VERMONT

AGENCY OF HUMAN SERVICES

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

January 29, 2019

Ms. Chrystal Locke, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Locke:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **January 3, 2019**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 An unannounced onsite investigation into multiple self-reported incidents was conducted by the Division of Licensing and Protection on 1/2/19 to 1/3/19. The following regulatory violations were identified.	F 000	St Johnsbury Health & Rehab provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The Plan of Correction is prepared and executed solely because it is required by federal and state law.	
F 600 SS=E	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure that residents were free from abuse for 2 of 5 residents (Residents #3, #5). Findings include: Per record review, Resident #3 was admitted at the same time as their spouse (Resident #4) in September 2018, and were sharing a room. Toward the end of October, there arose a concern about safety of the couple rooming together. Resident #3 has progressing dementia and began to not recognize their spouse and	F 600	F600 –Resident #3 care plan was reviewed and revised to reflect protection from abuse. An audit was conducted to ensure residents who may be exposed to similar situations were also reviewed and care plans were revised as needed. Resident #5 was moved to another room at the time of the report and Social Service support was provided. Education for staff regarding abuse, neglect, & exploitation was provided. CNE or designee will audit residents at risk for abuse care plans to ensure appropriate interventions are in place as needed. This will be reviewed weekly x4 and monthly x3.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: CEO | (X6) DATE: 1/25/19

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

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F 600	Continued From page 1 expressed fear and anxiety that there was a stranger in the room. Resident # 3 was moved to another room on the unit shared with Resident #5. 1. On 11/1/18, the facility reported an incident where Resident #4 went to the spouse's new room, and was yelling to try and wake them kicking their feet. Resident #4 was physically banging the walker into and running over their feet to rouse them. Staff intervened and Resident # 4 left the room. This was reported to the state agency as required. 2. On 12/4/18, the facility reported an incident that the married residents were in the hallway, and Resident #3 stated that they wanted to go back to their room. Resident #4 grabbed the spouse's arm and kicked the walker, pulling Resident #3 toward him/her. Staff intervened and brought Resident #3 to their room. Resident #4 followed them to the room and sat on the bed, but then was attempting to move the recliner that Resident #3 was sitting in and shook their walker and yelled at the spouse. Staff directed Resident #4 out of the room. 3. On 12/19/18, per review of documentation as well as a telephone interview with now discharged Resident #5 (the roommate of Resident #3), they had reported to staff that between 2:00 PM and 8:00 PM that day that Resident #4 had repeatedly entered the room and yelled at their spouse to wake up. After supper, Resident #4 entered the room, was yelling profanities and rummaging through the belongings of both residents. Resident #4 was attempting to change the spouse's clothing, took away a drink from them, and continued to yell. Resident #5 activated the call bell and told Resident #4 to stop. Resident #4	F 600	Findings will be reviewed at QAPI & recommendations will be made as needed. Date of compliance on or before January 30, 2019 F600 POC accepted 1/28/19 GColemanRN/PMC	

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F 600	Continued From page 2	F 600		

then slammed the room door and continued to yell and act angry toward their spouse. Resident #5 stated that they yelled for help as well, but that it was at least 15- 20 minutes before staff came to the room to intervene. Resident #5 stated that they were afraid for themselves, but even more for Resident #3 who was the focus of the aggression. Resident #5 was moved to another room after this incident, however they stated that they did not really want to leave as they wanted to protect Resident #3 from their spouse. Resident #5 said that they were very upset and afraid of Resident #4, but needed to move out as they were trying to get well and go home.
Per review of the incident report, this was not reported to administration until the following day. (refer to citation at F609).

4. During this onsite investigation on 1/3/19, a 4th incident was reported that occurred on 12/29/18. Per the facility report, Resident #4 was in Resident #3's room, and staff heard yelling coming from the room. Per staff witnesses, Resident #4 was yelling, "That's it, I never want to see you again, I'm leaving". The staff witnessed Resident #4 shaking a fist at Resident #3. When the staff told the resident that it wasn't nice to speak to their spouse that way, Resident #4 stated that they could treat their spouse any way they wanted to. Staff positioned themselves between the two residents, and Resident #4 was pushing them to try to get to Resident #3. Staff were able to get Resident #4 out of the room, and Resident #3 then said to the staff " I hope s/he did not hurt you", and was crying and appeared to be afraid. After they directed Resident#4 out of the spouse's room, they were going into other resident's rooms, yelling and saying to another resident that " I am leaving, this is goodbye". The

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F 600	Continued From page 3 nurse ended up calling the police, and Resident #4 was escorted by them and EMS to the local Emergency room, and returned later that day. Per interview on 1/3/19 at 11:05 AM, the Director of Nursing confirmed that these four incidents had occurred, and that Resident #4 had not been supervised closely enough to prevent them.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609	F609 – Resident #3 care plan was reviewed and revised to reflect protection from abuse. An audit was conducted to ensure residents who may be exposed to similar situations were also reviewed and care plans were revised as needed. Resident #5 was moved to another room at the time of the report and Social Service support was provided. Education for staff regarding timely reporting of abuse, neglect, & exploitation was provided. CNE or designee will audit residents at risk for abuse care plans to ensure appropriate interventions are in place as needed. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will	

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F 609	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to report an allegation of abuse both internally to administration and to the required state agencies in a timely manner for 2 of 2 residents(Resident #3, #5). Findings include: Per record review and resident interview, an incident on the evening of 12/19/18 was not reported to administration per facility policy until the following day when the resident told the Social Services staff what had happened. On 12/19/18, per review of documentation as well as a telephone interview with now discharged Resident #5 (the roommate of Resident #3), they had reported to staff that between 2:00 PM and 8:00 PM that day that Resident #4 had repeatedly entered the room and yelled at their spouse to wake up. After supper, Resident #4 entered the room, was yelling profanities and rummaging through the belongings of both residents. Resident #4 was attempting to change the spouse's clothing, took away a drink from them, and continued to yell. Resident #5 activated the call bell and told Resident #4 to stop. Resident #4 then slammed the room door and continued to yell and act angry toward their spouse. Resident #5 stated that they yelled for help as well, but that it was at least 15- 20 minutes before staff came to the room to intervene. Resident #5 stated that they were afraid for themselves, but even more for Resident #3 who was the focus of the aggression. Resident #5 was moved to another room after this incident, however they stated that they did not really want to leave as they wanted to protect Resident #3 from their spouse. Resident #5 said that they were very upset and afraid of Resident #4, but needed to move out as they	F 609	be made as needed. Date of compliance on or before January 30, 2019 F609 POC accepted 1/28/19 GColemanRN/PMC	

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F 609	Continued From page 5 were trying to get well and go home. There were no nursing notes in the medical record to indicate that staff instituted measures to protect the residents from further abuse or contacted their supervisors. Per interview on 1/3/19 at 10:40 AM, the Director of Nursing (DNS) confirmed that this was not reported to the administrative staff until the following day when Resident #5 spoke to the social worker, and that the facility policy states that nursing was supposed to call the DNS or Administrator at home if they were not in the building and report the incident at the time of occurrence.	F 609		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656	F656 – Resident #3 care plan was reviewed, and appropriate care plan interventions were put into place to prevent abuse. An audit was conducted to ensure residents who may be exposed to similar situations were also reviewed and care plans were revised as needed. Resident #4 record was reviewed, and the appropriate care plan interventions were put into place to provide abuse protection for resident #3. An audit was conducted to ensure residents who may be exposed to similar situations were also reviewed and care plans were revised as needed. A review of resident #1 MAR and orders was completed. Resident #1 was transferred to the hospital for medical treatment. A review of resident #2 MAR & orders was completed, and care plans were put into place to	

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F 656	Continued From page 6 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to develop/implement a care plan that included services to be furnished to attain or maintain the highest practicable physical, mental, and psychosocial well-being for 4 of 5 residents reviewed (Residents #1, #2, #3, #4). Findings include: 1. Per record review, Resident #4 had multiple incidents of being verbally and physically abusive to their spouse, and was seeking them out frequently. The interactions between them was sometimes pleasant and not a concern, however at times had quickly escalated to yelling or physical abuse toward the spouse. One incident happened in the hallway, and three others in Resident #3's room without staff present. Per review of the resident's plan of care, There were	F 656	reflect appropriate diagnosis and management of the chemotherapeutic medication. Education for staff was provided regarding writing appropriate comprehensive care plans. CNE or designee will audit care plans to ensure appropriate interventions are in place to provide psychosocial support, abuse prevention, and diagnosis & management of chemotherapeutic medications. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Date of compliance on or before January 30, 2019 F656 POC accepted 1/28/19 GColeman RN/PMC	

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F 656	Continued From page 7	F 656		

interventions dated 12/7/18 that addressed the resident's behaviors, including visiting their spouse in supervised, visible locations. Despite four instances of altercations between them in December 2018 , the care plan was not further developed since 12/7/18 to add measures for protecting the spouse, and the care plan was not implemented for the existing intervention of encouraging visits in supervised visible locations.

2. Per record review, Resident #3 has dementia, and was admitted to the facility in September 2018, at the same time as their spouse, and they started out as roommates. Resident #3 began to have episodes of not recognizing the spouse, and becoming afraid that there was a stranger in their room. The decision was made to place them into separate rooms at the end of October 2018. Resident #4 was frequently seeking out Resident #3, and often would go to their room to visit. On 11/1/18, Resident #4 was found in Resident #3's room, yelling at them to wake up, kicking at their feet and running into them with a walker. In December 2018, there were three incidents of Resident #4 becoming verbally and physically abusive towards Resident #3, once in the hallway and twice in their room. There was documentation by staff that Resident #3 expressed fear of their spouse, sometimes visibly upset and crying when Resident #4 was angry and acting out. There was also observations and record review that the married couple enjoyed spending time together, visiting at meals, or sitting together reading the paper in the living room for example. Per review of Resident #3's plan of care, there was no care plan developed that addressed the psychosocial impact of the abusive behavior of the spouse,and did not include interventions to protect Resident#3 from

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F 656	Continued From page 8 potential abuse. Per interview on 1/3/19 at 1:15 PM, the Director of Nursing confirmed that there was not a plan of care developed prior to 1/3/19 for Resident #3 that addressed the psychosocial impact of them being the recipient of abusive behavior from their spouse, and interventions that provided safe and supervised opportunities for socialization. The DNS also confirmed that Resident #4 did not have any updates with added interventions to the plan of care after 12/20/18, despite recurring abusive episodes toward their spouse after that date, and that supervision was not consistently provided for visitation in visible locations. 3. Per medical record review, 2 residents have rheumatoid arthritis included on their problem lists. (Resident #1 and Resident # 2). Both are receiving Methotrexate for this. Neither resident has a care plan that has been developed to reflect this diagnosis or how to manage these residents or the side effects to monitor for someone receiving a chemotherapeutic agent. Resident # 1 was administered 7 extra days of the medication that is ordered to be given weekly. This is confirmed by the unit manager and the nurse during interview on both days of the investigation.	F 656		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 658		

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F 658	Continued From page 9 Based on staff and pharmacist interviews and medical record review, the facility failed to meet professional standards of quality for 1 of 2 residents in an applicable sample regarding failing to follow physician's orders. (Resident #1 and #2). Findings include: Per medical record review, Resident # 1 was incorrectly administered Methotrexate during an admission to the facility for short term rehab following hip surgery. During this admission, Resident # 1 had a physician order to continue taking methotrexate (an oral chemotherapeutic agent, also used to treat RA (Rheumatoid Arthritis)) twice a day on Wednesdays. The physician order was written as "Methotrexate Tablet 2.5 mg. Give 4 tablets by mouth in the morning for RA and give 4 tablets by mouth in the evening every Wed for RA." This order was transcribed by a registered nurse onto the Medication Administration Record (MAR) on 2 separate lines to reflect 4 tablets on Wednesday evenings (12/12/2018 and 12/19/2018), and 4 tablets on days. Resident # 1 received 4 pills on the day shift on 12/13, 12/14, 12/15, 12/16, 12/17, 12/18 and 12/20 that were not ordered by the rheumatologist. On 12/21/2018 a nurse called the pharmacy to request more pills "because they would not have enough to get them through the weekend." Resident # 1 experienced a significant drop in his/her blood counts to critical levels for hemoglobin, hematocrit, white cell count and platelets: 12/08/2018 labs revealed a white cell count of 12.92, a hemoglobin of 9.4, a hematocrit of 30.1 and platelets of 165x1000. Labs ordered and drawn on 12/23/2018, after the additional methotrexate doses, revealed a white cell count	F 658	F658 – A review of resident #1 MAR and orders was completed. Pharmacy conducted Med Error training and Med Pass reviews. Resident #1 was transferred to the hospital for medical treatment. Education for staff was provided regarding professional standards of care. CNE or designee will audit MARs to ensure proper professional standards of care are followed. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Date of compliance on or before January 30, 2019 F658 POC accepted 1/29/19 GColemanRN/PMC	

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F 658	Continued From page 10 of 1.9, a hemoglobin of 6.8, a hematocrit of 26.6 and platelets of 62. Resident # 1 experienced bleeding from the lining of the stomach, hospitalization in the intensive care unit and intubation for respiratory distress. The pharmacist confirmed, during interview that s/he had dispensed 32 tablets to cover a 4 week span (8 tablets /day 1 time per week). The nurse confirmed, during interview that 7 extra doses of the medication were administered because of a transcription error. The nurse further confirmed, that facility policy of having a second nurse verify the orders did not happen. Cross cite at: F0760 Ref: Lippincott Manual of Nursing Practice (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins, pg 17.	F 658		
F 741 SS=F	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with §483.70(e). These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:	F 741		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 01/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 741	Continued From page 11 §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e), and [as linked to history of trauma and/or post-traumatic stress disorder, will be implemented beginning November 28, 2019 (Phase 3)]. §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure sufficient staffing to provide direct services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident for 3 of 5 residents (Residents #3, #4, and #5). Findings include: 1. Per review of resident to resident incidents between Resident # 3, #4, and #5, there was a lack of supervision and timely response to call bells to prevent abuse by Resident #4 toward others. Per interview with Resident #5, during an abusive episode by Resident #4 toward their spouse, the staff did not respond in a timely manner to yelling coming from the room, including Resident #5's calls for help. Resident #5 also stated that it took 15- 20 minutes after they activated the call bell for staff to come to the room and intervene. Per interview with nursing staff on this unit, the level of acuity is very high on the unit, and they do not have enough staff to consistently supervise Resident #4 to monitor the	F 741	F741 – A review of staffing levels and census was conducted. Resident #3 & #4 care plans were reviewed and revised to provide appropriate interventions for abuse prevention. Resident #5 was moved to another room and provided with support from Social Services. Education for staff was provided regarding F741 staffing guideline regulations to provide sufficient services. CED or designee will audit the staffing levels as needed. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Date of compliance on or before January 30, 2019 F741 POC accepted 1/28/19 GColemanRN/PMC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 741	Continued From page 12 interactions and know when Resident #4 has entered Resident #3's room. There were statements from multiple nursing staff that indicated they were working a lot of overtime hours, many 16 hour double shifts, and that it was difficult to keep up with the unit's frequent admissions and high acuity with the current staffing levels.	F 741		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff and pharmacist interviews and medical record reviews, the facility failed to assure that 1 of 2 residents in an applicable sample (Resident # 1) was free from significant medication errors. Findings include: Per medical record review, Resident # 1 was incorrectly administered Methotrexate during an admission to the facility for short term rehab following hip surgery. During this admission, Resident # 1 had a physician order to continue taking methotrexate (an oral chemotherapeutic agent, also used to treat RA (Rheumatoid Arthritis) twice a day on Wednesdays. The physician order was written as "Methotrexate Tablet 2.5 mg. Give 4 tablets by mouth in the morning for RA and give 4 tablets by mouth in the evening every Wed for RA." This order was transcribed by a registered nurse onto the Medication Administration Record (MAR) on 2 separate lines to reflect 4 tablets on Wednesday evenings (12/12/2018 and 12/19/2018), and 4	F 760	F760 – A review of resident #1 MAR and orders was completed. Pharmacy conducted Med Error training and Med Pass reviews. Resident #1 was transferred to the hospital for medical treatment. Education for staff was provided regarding Medication and Transcription errors. CNE or designee will audit MARs to ensure proper professional standards of care are followed. This will be reviewed weekly x4 and monthly x3. Findings will be reviewed at QAPI & recommendations will be made as needed. Date of compliance on or before January 30, 2019	

F760 POC accepted 1/28/19 GColemanRN/PMC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 760	Continued From page 13	F 760		

tablets on days. Resident # 1 received 4 pills on the day shift on 12/13, 12/14, 12/15, 12/16, 12/17, 12/18 and 12/20 that were not ordered by the rheumatologist. On 12/21/2018 a nurse called the pharmacy to request more pills "because they would not have enough to get them through the weekend."

Resident # 1 experienced a significant drop in his/her blood counts to critical levels for hemoglobin, hematocrit, white cell count and platelets: 12/08/2018 labs revealed a white cell count of 12.92, a hemoglobin of 9.4, a hematocrit of 30.1 and platelets of 165x1000. Labs ordered and drawn on 12/23/2018, after the additional methotrexate doses, revealed a white cell count of 1.9, a hemoglobin of 6.8, a hematocrit of 26.6 and platelets of 62. Resident # 1 experienced bleeding from the lining of the stomach, hospitalization in the intensive care unit and intubation for respiratory distress.

The pharmacist confirmed, during interview that s/he had dispensed 32 tablets to cover a 4 week span (8 tablets /day 1 time per week). The nurse confirmed, during interview that 7 extra doses of the medication were administered because of a transcription error. The nurse further confirmed, that facility policy of having a second nurse verify the orders did not happen.

Cross cite at F0658