the resident's medical record lacked documentation staff notified the physician regarding the resident not receiving the physician ordered medications.

On 7/19/17 at 2:00 PM, Administrative Nurse D verified the staff had not administered the resident's Pyridostigmine and prn Bumex medication, or notified the physician.

On 7/20/17 at 9:30 AM, pharmacist consultant E verified he/she had not identified the lack of administration of the physician ordered Pyridostigmine for several doses in June. Pharmacist consultant E stated the effects of not receiving the Pyridostigmine for several doses

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would include muscle rigidity, and increased salivation/secretions. Pharmacist consultant E verified he/she had not addressed the lack of administration of prn Bumex for a 3# weight gain in one day, or notified the director of nursing or the physician of the lack of administration of Pyridostigmine and prn Bumex.

On 7/20/17 at 9:45 AM, Administrative Nurse F verified staff should have notified the resident's physician of the missed doses of Pyridostigmine, and staff should have contacted the local pharmacy for the medication as soon as possible. Administrative Nurse F stated the pharmacist had not notified him/her of the lack of documentation regarding administration of Pyridostigmine for 11 doses or the lack of administration of prn Bumex for a weight gain of 3# or more in a day.

The facility's 7/2017 policy for Administration of Medication instructed staff to use the (EMAR) Electronic Administration Record to administer medications. The policy instructed staff to carefully check the EMAR for instructions on each medication. When staff are unable to administer a medication, document on the EMAR with the reason, and write a progress note. The policy stated if a medication is ordered, but not present, staff are to check other locations for the medication, confirm the medication was ordered, and if not, order the medication immediately. The policy instructed staff to notify the resident's physician, the director of nursing, or designee, and the resident's representative, for each day the medication is not given. The policy stated if the medication are to come from a pharmacy other than the local pharmacy, and was still not available on day three, the charge nurse would notify the resident's representative and inform

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F 425	Continued From page 17 them the medication would be ordered through our local pharmacy and staff were to submit a faxed medication order to the pharmacy. The monthly Medication Review policy stated the pharmacist would review all drugs currently ordered and assure that all diagnostic and monitoring information was available in the resident's EMAR. The facility failed to provide physician ordered Pyridostigmine for 11 doses, and prn Bumex for 11 times, when the resident had a 3# or more weight gain, which placed Resident #1 at risk for health complications.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (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 categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (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.	F 428		

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F 428	Continued From page 18 (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (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 had a census of 59 residents. The sample included 11 residents, of which 5 were reviewed for unnecessary medications. Based on observation, interview and record review, the facility's consultant pharmacist failed to notify the director of nursing or the resident's physician of the lack of documentation of administration of scheduled and (prn) as needed medications for 1 of 5 sample residents. (#1)	F 428		

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Findings included:

- Resident #1's (POS) Physician Order Sheet, dated 6/11/17, documented diagnoses of myasthenia gravis (an autoimmune disease in which the immune system attacks the body's own tissues), and hypertension (elevated blood pressure).

The significant change (MDS) Minimum Data Set assessment, dated 3/20/17, documented the resident cognitively intact with a (BIMS) Brief Interview for Mental Status score of 15. The mood score of 11 indicated moderate depression. The MDS documented no behaviors, and the resident required supervision with eating and extensive staff assistance for all other (ADL) activities of daily living. The resident received scheduled pain medications, reported almost constant, moderate pain, shortness of breath, and difficulty with choking/swallowing.

The quarterly MDS, dated 6/14/17, documented the same except the resident was independent with eating, and reported no pain.

The 3/20/17 (CAA) Care Area Assessment summary for (ADLs) activities of daily living stated the resident had limited functional (ROM) Range of Motion in both shoulders and lower extremities related to myasthenia gravis.

The 3/31/17 (reviewed 6/28/17) care plan for medication stated the resident had pain and numbness related to myasthenia gravis. The care plan directed staff to monitor the resident for signs and symptoms of respiratory distress, circulation and numbness in fingers and toes,

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cool skin to touch, pain, change in skin color from pale to blue to red, restlessness, impaired judgment, dizziness, unresolved rapid heartbeat, excessive agitation, nervousness, insomnia, tremors, change in vision, and report to the physician. The care plan indicated Bumex was a potent diuretic (medication to promote the formation and excretion of urine) which required careful medical supervision, and dosage amount and a medication schedule have to be adjusted to the individual patient's needs.

The 6/11/17, signed physician's medication orders, directed staff to administer: Pyridostigmine bromide (used to improve muscle strength in patients with myasthenia gravis, 60 (mg) milligrams, three times daily, initiated 2/7/17. Bumex (diuretic), 1 mg, (prn) as needed, for weight gain, initiated 5/25/17. Give 1 tablet, as needed, if the resident's weight increased greater than or equal to 3 # (pounds) in a day.

The 6/1/17 physician's order directed staff to ensure staff collect the resident's daily weight.

Review of the medical record revealed the following one day weight gains:

06/08/2017 - 212
06/09/2017 - 215 3# gain
06/16/2017 - 209
06/17/2017 - 213 4# gain
06/30/2017 - 208.4
07/03/2017 - 213.3 4.9# gain
07/04/2017 - 213.4
07/05/2017 - 217 3.6# gain
07/06/2017 - 207.5
07/07/2017 - 219 12.5# gain
07/10/2017 - 212.6

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07/11/2017 - 217.2 4.7# gain
07/13/2017 - 195.5
07/14/2017 - 201.5 6# gain
07/15/2017 - 209.5 8# gain
07/16/2017 - 213.4 3.9# gain
07/18/2017 - 218 4.6# gain
07/19/2017 - 222.5 4.5# gain

The 6/15/17 at 4:54 PM, progress note documented the nurse called the physician's clinic last week, requesting a Pyridostigmine prescription be faxed to the resident's assigned medication provider, in order to be refilled. The note documented the facility ran out of this medication, and the nurse called requesting the prescription be re-sent to the assigned medication provider, as well as to the local pharmacy.

The June 2017 (MAR) Medication Administration Record documented nursing staff had not administered Pyridostigmine from 8:00 PM on 6/11/17 through 12:00 PM on 6/15/17 (11 missed doses).

The June and July 2017 MARs lacked documentation the staff administered prn Bumex, per physician orders, for a weight gain of 3# or more in one day.

The 6/18/17 at 7:49 PM, progress note documented the resident complained of feeling poor today, reported he/she had no appetite, and felt lethargic. The resident stated he/she just doesn't feel right, and agreed to notify staff immediately if he/she began to feel worse this evening.

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The 6/19/17 at 2:21 PM, progress note documented the resident exhibited intermittent confusion and did not appear to be feeling well. The nurse notified the physician's office nurse and awaited a call back.

The 6/19/17 at 5:18 PM, progress note documented the resident was admitted to the hospital with diagnoses of weakness, tremors, and possible sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs. Common signs and symptoms include fever, increased heart rate, increased breathing rate, and confusion).

The 7/19/17 pharmacist consultant review lacked documentation regarding the missed administration of 11 doses of Pyridostigmine and prn Bumex.

On 7/19/17 at 8:45 AM, observation revealed the resident sat in a wheelchair, at the dining table, while Medication Aide B administered medications to the resident.

On 7/19/17 at 9:23 AM, observation revealed the physician visited with the resident in his/her room.

On 7/19/17 at 12:50 PM, Medication Aide B stated the resident's medications come from the assigned medication provider, and he/she received a 3 month supply. Medication Aide B stated it took 10 days to get new medication from the assigned medication provider, but the facility usually does not run out, because we get 14 day supply from the local pharmacy. Medication Aide B stated staff contact the local pharmacy for more medications as needed, and if the resident did not

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have a medication, he/she notified the nurse. Medication Aide B stated staff usually contact the physician if the resident had not received his/her medications for a few days.

On 7/19/17 at 12:55 PM, Nurse C stated he/she had not notified the physician of the lack of administration of Pyridostigmine and prn Bumex, and verified the resident's medical record lacked documentation staff notified the physician regarding the resident not receiving the physician ordered medications.

On 7/19/17 at 2:00 PM, Administrative Nurse D verified the staff had not administered the resident's Pyridostigmine and prn Bumex medication, or notified the physician.

On 7/20/17 at 9:30 AM, pharmacist consultant E verified he/she had not identified the lack of administration of the physician ordered Pyridostigmine for several doses in June. Pharmacist consultant E stated the effects of not receiving the Pyridostigmine for several doses would include muscle rigidity, and increased salivation/secretions. Pharmacist consultant E verified he/she had not addressed the lack of administration of prn Bumex for a 3# weight gain in one day, or notified the director of nursing or the physician of the lack of administration of Pyridostigmine and prn Bumex.

On 7/20/17 at 9:45 AM, Administrative Nurse F verified staff should have notified the resident's physician of the missed doses of Pyridostigmine, and staff should have contacted the local pharmacy for the medication as soon as possible. Administrative Nurse F stated the pharmacist had not notified him/her of the lack of documentation

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F 428	Continued From page 24 regarding administration of Pyridostigmine for 11 doses or the lack of administration of prn Bumex for a weight gain of 3# or more in a day. The monthly Medication Review policy stated the pharmacist would review all drugs currently ordered and assure that all diagnostic and monitoring information was available in the resident's EMAR. The facility's consultant pharmacist failed to notify the director of nursing or the resident's physician of the lack of documentation of administration of scheduled Pyridostigmine and (prn) as needed Bumex, which placed Resident #1 at risk for adverse effects.	F 428		