STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155255	A. BUILDING 00 B. WING	03/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WOODVIEW A WATERS COMMUNITY	3420 EAST STATE BLVD FORT WAYNE, IN 46805

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00286137, IN00288099, and IN00288978. Complaint IN00286137 - Substantiated. No deficiences related to the allegation are cited. Complaint IN00288099 - Substantiated. Federal/State deficiencies related to the allegations are cited at F656, F659, F693, and F760. Complaint IN00288978 - Substantiated. Federal/State deficiencies related to the allegation are cited at F659. Survey dates: March 11, 12, 13, and 14, 2019 Facility number: 000158 Provider number: 155255 AIM number: 100291490 Census Bed Type: SNF/NF: 50 SNF: 26 Total: 76 Census Payor Type: Medicare: 4 Medicaid: 63 Other: 9 Total: 76 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 18, 2019.	F 0000	**Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by the facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/ or executed in compliance with state and federal laws.**	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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 0656 SS=D Bldg. 00	483.21(b)(1) Develop/Implement Comprehensive Care Plan §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 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			

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	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. Based on observation, interview, and record review, the facility failed to develop a care plan for 1 of 3 resident's reviewed for care plans (Resident G). Findings include: On 3/12/19 at 12:04 P.M., Resident G's record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, depression, anxiety disorder, and intractable, chronic, recurrent tension-type headaches. An admission MDS (Minimum Data Set) assessment, dated 12/7/18, did not assess the resident's cognition or mood. During the assessment, he rejected care 1-3 days. He indicated he had moderate, constant, daily pain which limited his day to day activities. A Pain CAA (Care Area Assessment), dated 12/13/18, indicated the resident was alert and oriented with periods of confusion. He had chronic headaches and rated his pain a 10/10 on the pain scale. He had received scheduled Tramadol (pain medication used to treat acute moderate pain) and had a Lidocaine patch (a topical anesthetic used to "numb" an area) prescribed. The CAA indicated Resident G's pain would be addressed in the care plan. On 3/12/19 at 11:50 A.M., Resident G was observed sitting on the side of his bed in his room. The residents room was located on the memory care unit and faced the dining/activity	F 0656	**Element #1** Resident's G Care pain care plan was updated with non-pharmacological interventions put into place to address his constant pain. **Element #2** The facility evaluated all residents for pain, identified residents experiencing pain; evaluated the existing pain and the causes (s). Determine the type and severity of the pain; and develop a care plan for pain management consistent with the comprehensive care plan and the resident's goal and preference. **Element #3** The policy titled "Pain Management" was reviewed and updated on March 26, 2019 by the QAPI committee. All staff will be in serviced regarding pain management to include but not limited to, evaluation for the presence of pain, evaluation of pain, development of pain and Development of individuated care plan, execution of the care plan and regular re-evaluation. Licensed Nurses will perform pain management audits X7 days weekly, with immediate interventions put in place per	03/18/2019

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	room. A jukebox was located outside his door which was playing loud music. He indicated he was in severe pain and explained that he had experienced unrelenting headaches for "18" years. He indicated the pain was in the back of his head and spread over the top to his forehead. He indicated he had received several treatments over the years to try and help with the pain but he always had it. He had a tattered, folded piece of paper that had the name and number of a pain clinic that he had asked staff to call to schedule him an appointment. He indicated he had been given injections "into the occipital nerve" in the past which had been effective in relieving some of his head pain. On 3/12/19 from 3:09 P.M. - 4:00 P.M., the resident was observed and interviewed. During the observation and interview, the resident was seated in a wheelchair at the nurses station. He was very agitated and raised his voice at times. He had tremors in both arms while at rest and with movement. He alternated between being articulate and insightful to periods of crying, holding his head, and running his hands repeatedly through his hair. He complained of severe pain in his head and the need to see a doctor. He requested an injection like he'd had before at the VA (Veterans Administration) Medical Center. He indicated the medication the staff gave him did not help his headaches so he didn't see the need to take it and continued to request he be sent to the hospital for pain relief. Pain assessments indicated the following: 12/3/18 at 1:26 p.m., the resident indicated he had frequent pain over the last 5 days. The pain was "moderate" and made it difficult to participate in daily activities. He indicated the pain was chronic		policy and procedure. The Director of Nursing will complete Weekly Random audits X3 Months to ensure compliance and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for review and recommendations of compliance. **Element #4** The facility held a Ad Hoc quality assurance Committee/Four Point Plan of Correction meeting on March 15, 2019, to address the opportunity for improvement in regards to development of residents care plans in regards to pain, and implementations of non-pharmacological interventions put in place to address pain. The Director of Nursing will complete Weekly Random audits X6 Months to ensure a minimum of 90% compliance is maintained and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for 6 months for review and recommendations of compliance. All audits will be provided to the Administrator, reviewed by QAPI monthly. If continued non-compliance noted, QAPI committee will re-evaluate, immediate education to staff will be completed, and auditing will continue until a min. of 90% substantial compliance achieved for 6 consecutive months.	

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	and he'd had it most of his life. He received routine and as needed pain medications. Pain management recommendations were the resident had satisfactory pain management and to continue with the current care plan. 1/17/19 at 1:44 a.m., Resident G complained of constant pain over the last 5 days which interfered with his sleep, moods, and ability to participate in daily activities. He rated his pain as an 8 out 10 with 10 being the worst pain ever. The pain was at the back of his head and over the top of his scalp. He indicated the pain was constant and the pain medications he received were not effective. Pain management recommendations were the resident had satisfactory pain management and to continue with the current care plan. 1/30/19 at 12:55 p.m., the resident indicated he had frequent pain over the last 5 days. The pain was "moderate" but didn't affect his sleep or ability to participate in daily activities. He indicated the pain was over the top of his scalp. He had frequent headaches which was not a new occurrence. He's had the headache for "8" years and has a diagnosis of dementia. Pain management recommendations were the resident had satisfactory pain management and to continue with the current care plan. 2/8/19 at 10:50 a.m., Resident G complained of constant pain over the last 5 days which interfered with his sleep, moods, and ability to participate in daily activities. The pain was very severe and horrible! He indicated the pain was over the top of his scalp and his left rib area due to recently diagnosed rib fractures. He received routine and as needed pain medications. Pain management recommendations were the resident		**Element #5** Date of Compliance: 3/18/2019	

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	had satisfactory pain management and to continue with the current care plan. Nurse Progress Notes indicated the resident complained of headache pain on the following days: 12/3/18, 12/4, 12/5, 12/6. 12/7, 12/10, 12/19, 12/26, 12/28, 1/18/19, 1/21, 2/8, 2/20, 2/27, 3/8, 3/9, 3/12, and 3/13/19. A Psychological NP (Nurse Practitioner) Progress Note, dated 2/22/19 at unknown time, indicated the resident was seen for increased agitation and anxiety. The note indicated the resident was anxious and was very focused on his pain. New orders were given to increase his anti-anxiety medication. A Psychological NP Progress Note, dated 3/8/19 at unknown time, indicated the resident was seen following a stay at a behavioral unit hospital from 2/27/19 - 3/8/19. The resident had several medications discontinued during his hospital stay. During the visit, the resident was anxious, agitated, and complained of pain. He stated "I hurt so bad in my head, do you want me to die" and "I might as well die". The physician at the behavioral unit hospital was contacted due to the resident's complaint of severe pain in his head. He requested an injection to his occipital nerve to block the pain or some other form of "anesthesia". The physician approved an order for Tramadol for the resident and indicated he had been trying to remove all the pain medications because they were not effective and the resident had continued to complain of pain. On 3/12/19 at 4:05 P.M., the Unit Manager who was an LPN (Licensed Practical Nurse) was interviewed. During the interview, she indicated she was aware the resident had headaches which			

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	he complained of daily. He was prescribed routine pain medication in addition to as needed medications but would often refuse them because he indicated they didn't help. She also indicated Resident G was alert and interviewable. There was no care plan developed to address the resident's constant pain. There were no non-pharmacological interventions put into place to address his constant pain. On 3/14/19 at 11:35 A.M., the DON (Director of Nursing) was interviewed. During the interview, she indicated the facility did not have a policy to address pain management. She indicated the NP and nursing staff had focused on the resident's behaviors rather than his complaints of pain. The DON also indicated Resident G should have had a care plan developed to address his complaints of pain. This Federal tag relates to Complaint IN00288099 3.1-35(a)			
F 0659 SS=D Bldg. 00	483.21(b)(3)(ii) Qualified Persons §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to follow physician orders for 3 of 3 residents reviewed with physician orders (Resident E, Resident G, and Resident L). Findings include:	F 0659	**Element #1** Residents E Medications identified as missing per physician orders were immediately address by contacting the residents primary care physician no new order were	03/18/2019

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	1. On 3/11/19 at 2:54 P.M., Resident E's record was reviewed. Diagnoses included, but were not limited to, chronic pain and dependence on narcotic usage. A Physician order, with unknown start date, was for Suboxone 8-2 mg (milligrams) (Buprenorphine HCL-Naloxone HCL) - give 1 film sublingually 2 times a day related to pain. Suboxone is a prescription medicine used to treat adults who are dependent on opioid drugs. The medication was to be taken exactly as prescribed by the physician. Suboxone was not to be stopped suddenly as the patient could become sick and have withdrawal symptoms. (FDA-Federal Drug Administration website - retrieved on 3/13/19). Review of the MAR's (Medication Administration Record) and Controlled Drug Use Records indicated the following: January 2019 MAR: 1/31/19 - Suboxone was not administered at 8:00 p.m. February 2019 MAR: Suboxone was not administered as ordered on 2/1/19 at 8:00 p.m., 2/4/19 at 8:00 a.m., and 2/7/19 at 8:00 p.m. March 2019 MAR: Suboxone was not administered as ordered on 3/4/19 at 8:00 a.m. and 3/5/19 at 8:00 a.m. On 3/12/19 at 10:15 A.M., the physician (MD) that prescribed the Suboxone was interviewed. During the interview, the MD indicated concern that the medication had not been re-ordered sooner than it was and expressed concern the resident hadn't		given. Resident G Medications identified as missing per physician orders were immediately address by contacting the residents primary care physician no new order were given. Residents L Medications identified as missing per physician orders were immediately address by contacting the residents primary care physician no new order were given. **Element #2** The facility Audited all residents to ensure physician orders were followed. No further issues have been identified. **Element #3** The policy titled “Physician Orders” was reviewed and updated on March 26, 2019 by the QAPI committee. All staff will be in serviced regarding physician orders, to ensure clear direction regarding the care of each resident. Licensed Nurses will perform pain management audits X7 days weekly, with immediate interventions put in place per policy and procedure. The Director of Nursing will complete Weekly Random audits X3 Months to ensure compliance and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for review and recommendations of compliance. **Element #4**	

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	received the medication as prescribed. The MD had not been made aware that the resident had been hospitalized several times since his last visit. The MD was notified the resident missed 6 doses in the last 3 months that couldn't be attributed to hospitalizations. The MD indicated the doses that were missed, would not cause the resident to become sick or have withdrawal symptoms, however, the resident should not have missed any doses. 2. On 3/12/19 at 12:04 P.M., Resident G's record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, depression, anxiety disorder, and intractable, chronic, recurrent tension-type headaches. A Physician order, dated 1/28/19 at 11:42 a.m., indicated blood work was to be completed. the blood work included, a lipid panel (cholesterol), vitamin D, and A1C (blood sugars). The orders were faxed to the facility and were ordered by the resident's primary care physician at the VA Medical Center. There were no completed labs found on the electronic or written medical record. On 3/12/19 at 4:05 P.M., the Unit Manager was interviewed. During the interview, she indicated she was not aware that the resident had orders for blood work to be done in January. She indicated it was her belief that the faxed orders were inadvertently put onto the resident's written chart before she had seen them. She indicated the resident did not have lab work completed for a lipid panel, vitamin D or A1C as ordered, but should have had the labs completed. 3. On 3/13/19 at 3:42 P.M., Resident L's record was reviewed. Diagnoses included, but were not limited to, aphasia following cerebral infarction		The facility held a Ad Hoc quality assurance Committee/Four Point Plan of Correction meeting on March 15, 2019, to address the opportunity for improvement in regards to failure to following physician orders. The Director of Nursing will complete Weekly Random audits X6 Months to ensure a min of 90% compliance is maintained and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for 6 months review and recommendations of compliance.All audits will be provided to the Administrator, reviewed by QAPI monthly. If continued non-compliance noted, QAPI committee will re-evaluate, immediate education to staff will be completed, and auditing will continue until a min. of 90% substantial compliance achieved for 6 consecutive months. **Element #5** Date Of Compliance: 3/18/2019	

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	(stroke), tracheostomy, diabetes, and metabolic encephalopathy. A Physician order, dated 2/22/19 at 6:10 a.m., indicated the resident was to have blood work done to check his CBC (complete blood count), UA (urinalysis), BMP (basic metabolic profile), and a chest x-ray. A chest x-ray was found to have been completed. There were no CBC, UA, or BMP results found in the resident's electronic or written record. On 3/14/19 at 12:06 P.M., the Unit Manager was interviewed. She indicated she was not able to find any lab results for Resident L's CBC, UA, or BMP ordered on 2/22/19 and believed they had not been obtained as ordered. This Federal tag relates to Complaints IN00288099 and IN00288978. 3.1-35(g)(2)			
F 0693 SS=G Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			

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	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview, and record review, the facility failed to provide tube feedings as ordered by the physician for 1 of 1 residents reviewed for tube feedings (Resident L). This resulted in significant weight loss for Resident L. Findings include: On 3/13/19 at 3:42 P.M., Resident L's record was reviewed. Diagnoses included, but were not limited to, aphasia following cerebral infarction (stroke), tracheostomy, diabetes, and metabolic encephalopathy. A admission MDS (Minimum Data Set) assessment, dated 2/18/19, indicated the resident's cognition was not tested due to his inability to speak. The resident was dependent with all ADL's (activities of daily living). He swallowed nothing by mouth and had a tube feeding which was to run continuously. His weight was 158 pounds. On 3/13/19 from 1:38 P.M. - 2:50 P.M., Resident L was observed sitting up in his w/c in his room next to his bed. His call light was observed on the other side of the bed and was clipped on the top of the room curtain divider. He was well groomed and had a tracheostomy covered by an oxygen mask. The resident was alert and appeared to understand conversation as evidenced by nods, smiles, direct eye contact, and attempts to	F 0693	**Element #1-** Resident L's, primary care physician and registered Dietitian were consulted regarding tube feeding not being provided as ordered, new orders were provided. **Element #2** The facility Audited all residents to ensure tube feeding order are were followed. No further issues have been identified. **Element #3** The policy titled " Medical Nutrition Therapy" was reviewed and updated on March 26, 2019 by the QAPI committee. Nursing and appropriate disciplinary team staff will be in serviced regarding tube feeding management. Nurse managers will perform tube feeding weekly random audits X5, with immediate interventions put in place per policy and procedure. The Director of Nursing will complete Weekly Random audits X3 Months to ensure compliance and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for	03/18/2019

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	articulate words. The resident's tube feeding pump machine was observed off during the entire observation period and he did not receive any fluids or enteral tube feeding. A 1000 ml (milliliter) bag of water, with approximately 850 ml's of water present, was hanging on an IV pole and was attached to tubing that ran from a 1200 ml full bottle of enteral feeding labeled as Glucerna 1.2 calorie liquid supplement. Written on the label of the bottle was a date of "3/13/19, opened at 9:30 a.m.". Tubing from the enteral bottle had liquid in it with multiple air bubbles and extended from the bottom of the enteral bottle into the feeding machine. Resident L's family member was present on 3/13/19 at 1:38 P.M. They expressed several care concerns including, but not limited to, the resident's gastric tube feeding. She indicated the resident had been noted, on several occasions, to not have his gastric tube feed running. The family member indicated the resident's tube feeding was to be continuous and around the clock because the resident was not able to eat anything. She indicated the resident had lost a significant amount of weight since admission to the facility. The family member expressed concern that the resident hadn't received any tube feeding since 9:30 a.m. On 3/13/19 at 2:54 P.M., the DON (Director of Nursing) was notified of the resident's gastric tube feeding not being turned on and that it had been observed off since 1:38 p.m. She entered the resident's room and indicated the tube feeding machine was turned off but should have been on as the resident was to receive continuous tube feedings. She summoned a nurse (LPN 5) to the room to restart the resident's feeding.		review and recommendations of compliance. **Element #4** The facility held a Ad Hoc quality assurance Committee/Four Point Plan of Correction meeting on March 15, 2019, to address the opportunity for improvement in regards to medical nutrition therapy related to tube feeding. The Director of Nursing will complete Weekly Random audits X6 Months to ensure a min of 90% compliance is maintained and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for review and recommendations of compliance. All audits will be provided to the Administrator, reviewed by QAPI monthly or 6 months. If continued non-compliance noted, QAPI committee will re-evaluate, immediate education to staff will be completed, and auditing will continue until a min of 90% substantial compliance achieved for 6 consecutive months. **Element #5** Date of Compliance: March 18, 2019	

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	155255	A. BUILDING 00 B. WING	03/14/2019

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	On 3/13/19 at 3:02 P.M., the DON was interviewed. During the interview, she indicated she had spoken with the Rehabilitation Therapist to see if the resident had just received treatment and perhaps the tube feeding had yet to be restarted. The therapist indicated to her that the resident's tube feeding was not on or hooked up to the machine when he received his therapy treatments. On 3/13/19 at 3:50 P.M., Resident L was observed lying in bed with his gastric tube feeding machine on and running at 60 ml's per hour. The Glucerna 1.2 calorie supplement had approximately 1150 ml's in the bottle. On 3/13/19 at 3:52 P.M., LPN (Licensed Practical Nurse) 5 was interviewed. During the interview, she indicated she had reattached the resident's tube feeding after he was assisted to bed. She indicated the bottle of Glucerna had been full at 1200 ml before starting his feeding. The bottle stated it had been opened and hung on 3/13/19 at 9:30 a.m. however, the bottle was full and the machine had not been turned on when she had been asked to restart the residents feeding. Review of the resident's weights indicated the following: 2/11/19 - 158.3 3/4/19 - 159.4 3/7/19 at 12:51 p.m. - 132.0 3/7/19 at 2:05 p.m. - 132.0 3/14/19 - 134.2 A Physician order, dated 2/12/19 at unknown time, was for Glucerna 1.2 calorie liquid (Nutritional Supplement) - give 55 ml per hour by gastric tube every shift for enteral feeding.			

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	A Dietary progress note, dated 2/14/19 at 1:21 p.m., indicated the resident's current weight was 158.3. The resident was NPO (nothing by mouth) and received Glucerna 1.2 at 55 ml/hr continuously per tube feed. His estimated nutrient needs were: 1799-2015 calories per day which included 1.2-1.4 gm's (grams) of protein. He required 1799-2159 ml's of water. The resident had no pressure areas noted at the time but was at high risk of developing them. A recommendation was made to add 30 ml of ProStat sugar free 2 times per day for added protein and obtain weights on Mondays and Wednesdays. A Dietary progress note, dated 3/5/19 at 1:09 p.m., indicated the resident's current weight was 159.4. There were no changes or new recommendations made. A Physician order, dated 3/7/19 at unknown time, was to increase the Glucerna 1.2 calorie liquid (Nutritional Supplement) to 60 ml per hour by gastric tube every shift for enteral feeding related to the significant weight loss from 159.4 to 132. A review of the Medication and Treatment Administration records dated February and March 2019 did not indicate documentation of any tube feeding intakes. On 3/14/19 at 11:35 A.M., the DON indicated she was unable to find a facility policy regarding enteral nutrition and tube feedings. She indicated nurses were expected to follow the physician orders as written. She indicated there were no documents to indicate the amount of tube feeding infused. The resident's enteral feeding should have been administered continuously as ordered and intakes should hae been documented.			

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	This Federal tag relates to Complaint IN00288099. 3.1-44(a)(2)			
F 0760 SS=G Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to administer pain medications as ordered per the physician for 1 of 3 resident's reviewed for medication administration (Resident G). This resulted in Resident G experiencing unrelenting daily pain and aggressive behaviors which required hospitalization. Findings include: On 3/12/19 at 12:04 P.M., Resident G's record was reviewed. Diagnoses included, but were not limited to, dementia with behavioral disturbance, depression, anxiety disorder, and intractable, chronic, recurrent tension-type headaches. An admission MDS (Minimum Data Set) assessment, dated 12/7/18, did not assess the resident's cognition or mood. During the assessment, he rejected care 1-3 days. He indicated he had moderate, constant, daily pain which limited his day to day activities. A Pain CAA (Care Area Assessment), dated 12/13/18, indicated the resident was alert and oriented with periods of confusion. He had chronic headaches and rated his pain a 10/10 on the pain scale. He had received scheduled Tramadol (pain medication used to treat acute moderate pain) and had a Lidocaine patch (a	F 0760	**Element #1** Resident G's physician was contacted regarding the recommendations for Fioricet. Residents G's attending physician prescribed Fioricet 50/mg/325mg/40mg. The IDT team will monitor the residents response to this intervention. **Element #2** The facility Audited all residents to ensure physician orders were followed. No further issues have been identified. **Element #3** The policy titled "Physician Orders" was reviewed and updated on March 26, 2019 by the QAPI committee. All staff will be in serviced regarding physician orders, to ensure clear direction regarding the care of each resident. Licensed Nurses will perform pain management audits X7 days weekly, with immediate interventions put in place per policy and procedure. The Director of Nursing will complete Weekly Random audits X3 Months to ensure compliance and quarterly thereafter with patterns	03/18/2019

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	topical anesthetic used to "numb" an area) prescribed. The CAA indicated Resident G's pain would be addressed in the care plan. There was no care plan developed to address the resident's pain. On 3/12/19 at 11:50 A.M., Resident G was observed sitting on the side of his bed in his room. He appeared thin, poorly groomed, unshaven, and his hair was uncombed. He kept running his hands through his hair. On 3/12/19 at 11:50 A.M., Resident G indicated he was in severe pain and explained that he had experienced unrelenting headaches for "18" years. He indicated the pain was in the back of his head and spread over the top to his forehead. He indicated he had received several treatments over the years to try and help with the pain but he always had it. He had a tattered, folded piece of paper that had the name and number of a pain clinic that he had asked staff to call to schedule him an appointment. He indicated he had been given injections "into the occipital nerve" in the past which had been effective in relieving some of his head pain. He indicated staff would not call the number for him. On 3/12/19 from 3:09 P.M. - 4:00 P.M., the resident was observed and interviewed. During the observation and interview, the resident was seated in a wheelchair at the nurses station. He was very agitated and raised his voice at times. He had tremors in both arms while at rest and with movement. He alternated between being articulate and insightful to periods of crying, holding his head, and running his hands repeatedly through his hair. He complained of severe pain in his head and the need to see a doctor. He requested an injection like he'd had before at the VA (Veterans		and trends reported to the Quality assurance Committee for review and recommendations of compliance. **Element #4** The facility held a Ad Hoc quality assurance Committee/Four Point Plan of Correction meeting on March 15, 2019, to address the opportunity for improvement in regards to following physician orders. The Director of Nursing will complete Weekly Random audits X6 Months to ensure a min of 90% compliance is maintained and quarterly thereafter with patterns and trends reported to the Quality assurance Committee for review and recommendations of compliance.All audits will be provided to the Administrator, reviewed by QAPI monthly for a min of 6 months. If continued non-compliance noted, QAPI committee will re-evaluate, immediate education to staff will be completed, and auditing will continue until a min of 90% substantial compliance achieved for 6 consecutive months. **Element #5** March 18, 2019	

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	Administration) Medical Center. He indicated the medication the staff gave him did not help his headaches so he didn't see the need to take it and continued to request he be sent to the hospital for pain relief. A VA Medical Center progress note, dated 12/23/18 at 10:51 p.m., indicated the resident was seen for "Acute exacerbation of chronic muscle tension headaches". He was given a nerve block while in the emergency department which he tolerated well. The note indicated the resident was to be given 2 Fiorcet (pain medication used to treat tension headache, migraine and mild to moderate pain especially when antianxiety or relaxant effects are needed-retrieved from the mobile PDR [Physician Desktop Reference] on 3/12/19) tablets upon his arrival for his headache discomfort. The note also recommended to give a tramadol as well. A Nurse progress note, dated 12/23/18 at 11:56 p.m., indicated the resident returned to the facility via taxi. The note indicated the resident had received a medical procedure for acute exacerbation of chronic muscle tension headache. The resident was recommended to receive Fiorcet tablets which was a narcotic. The resident didn't have this medication in the facility and the VA had not sent a prescription back with him. The nurse attempted to contact the VA but the calls made were repeatedly disconnected. The note indicated the information would be passed on in report to the oncoming nurse for follow up. A Nurse progress note, dated 12/24/18 at 10:12 a.m., indicated the resident continued to complain of anxiety. He indicated Tramadol, given for his headaches, was not effective. He was given Excedrin (other the counter medication for migrain			

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	headache) 2 tablets by mouth at 8:30 a.m. for complaints of a severe headache. The note indicated the medication had no effect and the resident continued with a severe headache. The resident was to return to the VA center for a follow up appointment at 1:00 p.m. A VA hospital progress note, dated 12/24/18 at 2:18 p.m., indicated the resident had been seen for a headache and the injection administered the day before had not been effective in relieving his pain. Migraine protocol was ordered: IV fluids, Toradol (pain medication), Benadryl (anti-histamine), and Compazine (anti-nausea). The resident was to be discharged after he received the medications. The progress note indicated the resident's current medications for treatment of his headaches, included, but were not limited to, Fioricet 2 tablets by mouth 4 times daily as needed. Nurse Progress notes indicated the following: 12/26/18 at 10:29 a.m., Resident G had been complaining of a severe headache since the start of the shift. Routine pain medications provided as ordered but the resident indicated the medications had little to no effect on his headache. Re-direction was ineffective, the resident continued to complain of pain and made negative statements about his life. 12/28/18 at 10:33 a.m., the resident had increased anxiety. He complained of a headache and indicated that no medications helped except narcotics. 1/8/19 at 6:18 a.m., at 1:45 a.m., the resident was found on the floor in his room having an altercation with another resident. The other resident had been standing over the resident as			

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	Resident G kicked at him. 1/10/19 at 10:15 a.m., the Social Service Director (SSD) indicated she had spoken with the resident's POA (Power of Attorney) who indicated the resident had called her 2 times and had stated he wanted to harm himself because his head hurt so bad. 1/10/19 at 10:59 a.m., the SSD indicated a referral had been made to a geriatric behavioral unit due to the resident making negative statements. The resident was then transferred to the hospital behavioral unit. Hospital progress notes from 1/10/19 - 1/16/19 indicated during his hospital stay, the resident complained of severe headaches which he'd dealt with for several years. The notes indicated had periods of irritability and anxiety when he complained of headaches, he requested narcotics and a spinal block for pain relief. 1/17/19 at 2:15 p.m., the resident continued to adjust to the facility after readmission from a psychiatric hospital stay. He complained of a headache and routine pain medications were administered as ordered. 1/18/19 at 2:39 a.m., The only negative statements made during the shift were related to the resident's headaches which "never go away". 1/21/19 at 3:21 p.m., the resident indicated he was doing "fine" since readmission to the facility other than his head hurting. A VA Primary Care Attending progress note, dated 2/13/19 at 10:30 a.m., indicated the resident was seen for a routine visit. The note indicated			

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	the resident had chronic headaches which had been treated with acupuncture (nerve block) with some success. The resident was taking Fioricet for headache pain in addition to other medications. He complained of a "screaming headache in the occipital (back of head) area". The resident was tearful. Orders were given to obtain a neurology consult, geriatric and mental health consults, discontinue Fioricet, and repeat an injection of Toradol which had been helpful at his prior visit. A review of Resident G's Medication Administration records dated December 2018, January, February, and March 2019 indicated fioricet had not been given as ordered. On 3/12/19 at 4:05 P.M., the Unit Manager was interviewed. She indicated she was not aware that the resident had been seen by VA services in December 2018. She had not been aware that the resident had orders for Fioricet to treat his headaches which had been prescribed by physicians at the VA center prior to his initial admission to the facility. She was aware the resident had headaches which he complained of daily. He was prescribed routine pain medication in addition to as needed medications but would often refuse them because he indicated they didn't help. The Unit Manager indicated there had been no follow up to the resident's VA emergency room visit on 12/23/18 or the visit on 12/24/18 where the VA physician's had indicated the resident was to take Fioricet after his ER visit and was ordered as needed for headaches 4 times per day. She indicated there were no orders on the chart written to discontinue Fioricet on 2/13/19. She indicated the resident was alert and able to be interviewed. On 3/13/19 at 12:35 P.M., the Medical NP (Nurse			

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	Practitioner) was interviewed. During the interview, she indicated she had not been aware that the resident had been seen by the VA in December or that they had requested the resident be given Fioricet after this visit. She indicated it was her understanding that the resident was waiting to be assigned to a primary care physician at the VA. She had not prescribed Fioricet. On 3/13/19 at 12:49 P.M., LPN 2 indicated she had spoken with the VA center and learned that the resident had originally been prescribed Fioricet for his headaches in May of 2018. She indicated during the resident's VA visits on 12/23/18, 12/24/18, and 2/13/19, the VA had Fioricet listed on the residents current medication records but Fioricet had never been ordered by the facility's physician's or NP's. She indicated she had just received, by fax, the resident's VA progress notes from 12/24/18 and 2/13/19. There had been no follow up completed after the 12/23/18 VA emergency room visit to clarify or obtain orders for Fioricet to treat the resident's severe headaches. This Federal tag relates to Complaint IN00288099. 3.1-25(b)(9)			