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	145668	A. BUILDING _____ B. WING _____	C 12/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIA OF BELLEVILLE	**150 NORTH 27TH STREET BELLEVILLE, IL 62226**

(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 Complaint Investigation 1646736/IL90073 - F327, F333, F425 1646695/IL90035 - F323 1646862/IL90209 - F323	F 000		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on interview and record reviews the facility failed to implement interventions to	F 323		

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

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prevent falls for 1 of 3 residents (R3) reviewed for falls in the sample of 5.

Findings include:

Prior to admission to the facility, R3's "Hospitalist History and Physical - local hospital," dated 10/27/2016, documents in part, "CAT (CT) Scan - small right subdural hematoma which appears subacute."

R3 is a 93 year old female admitted to the facility on 11/4/2016, from the local hospital.

R3's "Order Summary Report," dated 11/04/2016 through 11/18/2016, documents in part, a diagnosis of Cerebral Infarction, Dementia, Absolute Glaucoma, Cognitive Communication Deficit, Muscle Weakness, and Nontraumatic Subdural Hemorrhage.

R3's "Fall Risk Evaluation," dated 11/04/2016, documents in part, "(R3's) score: 12. A risk score of 10 or greater will be considered High Risk for falling."

R3's Minimal Data Set (MDS), dated 11/11/2016, documents in part, R3's cognitive skills for daily decision making is severely impaired. R3's MDS documents she requires extensive assistance from staff for bed mobility, transfers, toileting and activities of daily living (ADLs).

R3's Care Plan, dated 11/8/2016, documents in part, "Focus: (R3) is at risk for complications (related to) subdural hematoma (related to) Cerebral Vascular Accident (CVA), family has decided not to seek treatment. Date initiated 11/11/2016. Goal: Staff will report to staff any

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injury, incident, or bruising immediately throughout next quarter. Interventions/Tasks: Monitor for and report any following symptoms to Medical Doctor (MD): nausea, vomiting, dizziness, fainting, headache, mental confusion. Focus: Fall: (R3) is at high risk for falls (related to) muscle weakness. Date initiated 11/08/2016. She had a (CVA) on 9/2016 resulting in a subdural hematoma she also has dementia. Goal: Monitor and promote safety through next review. Interventions/Tasks: Bed alarm. Date initiated: 11/17/2016."

In R3's "Progress Notes", dated 11/4/2016 through 11/18/2016, there is no documentation related to a chair or bed alarm being used for R3.

R3's "Functional Assessment Shiftly," dated 11/07/2016, documents in part, "R3's Bed mobility - repositions self in bed, turns to right side, turns to left side, comes to sitting position, transfers to/from chair, transfers to/from bed, locomotion/ambulation, bathing and grooming - score: total dependence, Safety devices (floor mat, contour mattress, other)." There was no documentation on "Safety Devices (floor mat, contour/perimeter mattress, other)" section.

R3's "Occupational Therapy Notes," dated 11/17/2016, documents in part, "(R3) engaged in reciprocal Lower Extremity (LE) movement during wheelchair propulsion to/from room and therapy room. (R3) minimal assistance for sit-stand with (R3) engaging Lower Extremities (LE) with improved independence."

R3's "Occupational Therapy Notes," dated 11/18/2016, documents in part, "Certified Occupational Therapy Assistant (COTA) walking

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past (R3's) room and noticed (R3) not in bed. Consulted nurse per (R3's) location and nurse stated (R3) in room. Upon assessment (R3) on floor on Right side of bed between window and bed in prone with Right Upper Extremity (RUE) behind (R3). (R3's) nurse in room to assess (R3) near total dependence (NTD) of 2 to transfer back to edge of bed (EOB) and maximum assistance sit-supine. (R3) supine in bed with nurse and Certified Nurses Aide (CNA) for assessment. Will return at later time with consultation with nurse per further therapy treatment is appropriate and tolerable. Upon return (R3) setup with breakfast. (R3) required maximum assistance to feed self with utensils. Attempted hand over hand drinks and utensils however required maximum assistance."

The facility's untitled witness report, dated 11/18/2016, documents in part, "11/18/2016 at approximately 6:45 AM (E12, Registered Nurse, RN) did rounds on 100 hall. (E12) noted (R3) not in bed during rounds. (E4, Certified Occupational Therapist Assistant) asked me where was (R3) at. (E12) went back to (R3's) room, walked around the bed and noticed (R3) face down on the floor, right arm slightly under her. (E12) noted the floor under (R3) was wet under (R3). (E12) along with (E4) rolled (R3) on her back. Range of Motion (ROM) applied to all extremities, no pain noted. (R3) respond to name when called. (R3) assisted back in bed. (E12) re-assess (R3) again. No open areas, bruises or abrasion noted. (E12) assessed (R3's) head, noted a lump on the right side of head near hair line. No pain noted when touched. (R3) was cleaned with fresh linen on. Assisted (R3) in wheel chair and placed close by (E12). Neuro checks initiated immediately. (Z8, R3's daughter) (R3's)

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responsible party notified."

R3's "Progress Notes", dated 11/18/2016, documents in part, "Responsible party here to visit (R3) this morning. Request for (R3) to be sent to (local hospital) to be evaluated related to recent fall."

R3's "CAT (CT) Scan" Report from the emergency room from the local hospital, dated 11/18/2016, documents in part, "History: Patient found on floor this morning, altered mental status. Comparison: (CT Scan) 10/27/2016. Findings: There is acute on chronic right cerebral convexity subdural hematoma. This measures 7 millimeters in greatest diameter. Impression: Acute on chronic right subdural hematoma."

The facility's undated, "Final Report: Resident Incident related to fall" investigation into R3's fall on 11/18/2016, documents in part, "On 11/18/2016 (R3) was found lying on floor next to bed between bed and wall by (E12) on floor and (E4). (R3) was lying in prone position with face turned to left and right hand underneath her. (R3) was sent to hospital for evaluation and treatment. (R3) was admitted to local hospital with admitting diagnosis of Subdural hematoma."

On 11/30/2016 at 10:04 AM, E3, Assistant Director of Nurse (ADON) stated "When (R3) was admitted for the first 72 hours we put alarms on until we evaluated her need. The daughter requested the alarms be put back on her mother's bed. On the actual morning of the fall, (E12) told me when I made rounds about 8:30 AM and this is the first I knew of the fall. I started my investigation of the fall."

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On 11/30/2016 at 11:47 AM, E12, stated, "(R3) is alert and oriented to self. She attends therapy daily. The day she fell 11/18/2016, I went down the hall on round about 6:45 AM. I didn't see (R3) in her bed as I went down the hall. I went to my cart. (E4) asked me where (R3) was, about 3 minutes later. I said they must have gotten her up already. Then the therapist was standing in (R3's) door and said (R3) is not in her room. I said well check the dining room maybe they put her in there. (E4) went to the dining room and (E4) said no (R3) is not in there. I said well let me go check, I know I didn't see her in her room. We both, (E4) and I went to (R3's) room. The covers were back and the half bed rails were up on the door side of her bed, on the window side of her bed the foot rail was up but the head rail was only up to the second level so it was even with the mattress, the rails have 2 levels. The head rail wasn't up to full potential. The sheets, bed pad, like linen saver, and blankets were on the bed, but the blankets were folded back like someone had gotten her out of bed. We walked around the bed and that was when we found her lying on the floor. She was face down, head slightly to the left. She was on her right side, face down turned slightly to left and her right arm was slightly under her. There was urine on the floor. I called her name and asked are you okay and she made some noise. She never really spoke a word just a moan. So it was her normal response. (E4) and I rolled her onto her side to see if there was any blood under her, when rolling she groaned. From her side we put her on her back. When she was on her back we continued to call her name and she would moan. I did my assessment Range of Motion (ROM) to her legs and arms she did not moan out. I asked if she was ok. We sat her up in sitting position. (E4)

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had her gait belt. We put it around her and lifted her into the bed. When (R3) was in the bed, (E4) went to get clean linens and gown. I reassessed her legs and arms. She did not moan or groan. I checked her skin. I rolled her on her left side and back side checking for bruises, cut, etc then I went onto her head. When I massaged her head she had a lump on her right side inside her hairline behind her forehead. I touched it I asked if it hurt but she didn't moan or groan. Then I took her vitals, washed her head to toe, changed her linens. After she was clean I took the alarm off her chair and stuck it to her gown so we would know if she made any type of movement. I put the tab alarm off the chair and attached it to her gown. I raised the right head and right foot and left head rails raised her left foot was down. The chair alarm was clipped on her wheelchair. I made sure the bed was in the lowest position possible. I followed protocol with neurochecks. I called her son first he didn't answer so I called the second number and no answer so I went back and called the first number again and left a voice mail then I called the second name on the list, her daughter who answered on the first ring. The daughter questioned me how she feel was she okay. The daughter wanted to talk to me, (E1, Administrator) and (E3) when she got here. The daughter came about 20 minutes later. The daughter talked to (E1) and (E1) came to me and said to send her to the hospital around 7:45 AM. The doctor was notified. I was working the day shift. I started at 6:00 AM that day. The CNA on the hall that morning was (E11, CNA)."

On 11/30/2016 at 12:34 PM, E4 stated "On 11/18/2016, I went to go get linen for another resident about 7:00 AM and I noticed as I walked by, that linens were all rolled up like (R3's) bed

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wasn't made, almost like someone pulled the sheets back at the end of the bed. (R3) was on my list to see that day. I asked (E12) if (R3) had an appointment that day and (E12) said no she's in her room. I told (E12) that (R3) wasn't in her bed. (E12) followed me back to her room about 7:05 AM. We went in her room. There was no sound. She was not making any noise. I've seen her try to get out of bed especially if she needed to use the bathroom. The bed has 4 rails. All 4 rails were up except the top right rail towards the window was not all the way up it was partially down. It looked like someone had pulled the sheets back, the bed was elevated a little but the head of the bed was slightly not all the way up. I don't think she had an air mattress I think it was a regular mattress. I think she had 1 pillow on the bed. There was a sheet pulled back and mattress pad, like a linen saver, that was slightly soiled on the right side. The top sheet and the comforter were pulled back. We rounded the bed and saw her on the floor. (R3) was lying on her stomach, her head turned to the left, and her right arm under her. A pool of urine was under her. (R3) is not much of a talker but we asked her what happened, she responded she had to go to the bathroom." On 12/6/2016 at 11:48 AM, E4 stated "There wasn't anything attached to (R3's) gown when she was on the floor after she fell. I don't recall an alarm sitting on her bed. There was no alarm going off or sounding when she fell. I think the alarm was on the chair."

On 11/30/2016 at 12:57 PM, E11, CNA, stated "On 11/18/2016, I was working with another resident and I don't know who came and got me to help because (R3) had fallen. I remember (E12) was in her room. I started work at 6:00 AM, that day. When I first get here I walk all the way

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down to the end of the hall. On this day, 11/18/2016, I stopped to help the patient in room 114. I don't exactly remember what time it was but it was early into my shift, they called for me to help get (R3) into her bed and once I got her back in the bed, I went down and finished up with the name I was helping. When I was walking down the hall that morning I didn't hear anything out of the ordinary. I did not hear any alarms going off around (R3's) room."

On 11/30/2016 at 2:54 PM, Z8, (R3's daughter) stated "I requested alarms to be placed on (R3's) bed. She gets up occasionally. There were alarms on her bed the first week but the second week they were gone. On 11/16/16, I asked (E3, Assistant Director of Nursing (ADON)) to put the alarms back on but she didn't. We were visiting her until about 9:00 PM on 11/17/2016, and (R3) did not have any alarms on her bed. She did have three of the bed rails up the two by her head and one foot rail. (E12) told me that the rail by her head was down when she fell, we don't know who did that. We don't know how long she was on the floor. On 11/18/2016 when I got to (the facility) (E4) was feeding her. She had a huge goose egg on her head. (R3) was sent to the (local hospital) and they said she had bleeding on the brain. (R3) has had a setback. (R3) had bruising to her right arm which was her only working arm and was in the hospital 3 or 4 days. (R3) is showing signs of improvement but still has increased confusion. We were there on 11/17/2016 until 9:00 PM and there was no bed alarm on the bed. I had asked (E3) and she said she would get an alarm but she did not follow through and get it."

On 11/30/2016 at 2:56 PM, E6, Medical Director

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and R3's physician, stated "(R3) tried to get out of bed and fell striking her head. On 11/18/2016 the subdural hematoma was 5-6 millimeters (mm) bigger than a month before when it (the subdural hematoma) previously had been 2-3 mm."

On 12/1/2016 at 11:23 AM, E8, Restorative CNA, stated "The chair alarm is a tab alarm where the silver thing clips on the back of a chair and a wire clips to the resident's clothing and if the resident moves too much it sounds real loud. If someone was in there room or if someone if walking down the hallway they could hear it. The bed alarm is a pad that goes across the bed under the resident ' s bottom so if the resident moves too much like rolls over it goes off. The wire runs from the pad to the box also straps by clicking together to the bed rail. They were like a telephone cord we put it on the rail of the bed. It has an on off button and it has to be turned on. The CNA has to make sure the device is on."

On 12/1/2016 at 3:55 PM, E10, Certified Nurses Aide (CNA), stated "I worked with (R3) the night before she fell 11/17/2016 to 11/18/2016. (R3) would throw her leg out of the bed when she has to go to the bath room, but she slept all night that night. I put her pillow under her head about 5:45 AM and covered her up. I changed her pad every 2 hours. I checked her at midnight, 2:00 AM, 4:00 AM. When I changed her pad at 2:00 AM she didn't sit up in bed or throw her leg out like she usually did, she just went back to sleep. She slightly opened her eyes. Sometimes I would know she was wet when she would throw her leg out of the bed but that night she just went back to sleep. There was no noise in her room while I changed her pad. I had to roll her from side to side but I didn't have to change her night gown.

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When moving her from side to side there was no noise. She didn't have a bed alarm on that night she had a chair alarm on I had clipped it to her night gown."

On 12/1/2016 at 3:57 PM, E7, CNA, stated "On 11/18/2016 I did check on (R3), she wasn't really doing much that night. Her bed was in low position and all four rails were up. She sleeps on her back. We clipped the alarm onto her and if she moves it will sound. If she moves a certain distance an inch it (the chair alarm) will come off and the sound."

On 12/1/2016 at 2:15 PM, E2, Director of Nursing (DON), stated "We have no policy on bed or chair alarms."

On 12/6/2016 at 1:25 PM, Z8 stated "(R3) continues to recover, (the fall) was a setback. The policy of the facility is they keep the resident in house after the fall. I would have expected they should have sent (R3) out where she will at least get a doctor to look at her. She did not have a bed alarm and the head rail was not up when she fell. I feel that is negligence because the fall did make a difference in her well being. The doctors at (the local hospital) didn't know how she was doing before the fall. She was incapacitated due to the fall. There was no reason to have surgery but it did set her back. She is only now after two weeks of therapy, able to walk with a walker again. She is less verbal after the fall. She was able to walk and she talked to us before the fall, but after the fall she had such a setback she wasn't able to do those things until after 2 weeks of therapies. This has diminished her quality of life and it has cost a lot of money because (the facility) did not prevent the fall."

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F 323	Continued From page 11 The facility's "Fall Prevention" policy dated 5/2015, documents in part, "General: This facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed and the resident's existing plan of care shall be evaluated and modified as needed. Guidelines: Upon admission: 1. A Fall Risk Assessment will be completed on admission, readmission, and quarterly, with each significant change and after each fall. 2. Residents at risk for falls will have Fall Risk identified on the interim plan of Care and the ISP (Individual Service Plan) with interventions implemented to minimize fall risk." The facility had no policy or guidance on the use of bed or chair alarms. The bed and chair alarm manufacturer's Owner's Manual, dated January 2011, documents in part, "(Alarms) are intended to help augment caregivers' comprehensive resident mobility management programs. They are not a substitute for visual monitoring and care of residents by trained caregivers."	F 323		
F 327 SS=D	483.25(g)(2) SUFFICIENT FLUID TO MAINTAIN HYDRATION (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's	F 327		

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comprehensive assessment, the facility must ensure that a resident-

(2) Is offered sufficient fluid intake to maintain proper hydration and health.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to assess and provide timely treatment to address potential dehydration for one of five residents (R2) reviewed for hydration in the sample of 9.

Findings Include:

R2's Electronic Medical Record Medical Diagnosis Form, dated 11/01/16, documents R2 has in part diagnoses of Unspecified Dementia and Hemiplegia.

R2's Minimum Data Set (MDS), dated 09/22/16, documents R2 needs extensive assistance with eating.

R2's Physician Order Sheet (POS), dated 11/1/16, documents R2's diet is pureed with regular consistency liquids.

R2's Dietary Progress Note, dated 11/7/16 documents R2's sodium was 150. The Note did not document any recommendations to address R2's elevated sodium level.
The website Mayo Clinic, www.mayoclinic.org/diseases-conditions/dehydration/diagnosis-treatment, documents "A normal sodium level is between 135 and 145 milliequivalents per liter (mEq/L) of sodium." The website documents "To help confirm the diagnosis and pinpoint the degree of dehydration,

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you may have other test such as : Blood tests. Blood samples may be used to check for a number of factors, such as the levels of your electrolytes - especially sodium and potassium - and how well your kidneys are working."

R2's Physician Progress Note, written by Z4, R2's Primary Care Physician, dated 11/16/16, documents R2's lab results were reviewed and her sodium was 164, blood urea nitrogen (BUN) was 22 (normal 8-20 milligrams per deciliter, mg/dL) , potassium was 3.2 (normal 3.6 to 5.2 millimoles per liter, mmol/L). The Note documents "(R2) has poor fluid intake, likely related to dehydration. R2's potassium is 3.2, and we will add potassium chloride 20 meq daily." There were no recommendations as to how the facility should address R2's elevating sodium level and potential dehydration.

R2's Nurse's Note dated 11/20/16 at 11:26 AM documents R2's appetite is decreased, and medication administration was unsuccessful. R2 pocketed her medications in her cheeks. R2's medical doctor was paged.

R2's Nurse's Note dated 11/20/16 at 11:45 AM documents the facility received a call back from Z5, Nurse Practitioner (NP) of Z4, and stat orders for a Basic Metabolic Panel (BMP) and Complete Blood Count (CBC) were given.

R2's Laboratory Report/ BMP, dated 11/20/16, documents R2's sodium level as 175 mEq/L , BUN 32 mg/dL, and potassium 3.6 mmol/L.

R2's Nurse's Note dated 11/20/16 at 9:47 PM, documents, Z5 was notified of lab results. At this point, no recommendations or new orders were

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received to address R2's abnormal laboratory results.

R2's Nurse's Note dated 11/22/16 at 10:44 AM documents R2 has not been eating even when assisted with feeding. R2 "Will not take much fluids or her medications."

R2's Nurse's Note Dated 11/22/16 at 1:37 PM documents R2 is displaying poor appetite and a decreased pre-albumin, and she is less responsive than usual. The Nurse's Note dcoumented R2 is usually alert to her name. Z3, Z4's Nurse's Practitioner, was notified, and R2 was sent to a local hospital. This was 15 days after the facility noted/documented R2 had an elevated sodium level.

R2's Local Hospital History and Physical (H&P) dated 11/22/16 documents upon presentation to the emergency department R2 was found to be unresponsive with decreased gag reflex and a minimal response to painful stimuli. The H&P documented R2 was given a 1 liter normal saline bolus and 2.5 lactated ringers. The H&P documented despite all of the fluids R2 was still hypotensive at 62/40. R2 had severe electrolytederangements including hypernatremia, hyperchloremia, and hypokalemia. R2 also had elevated cardiac biomarkers.

R2's local hospital lab report, dated 11/22/16, documents R2's sodium at 240, potassium at 3.3, and BUN at 63, and a repeated lab had sodium of 170.

R2's local hospital nephrologist consult (Z10 nephrologist), dated 11/24/1,6 documents R2's free water deficit was close to 6 liters at

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F 327	Continued From page 15 admission. The Consult documented "At this time I recommend consideration of a hypotonic fluid that will give her free water for the correction of the deficit." On 11/30/16 at 9:45 AM Z1, R2's daughter stated " I visited the facility from November 11-13, and my mother never had water on her tray or in her room. We had to obtain water from the nurses medication cart." On 11/30/16 At 3:45 PM E2, Director of nursing stated " water pitcher should be checked once per shift, and in between shifts if needed." On 11/30/16 at 10:30 AM, Z6, Medical Director stated "I was not notified about (R2's) dehydration, but a delay in treatment could have contributed to her dehydration." The facility Intake and Output Policy, dated 06/2015, documents "If a resident has no intake and or output for a shift alert the health care provider."	F 327		
F 333 SS=G	483.45(f)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS (f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide antibiotic treatment for an infected pressure ulcer for one of four residents (R2) reviewed for pressure ulcers in the sample of 9. This failure resulted in R2 being admitted to the hospital with septic shock, possible source left lateral foot ulcer.	F 333		

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Findings Include:

R2's Electronic Medical Record Medical Diagnosis Form, dated 11/01/16, documents R2 has a Stage 3 pressure ulcer.

R2's Wound Report, dated 11/17/16, documents R2 has an unstageable pressure ulcer on her left lateral foot measuring 0.80 centimeters (cm) length and 1.5 cm width.

R2's Culture and Sensitivity Laboratory Form, dated 11/17/16, documents R2 has heavy growth of Proteus Mirabilis in her left lateral foot wound.

R2's Physician Order Sheet (POS), dated 11/17/16, documents an order from Z2, Wound Physician, for Cipro (an antibiotic) 500 milligrams (mg) orally twice daily for left lateral foot for 10 days.

R2's POS, dated 11/17/16, documents the order from Z3, Nurse Practitioner for Z4, R2's Primary Physician, to discontinue the antibiotic Cipro which was ordered by Z2. R2's POS, dated 11/18/16, documents the order from Z3 for Ertapenem (an antibiotic) 1 gram (GM) intramuscularly (IM) once daily for 14 days.

R2's Physician Progress Note, dated 11/18/16, documents R2's wound culture results from her foot as heavy proteus mirabilis. The Note also documents "We will begin Ertapenem 1 Gram daily for 14 days due to poor absorption and deconditioning."

R2's Nurses Note, dated 11/20/16, documents a call was received from pharmacy stating

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Ertapenem is not available in the back up pharmacy and medication will be available tomorrow through regular pharmacy.

R2's Nurses Note, dated 11/20/16, documents that Z5, Nurse Practitioner for Z4, was notified the Ertapenem was not available until 11/21/16. There is no documentation that Z2, Wound Physician, was ever notified that there was a change in antibiotics or that R2 was not receiving any antibiotics for the infection of the pressure ulcer since 11/17/16. There is no documentation that Z3, who originally ordered the Ertapenem, was notified that it was not available.

R2's 11/2016 Medication Administration Record (MAR) documents R2 did not receive Ertapenem 1 GM daily from 11/18/16 to 11/22/16 due to not available until 11/21/16. R2's 11/2016 MAR has no documentation that R2 ever received Ertapenem. R2's 11/2016 MAR has no documentation that R2 received any antibiotic since 11/17/16.

R2's Nurses Note, dated 11/20/16, documents R2 has decreased appetite, and medication administration was unsuccessful. "Stat labs were ordered bmp (basic metabolic panel) and cbc (complete blood count) was ordered. (Z5) was notified of lab results. (Z5) was notified medications will start tomorrow."

R2's Nurses Note, dated 11/22/16 at 10:44 AM, documents R2 has not been eating, when assisted with feeding and R2 will not take in fluids or medication.

R2's Nurses Note, dated 11/22/16 at 1:37 PM, documents R2 is displaying poor appetite,

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decreased prealbumin. "(R2) is less responsive then her usual, alert to her name. New orders were received send R2 to (local Hospital)."

R2's local hospital History and Physical, dated 11/22/16, documents R2 was found to be unresponsive with decreased gag reflex, minimal response to painful stimuli, and R2's temperature was 99. The skin examination on the above form documents an ulceration to the left lateral foot is 3 x 4 cm and 0.4 cm in depth. R2's Sepsis Assessment documents Severe Sepsis signs and symptoms plus organ dysfunction. It also documents R2 has septic shock severe with low blood pressure and low fluid. It documents the possible source of the septic shock as the left lateral foot ulcer. It documents R2 was given Levaquin upon arrival and R2 was also placed on Meropenem and Vancomycin.

On 11/30/16 at 8:06 AM, when asked if she was aware that R2 did not receive Ertapenem, Z2 stated "No, I didn't know she didn't receive her Ertapenem, but I didn't order the medication. I haven't seen a wound cause septic shock, but I can't say whether or not her foot wound contributed to septic shock."

On 11/30/16 at 10:48 AM, E7, Licensed Practical Nurse (LPN), stated "I don't remember the date, but I faxed the order off. The medication was to begin on the evening shift. I didn't know anything about the pharmacy not having the medication."

In an interview on 11/30/16 at 2:00 PM, E6, Minimum Data Set Coordinator, stated "(R2) had Cipro on the 18th, and she was suppose to start Ertapenem on the 19th. (Z5) was notified the medication was not available."

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F 333	Continued From page 19 The Facility Pressure Ulcer Policy, dated 06/2015, documents to prevent or reduce the incidence of pressure ulcers with pressure ulcer defined as any lesions caused by unrelieved pressure.	F 333		
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. (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: Based on interview and record review the facility failed to obtain and administer medication for one resident 1 of 9 residents (R2) reviewed for medications in the sample of 9. Findings Include: R2's Electronic Medical Record Medical Diagnosis Form, dated 11/01/16, documents R2 has a Stage 3 pressure ulcer. R2's Wound Report, dated 11/17/16, documents an unstageable pressure ulcer on her left lateral foot measuring 0.80 centimeters (cm) length and 1.5 cm width.	F 425		

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R2's Culture and Sensitivity Laboratory Form, dated 11/17/16, documents R2 has heavy growth of Proteus Mirabilis in her left lateral foot wound.

R2's Physician Order Sheet (POS), dated 11/17/16, documents the order by Z3, Nurse Practitioner for Z4, R2's Primary Physician, to discontinue Cipro (an antibiotic that was ordered by Z2, Wound Physician). R2's POS, dated 11/18/16, documents an order from Z3 for Ertapenem (an antibiotic) 1 gram (GM) intramuscularly (IM) once daily for 14 days.

R2's Physician Progress Note, dated 11/18/16, documents R2's wound culture results from her foot as heavy proteus mirabilis. The Note also documents, "We will begin Ertapenem 1 Gram daily for 14 days due to poor absorption and deconditioning."

R2's Nurses Note, dated 11/20/16, documents a call was received from pharmacy stating Ertapenem is not available in the back up pharmacy and medication will be available tomorrow through regular pharmacy.

R2's Nurses Note, dated 11/20/16, documents that Z5, Nurse Practitioner for Z4, was notified the Ertapenem was not available until 11/21/16. There is no documentation that Z2, Wound Physician, was ever notified that there was a change in antibiotics or that R2 was not receiving any antibiotics for the infection of the pressure ulcer since 11/17/16. There is no documentation that Z3, who originally ordered the Ertapenem, was notified that it was not available.

R2's 11/2016 Medication Administration Record

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(MAR) documents R2 did not receive Ertapenem 1 GM daily from 11/18/16 to 11/22/16 due to not available until 11/21/16. R2's 11/2016 MAR has no documentation that R2 ever received Ertapenem. R2's 11/2016 MAR has no documentation that R2 received any antibiotic since 11/17/16.

R2's Nurses Note, dated 11/22/16 documents R2 was sent out to the hospital.

In an interview on 11/30/16 at 10:48 AM, E7, Licensed Practical Nurse (LPN), stated, "I don't remember the date, but I faxed the order off. The medication was to begin on the evening shift. I didn't know anything about the pharmacy not having the medication."

In an interview on 11/30/16 at 2:00 PM, E6, Minimum Data Set Coordinator, stated "(R2) had Cipro on the 18th, and she was suppose to start Ertapenem on the 19th. (Z5) was notified the medication was not available."

The facility Medication Administration policy, dated 6/2015, documents, in part, "If the medication is not given as ordered, document the reason on the medication administration record, and notify the health care provider."