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	174004	A. BUILDING ______ B. WING ______	C 10/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAWATOMIE STATE HOSPITAL PSYCHIATRIC	500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064

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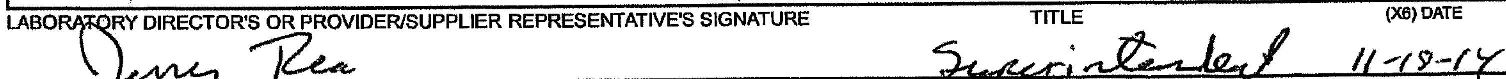
A 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #78907 and #79186 (ASPEN #MOD211) completed at the above named facility. The complaint investigation resulted in an Immediate Jeopardy with the Condition of Participation of Nursing Services 42 CFR 482.23 and the Condition of Participation of Pharmaceutical Services 42 CFR 482.25 that were not removed on exit 10/30/14.	A 000	**To Address A385 and A395** **Supervision and Care of Each Patient** The Registered Nurse (RN) will complete nursing assessments of medical issues at admission, when identified by the physician or reported by the patient, and document the results of their assessments in the electronic medical record (Patient Care System [PCS]). As indicated by the assessment, the RN will create a Nursing Care Plan for moderate or more severe issues. The RN will create a temporary issue for less severe issues expected to be resolved in 30 days or less. The RN will create orders within PCS for the medical issue(s) to be assessed as often as appropriate for the conditions. Ongoing reassessment and treatment is provided by nursing services, and any change in condition and/or patient refusal of care will be reported directly to the physician by the RN. Assessments and any actions taken are documented in the PCS. Wound and edema treatment templates have been developed to enhance assessment, treatment and	
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on medical record review, document review, and staff interview the hospital's nursing staff failed to: supervise and evaluate the care for each patient; provide necessary medications to treat patient medical needs; correctly transcribe physician orders; clarify physician orders; obtain laboratory tests and physician consultation; notify physician of changes in patient's condition; complete ongoing assessments of patient responses to interventions (refer to A-0395). The lack of an effective nursing service resulted in an immediate jeopardy identified by the Centers for Medicare/Medicaid Services on 10/30/14. The cumulative effect of the systematic failure to supervise and evaluate the care for each patient; to provide necessary medications to treat patient medical needs; to correctly transcribe physician	A 385		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jerry Rea — TITLE: Superintendent — (X6) DATE: 11-18-14

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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orders; to clarify physician orders; to obtain laboratory tests and physician consultation; to notify physician of changes in patient condition resulted in the hospital's inability to provide care in a safe and effective manner.

A 395 482.23(b)(3) RN SUPERVISION OF NURSING CARE

A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by:
The hospital reported a census of 258 patients with a licensed bed capacity of 206 beds. Based on observation, medical record review, document review, and staff interview the hospital ' s nursing staff failed to supervise and evaluate the care of each patient and provide necessary medications to treat patients' medical needs, correctly transcribe physician orders, clarify physician orders, and obtain ordered laboratory tests and physician consultation that resulted in the deterioration of patient's physical condition for two of twenty five sampled patients (patient #'s 9 and 24). Failure to supervise and evaluate patient's medical conditions places patients at risk for inadequate care.

Findings include:

- Registered Nurse Position Description reviewed on 10/22/14 at 4:30pm directed nursing staff to "...respond to, assess, intervene and provide direction in both physical and psychiatric

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monitoring of these conditions. See Attachments 1 & 2, respectively.

Physicians have been in-serviced on the importance of ordering dressing changes and their timely follow up based upon the clinical data contained in the wound and edema templates.

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Obtaining and Monitoring Laboratory Tests and Physician Consultations

When labs requiring nursing to collect a specimen, or consultations are ordered, the RN will ensure that an order is created within PCS for the lab or consult to be reviewed each day by the RN until it is completed, the physician's order is discontinued, or it is cleared by the laboratory due to the patient's repeated refusals. For all other lab orders, the RN will monitor daily until the order is completed, cleared or discontinued. In both instances a progress note of the daily review will be entered in PCS by the RN. If the patient is refusing the lab or consult, that information will be included in the "refusal of treatments/test" progress note (Attachment 3) and provided to the attending physician.

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crisis/emergency situations..." and "...perform direct nursing care to insure individualized quality patient care by utilizing appropriate Hospital/Nursing Service standards..." and ..."communicate all known medical issues to unit physician and document such..."

- The hospital ' s patient care policy " Assessment " reviewed on 10/29/14 at 3:40pm directed, " ...Initial and ongoing assessments are crucial to determine the appropriate care, treatment and services needed to meet the patients ' needs. During the course of hospitalization, the patients' needs may change; therefore it is important that reassessments are performed when clinically indicated".

- The hospital ' s medical management policy " Preparation, administration and Documentation of Medications " reviewed on 10/29/14 at 3:40pm directed, " ...Any missed dose (of medication)-Report all missed doses to the RN (registered nurse) who will inform the physician ... "

- The hospital's nursing policy "Assessment of Wounds/Major Injuries reviewed on 10/29/14 at 4:55pm directed "...A. ACTION BY NURSING STAFF 1. Treatments, Dressing Changes, and Assessment During each treatment application &/or dressing change, the RN/LPN will assess and document the following in a Progress Note: Location, Size...Dressing...Color, Temperature, Edema, Odor, Moisture and Appearance of Skin around the wound and if Exudate and drainage are present. 4. Assessment of Peripheral Edema

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Refusals of Care

In the event of patient refusals, the nurses or other clinical staff will encourage patients to participate in their plan of care as prescribed.

The licensed staff providing medications to the patients will note any medication refusals on a tracking sheet and the "refusal of treatments/test" progress note which will be reviewed with the attending physician or the covering physician.

Staff who escort patients to physical therapy or other appointments will notify the RN that a patient did not attend or refused therapy. The RN will communicate refusals to the physicians and document the refusal in PCS. In the event of ongoing refusals, the patient's treatment plan and/or nursing care plan will be revised to address the patient's needs.

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(swelling) from the initial time of occurrence the RN/LPN will; Establish a Temporary Issue addressing the location and type of edema (pitting or non-pitting) Write a Progress Note which includes the details of the initial assessment, and the location and type of the edema, physician notification, and any type of treatment the patient received Enter into the Patient Care System a Nurses order for the protocol of assessment of the edema as follows; a) RN/LPN to Assess and Document (insert edema site) every shift RN/LPN are to document in a Progress Note the following per protocol with each assessment: Location, Size (circumference may be measured using a cloth or paper measuring tape Skin Integrity-color, temperature, moisture, Appearance Pitting or Non-pitting edema.

- The hospital's Nursing Services (LD-3.21) policy directed "...Nursing care is the provision of care that is essential to the prevention of illness, helpful in the promotion, maintenance and restoration of health (both mental and physical), and well-being...D. STANDARDS OF PRACTICE Nursing services follows standards of nursing practice which are adapted for use ..., but based upon the American Nurse's Association's "Psychiatric-Mental Health, " Scope and "Standards of " Practice, 2007, and the "Code of Ethics for Nurses with Interpretive Statements, 2001".

- Patient #9's closed medical record review on 10/27/14 revealed an admission date of 8/24/14 with a psychiatric diagnosis of major depressive disorder with severe psychotic features and

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Transcribing and Clarifying Orders

The role of the RN in clarifying and transcribing physician orders has been revised in policy and procedures and the RNs have been trained regarding these changes. Please see the Plan of Correction for Tags A490 and Tags A500 below.

Ongoing Monitoring of Nursing Services

To ensure that nursing staff understand and maintain these processes, a flow chart has been developed that depicts the above processes. Nursing staff were in-serviced on these procedures and expectations.

Licensed Nursing staff have been in-serviced on the need to have BP/pulse vital signs taken prior to the administration of certain medications as required in our policy. To validate compliance that vital signs are obtained prior to these medications being administered, Nurse Managers will observe staff weekly performing these duties.

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medical diagnosis of diabetes mellitus.

- Physician's Diagnostic Orders dated 8/24/14 at 9:10pm requested a urinalysis and urine drug screen. Lab Result notes reported on 9/2/14 indicated that no specimen was submitted for urinalysis or drug screen. The medical record lacked any nursing documentation of notification to the physician of inability to obtain patient #9's urine sample.

- Physician staff G assessed patient #9 on 8/26/14 for medical issues. Physical examination indicated patient #9 had swelling of the legs and a superficial ulcer on the tip of the second toe left foot. Physician staff G ordered Coreg (a medication to lower blood pressure, digoxin (a medication used to treat irregular heart rates by making the heart beat slower and stronger), clindamycin (an antibiotic) 150mg (milligrams) three times a day by mouth, physical therapy for hydrotherapy (whirlpool baths) and a pain medication.

- Patient # 9's Medication Administration Record and Vital Sign Report Sheets reviewed on 10/30/14 revealed nursing staff directed to check blood pressure prior to administration of Coreg (a medication to lower blood pressure). The medical record lacked evidence the nursing staff documented the patient's blood pressure prior to the administration of the Coreg on 8/27/14 8:00pm, 8/28/14 7:31pm, 8/29/14 7:40pm, 9/3/14 7:45pm, 9/8/14 8:22pm, 9/11/14 7:01pm, 9/12/14 8:28pm, 9/15/14 7:36am and 7:43pm, and

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For patients with moderate to severe medical conditions, the Nurse Managers, Director of Nursing & Assistant Director of Nursing will review assigned patient charts for compliance. To validate the clinical information noted in the chart, nursing supervisors will randomly conduct physical assessments of the identified patients to ensure that the patient's clinical condition matches the patient chart and to make necessary adjustments in the treatment plan if necessary. The Medical Director will periodically review samples of the physicians' progress notes of these patients to ensure timely and accurate orders. The Director of Nursing or Assistant Director of Nursing and Medical Director will report the results of the monitoring to the Director of Quality Assurance who will compile the results and provide routine feedback to the Executive Committee. Any opportunities for improvement identified during the reviews will be addressed upon identification.

Procedure for Implementing the Plan

In-service training has been initiated and is ongoing for nursing, medical,

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9/17/14 7:19pm.

- Patient # 9's Medication Administration Record and Vital Sign Report Sheets reviewed on 10/30/14 revealed nursing staff directed to check apical pulse (heart sound heard over the lowest superficial part of the heart through a stethoscope) prior to administration of Digoxin (a medication used to treat irregular heart rates by making the heart beat slower and stronger). The medical record lacked evidence the nursing staff documented the patient's apical pulse prior to the administration of digoxin on the following days: 8/28/14, 8/29/14, 8/30/14, 9/1/14, 9/2/14, 9/3/14, 9/5/14, 9/6/17, 9/7/14, 9/8/14, 9/10/14, 9/11/14, 9/12/14, 9/14/14, 9/15/14, 9/16/14, 9/17/14, 9/19/14, 9/23/14, 9/24/14, and 9/25/14.

- Nursing Care Plan #7opened 8/24/14 directed "Patient will comply with all tests and treatment related to the wound for the next 5 days. Intervention: Encourage patient to comply with treatment as ordered. Encourage patient to take medication as ordered. Change dressing as ordered. Monitor for s/sx (symptoms) of complications and immediately notify the doctor " .

- Patient #9's medical record lacked evidence the Nursing Care Plans addressed the patient's peripheral edema found on initial assessment including establishing a temporary issue addressing the location and type of edema; writing a progress note which includes the details of the initial assessment and the location and type of the edema, and any type of treatment the

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laboratory and pharmacy staff. Staff who are not on duty prior to November 18, 2014, will be trained upon their return to work. Ongoing training will be provided as opportunities for improvement are identified through the monitoring process.

Quality Assurance Measure

There will not be any serious adverse outcomes due to standard of care failures. Any opportunities for improvement will be addressed and corrected promptly upon identification.

The title of the person responsible for implementing the acceptable plan of correction

The Director of Nursing is responsible for implementing the acceptable plan of correction.

The date when the hospital will be in full compliance by November 18, 2014

The hospital will be in compliance by Tuesday, November 18, 2014.

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A 395	Continued From page 6 patient received. The medical record lacked evidence the nursing staff entered progress notes following the protocol for the assessment of edema including: location, size, skin integrity and appearance. - Nursing notes on 8/25/14 lacked documentation of any assessment or attempted assessment of patient #9's left 2nd toe wound. - Nursing progress note dated 8/26/14 at 2:25pm indicated patient #9 refused am meds, refused to talk to the Interdisciplinary Team (IDT) refused assessment of left 2nd toe. The medical record lacked evidence nursing staff notified the physician the patient refused their medications or refused assessment of their toe wound or nursing staff encouraged the patient to comply with their treatments. - Nursing progress notes on 8/26/14 at 9:43pm indicated patient #9 started on an antibiotic for wound to left 2nd toe but lacked any assessment of the wound. - Physician progress note written on 8/27/14 revealed assessment completed by physician staff H on 8/26/14: Extremities, pitting edema grade 2, no calf tenderness both legs...Has superficial ulcer tip of second toe left foot. - Nursing notes on 8/27/14 lacked documentation of any assessment or attempted	A 395		

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A 395	Continued From page 7 assessment of patient #9's left 2nd toe wound. - Nursing progress notes on 8/28/14 at 9:53pm indicated patient #9 with pretibial (the area of the leg in front of the shinbone) edema and refused to allow the nurse to assess the infected toe. The medical record lacked evidence of nursing staff notification to the physician regarding the refusal of the assessment or nursing staff encouraged the patient to comply with their treatments or nursing staff described the peripheral edema assessment protocol. - Nursing notes on 8/29/14 lacked documentation of any assessment or attempted assessment of patient #9's left 2nd toe wound. - Nursing notes on 8/30/14 at 9:25pm and 9:31pm indicated patient #9 refused all nighttime medications including their antibiotic. The medical record lacked evidence nursing notified the physician that patient #9 refused their medications including the antibiotic or encouraged the patient to comply with their treatments. - Nursing notes on 8/30/14 lacked documentation of any assessment or attempted assessment of patient #9's left 2nd toe wound. - Nursing notes on 8/31/14 lacked documentation of any assessment or attempted	A 395		

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A 395	Continued From page 8 assessment of patient #9's left 2nd toe wound. - Nursing notes on 9/1/14 at 1:57pm indicated patient #9 complained of feet and body pain rated at 10 on a 1-10 scale and they received pain medication. The medical record lacked documentation of any nursing assessments of patient #9 infected left 2nd toe. - On 9/2/14 at 2:46am patient #9 complained of left foot pain at a 7 on a scale of 1-10 and received pain medication. The medical record lacked evidence of any nursing assessments of patient #9 infected left 2nd toe. - Physical therapy (PT) evaluation and treatment notes on 9/2/14 at 10:13am indicated patient had whirlpool therapy for ten minutes followed by debridement (removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) of left 2nd toe. Tip of toe has open sore measuring 1.0 cm (centimeter) X 0.7 cm. wound cleanser applied and covered with gauze bandage and taped in place. - Patient #9 requested pain medication for right foot pain on 9/3/14 at 2:43am.The medical record lacked evidence of any nursing assessment of patient #9's right foot or their infected left 2nd toe or nursing staff encouraged the patient to comply with their treatments.	A 395		

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- Nursing notes on 9/3/14 at 12:40pm and 12:49pm indicated patient #9 continued on an antibiotic for the wound to the left 2nd toe and had complained of foot pain twice and received pain medication and the patient refused to allow the wound on the left 2nd toe to be examined. The medical record lacked evidence nursing notified the physician patient #9 refused assessment of their left 2nd toe or they encouraged them to comply with their treatments.

- Nursing notes on 9/3/14 at 10:21pm indicated patient continues on antibiotic with no adverse effects and lacked evidence of any nursing assessment or attempted assessment of their infected left 2nd toe.

- PT treatment notes on 9/4/14 at 9:31am indicated patient had eschar (dead tissue that falls off (sheds) from healthy skin) still covering most of open area of their left 2nd toe wound.

- Nursing notes on 9/4/14 at 10:30pm indicated patient continues on antibiotic with no adverse effects and lacked evidence of any nursing assessment or attempted assessment of their infected left 2nd toe.

- Licensed Practical Nursing staff progress notes on 9/4/14 at 10:49pm indicated patient #9 requested pain medication at 4:03pm and at 9:30pm for left foot pain rated "over10" both times. The medical record lacked any evidence of any nursing assessment of the left foot.

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- Nursing progress notes on 9/5/14 at 12:31pm indicated patient #9 continued on antibiotic, refused an assessment of their toe and had requested pain medication in the morning for complaint of body pain. The medical record lacked evidence nursing notified the physician patient #9 refused assessment of their infected toe or encouraged them to comply with their treatments.

- Nursing progress notes on 9/6/14 at 5:15am indicated patient #9 requested and received pain medication for right foot pain twice during the night. The medical record lacked evidence of nursing assessments of patient #9's right foot or their infected left 2nd toe during this shift or any time on 9/6/14.

- Nursing progress notes on 9/7/14 at 0751 indicated patient #9 received pain medication at 5:50am for foot pain. The medical record lacked evidence of nursing assessments of patient #9's infected left 2nd toe.

- Nursing progress note on 9/7/14 at 9:23pm indicated patient refused all nighttime medications. RN was notified. The medical record lacked evidence nursing staff notified the physician of the missed medications or nursing staff encouraged the patient to comply with their treatments.

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A 395	Continued From page 11 - Nursing notes on 9/8/14 at 5:36am indicated patient #9 requested and received pain medication for foot pain at 12:57am. The medical record lacked evidence of nursing assessments of patient #9's infected left 2nd toe. - PT treatment notes on 9/9/14 at 10:28am indicated debridement of left 2nd toe completed and eschar still covering most of open area. - Nursing progress notes on 9/9/14 at 10:55pm indicated patient requested pain medication for unrated left foot and ankle pain at 8:22pm. The medical record lacked any nursing assessment of the infected left 2nd toe. - General progress notes on 9/10/14 at 2:30pm indicated patient #9 wanted a nurse to give them pain medication for his left foot saying that it was "more swollen and painful." and refused to allow staff to assess their toe. The medical record lacked evidence nursing notified the physician when patient #9 refused assessment of their infected toe or the nursing staff encouraged the patient to comply with their treatments. - Medical Physician staff H did not assess patient #9 again until 9/10/14 at 4:21pm (two weeks after the initial infected toe assessment) for left foot pain. Staff H indicated patient #9's left foot up to mid leg swollen, tender and left second toe has open ulcer, tender, no active bleeding, swelling and erythematous. Patient #9 currently took pain medication and an antibiotic. The medical record	A 395		

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A 395	Continued From page 12 lacked evidence that a medical physician had assessed the patient since the initial consultation on 8/26/14. - PT treatment notes on 9/11/14 at 9:45am indicated patient refused to complete his whirlpool treatment and allow the therapist to place a dressing on his toe. The medical record lacked evidence that nursing or therapy staff notified the physician of the patient ' s refusal or encouraged them to comply with their treatments. - Nursing notes on 9/11/14 at 11:37pm indicated patient #9 became agitated about their foot hurting and requested to see the physician. The medical record lacked evidence the nursing staff notified the physician of the patient's request or performed any assessment of the infected left 2nd toe. - Nursing notes on 9/12/14 at 5:14am indicated patient #9 requested and received pain medication. The medical record lacked evidence of an assessment of patient #9 ' s infected toe. - Nursing notes on 912/14 at 2:47pm indicated patient #9 requested pain medication and refused assessment of their 2nd toe left foot. The medical record lacked evidence the nursing staff encouraged the patient to comply with their treatment. - Nursing notes on 9/13/14 at 1:38am indicated	A 395		

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patient stated "I stay in bed all day because the cold floors hurt my foot to walk on...." and at 8:37am indicated patient #9 refused their morning medications including their antibiotic. The medical record lacked evidence nursing staff notified the physician patient #9 refused all their medications including the antibiotic and any evidence nursing staff encouraged the patient to comply with their treatments.

- Nursing notes on 9/14/14 lacked any evidence of documentation of assessment of the patient's infected left 2nd toe.

- Nursing notes on 9/15/14 at 2:01pm indicated patient #9 requested pain medication for their left toe pain and rated their pain at a 10. They continue on antibiotic. Patient #9 stated they could hardly walk and patient #9 was encouraged to elevate their foot. The medical record lacked documentation of any assessment of their infected left 2nd toe on 9/15/14.

- General progress note on 9/16/14 at 11:36 indicated that the patient stated that staff have not been taking care of their toe. The medical record lacked evidence nursing staff encouraged the patient to comply with their treatment.

- PT treatment notes on 9/16/14 indicated that the patient refused their therapy. The medical record lacked evidence therapy or nursing staff notified the physician of the patient ' s refusal or encouraged the patient to comply with their treatments.

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A 395	Continued From page 14 - Physician Reorder Sheet *Non-medicated Treatments* dated 9/17/14 directed nursing staff to: Document assessment of diabetic ulcer on 2nd toe left foot every shift starting 9/17/14. If patient refuses assessment, document. - Nursing notes on 9/17/14 at 6:08am indicated patient #9 requested and received pain medication for foot pain at 5:21am. The medical record lacked evidence nursing assessed patient #9 ' s infected toe. - Nursing progress in treatment notes on 9/17/14 at 9:06pm indicated patient #9 had been non-compliant with medications including antibiotic and pain medication for his toe. The progress in treatment note lacked any different nursing interventions or goals addressing patient #9 ' s non-compliance. - Nursing notes on 9/17/14 at 11:40pm indicated patient #9 had concerns about their toe and requested an assessment, dressing change, and pain medication. Nursing staff applied ointment and wrapped their toe. The medical record lacked nursing staff documentation of the wound including the exact location, size, type of dressing, the color, temperature, presence of edema, odor, moisture and appearance of the skin around the wound and if exudate and drainage are present. The medical record lacked evidence of physician orders for nursing staff to follow regarding the dressing change to the	A 395		

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infected left 2nd toe.

- Physician staff H did not assess patient #9 again until 9/18/14 (eight days after last medical exam) for a follow up for their left foot pain. Assessment revealed left second toe tender, erythematous, no discharge, plantar surface of the second toe gangrene, dryness and ingrown nails. Patient #9 continued on antibiotic and refused to go for hydrotherapy. Physician staff H ordered Hibiclens (a skin cleanser and antiseptic) solution to left foot daily for 7 days, a podiatry consultation, CBC (complete blood count) and BMP (basic metabolic panel) lab tests and a wound culture of the left second toe.

- Patient #9's medical record lacked evidence the podiatry consultation from 9/18/14 was ordered. The medical record lacked evidence that nursing staff notified the physician of the missed consultation. The lab result notes reported on 9/25/14 indicated the patient refused to complete lab tests (BMP and CBC) ordered on 9/18/14 at10:15am. The medical record lacked any nursing documentation indicating the patient refused their labs or that nursing staff notified the physician of the patient's refusal. The lab result notes reported on 9/25/14 indicated that no specimen was submitted for left toe wound culture ordered on 9/18/14. The medical record lacked any nursing documentation of the missed wound culture or notification to the physician of the inability to obtain the specimen.

The Administrative Nursing staff A interviewed on

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A 395	Continued From page 16 10/30/14 at 12:00pm acknowledged patient #9's medical record lacked evidence nursing staff scheduled a podiatry consult, obtained a wound culture and documented efforts to encourage compliance with medications or treatments. - General progress notes on 9/18/14 at 1:12pm indicated that the patient refused to go to physical therapy. The medical record lacked evidence nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/18/14 at 2:14pm indicated patient #9 requested pain medication and an assessment of their left 2nd toe. The nursing staff documented the toe had no drainage; skin is discolored and dark in color on the bottom. The medical record lacked complete documentation of the wound including the temperature, presence of edema, odor, or moisture and dressing applied. - PT treatment notes on 9/18/14 indicated patient refused therapy. The medical record lacked evidence the therapy or nursing staff notified the physician of the patient ' s refusal and lacked documentation the nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/19/14 at 1:51am indicated patient received pain medication and refused assessment of the affected area. The medical record lacked evidence the nursing staff notified the physician of the patient ' s medication refusal and encouraged the patient to comply with their	A 395		

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A 395	Continued From page 17 treatments. - Nursing notes on 9/19/14 at 2:21pm indicated patient #9 refused assessment of their toe. The medical record lacked evidence nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/19/14 at 6:21pm indicated patient #9 refused to allow assessment of their toe. The medical record lacked evidence nursing staff encouraged the patient to comply with their treatment. - Nursing notes on 9/19/14 at 10:39pm indicated the nurse noticed patient #9 limping and offered them pain medication. The patient refused medication or assessment of the left second toe. The medical record lacked evidence nursing notified the physician of the change in condition for patient #9 or encouraged them to comply with their treatments. - The medical record lacked nursing staff documentation of an assessment of patient #9's infected left 2nd toe the night shift of 9/19/14. - Nursing notes on 9/20/14 10:03am indicated patient refused all his morning medications. The medical record lacked evidence nursing staff notified the physician of the missed medications	A 395		

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A 395	Continued From page 18 and nursing staff encouraged patient #9 to comply with their treatments. - Nursing notes on 9/20/14 at 2:30pm indicated patient #9 refused assessment of their infected second toe. The medical record lacked evidence nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/20/14 at 10:39pm indicated patient refused assessment of his left 2nd toe. The medical record lacked evidence the nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/21/14 at 7:34am indicated patient #9 received pain medication at 2:39am and refused assessment of their infected toe. The medical record lacked evidence the nursing staff encouraged the patient to comply with their treatments. - General progress notes on 9/21/14 at 1:26pm indicated patient stated "I'm refusing medications from now". The Medication Administration Record indicated that patient had refused medications the morning of 9/20/14 and 9/21/14. The medical record lacked evidence that nursing staff notified the physician either day of the patient's refusal to take their medications and to encourage them to comply with their treatments. - Nursing notes on 9/21/14 at 9:04pm indicated	A 395		

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A 395	Continued From page 19 patient #9 refused assessment of their infected toe. Nursing notes on 9/21/14 at 9:46pm indicated patient #9 refused all medications. The medical record lacked evidence nursing notified the physician patient #9 refused their medications or encouraged the patient to comply with their treatments. - Nursing notes on 9/22/14 at 12:10am indicated patient #9 requested and received pain medication and allowed the nurse to assess their infected toe but refused a dressing. The medical record lacked nursing documentation of the wound description including size, color, drainage, temperature, presence of edema, odor, and moisture and any evidence nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/22/14 at 2:12pm indicated patient #9 refused assessment of their infected toe and morning medications. The medical record lacked evidence the nursing staff notified the physician of the missed medications or the nursing staff encouraged the patient to comply with their treatments. - Nursing notes on 9/22/14 at 9:54pm indicated patient #9 requested and received pain medications at 5:33pm and refused their evening medications. The medical record lacked evidence the nursing staff notified the physician of the missed medications or encouraged the patient to comply with their treatments. The medical record lacked documentation of a nursing staff	A 395		

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assessment of the patient's infected left 2nd toe on the evening shift 9/22/14.

- Nursing notes on 9/23/14 at 6:04am indicated patient #9 requested and received pain medications and refused to allow assessment of their foot. The medical record lacked evidence the nursing staff encouraged the patient to comply with their treatments.

- The medical record lacked documentation of a nursing staff assessment of the patient's infected left 2nd toe on the day, evening, and night shifts 9/23/14 and the day and evening shifts 9/24/14.

- Nursing progress notes on 9/25/14 indicated at 1:40am nursing staff assessed patient #9's toe. Documentation indicated "the entire foot is red with flaking dry skin. The end of the second toe is black with white flaking skin around the tip 1 cm vertically and 1.5 cm across distal to the nailbed. Proximal to the nailbed the skin appears darker and lower on the toe next to the third toe a half circle 1 cm at the base appears darker. The skin between the great toe and the second toe is intact and the skin between the second toe and third toe is intact." The wound assessment lacked documentation of the temperature, presence of edema, odor, and moisture and type of dressing applied. The medical record lacked evidence the physician was notified of the change in the patient's condition.

- Medical Physician staff H did not assess patient #9 until 9/25/14 (7 days after the last exam) at

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A 395	Continued From page 21 10:49am and found his left leg to be erythematous, tender, warm, swollen, left first toe tender, planter surface gangrene. Physician staff H documented the patient has known history of diabetes mellitus and the patient is noncompliant with the antibiotic treatment. Patient #9 required transfer to an acute care hospital on 9/25/14 for left leg cellulitis and gangrene and underwent amputation of the second toe of his left foot. - Physician progress notes on 9/30/14 indicated patient #9 remained at the medical hospital and required an amputation of the left second toe. - Nursing staff failed to: monitor vital signs prior to administration of medications, supervise and evaluate the nursing care needs of patient #9, create care plans to address the patient's peripheral edema, revise the patient's care plan regarding compliance with treatments, obtain physician orders for dressing change, notify the patient's physician of the patient's medication refusals or changes in condition, schedule a podiatry consultation, obtain laboratory tests, obtain a wound culture, and to encourage patient #9 to comply with their treatments. These failures resulted in the deterioration of the patient's physical condition and necessitated a transfer of the patient to a higher level of care and an amputation of a toe. - Patient #24's closed medical record reviewed	A 395		

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A 395	Continued From page 22 on 10/29/14 revealed a transfer date of 6/13/14 from a community hospital with a psychiatric diagnosis of schizoaffective disorder, depressive type and medical diagnosis of deep vein thrombosis (DVT). The medical record failed to indicate the location of the lower extremity DVT as right, left, or both legs. - Admission evaluation notes on 6/14/14 revealed Physician staff J's knowledge that patient #24's history included a DVT diagnosed approximately three to four months ago. A lab test completed on 6/13/14 at the hospital the patient transferred from showed a non-therapeutic Protime International Normalized Ratio (PT/INR- a test to measure the time it takes for blood to clot) of 1.1 (Therapeutic level is 2-3). Physician staff J ordered lab tests including a PT/INR, comprehensive metabolic panel (CMP) and a complete blood count (CBC) to be drawn on 6/16/14. - Physician orders dated 6/13/14 required Coumadin (medication used to prevent harmful blood clot from forming or growing larger) 5mg by mouth every other day and Coumadin 7.5mg every other day. Physician orders directed staff to begin Coumadin 7.5mg on 6/14/14 and Coumading 5 mg on 6/15/14. - Pharmacist Staff B provided printed page of patient #24 ' s medication order entered by the nursing staff on 6/13/14. The printed page revealed nursing staff entered a Coumadin order of 5mg to be given every day at 8:00pm and a Coumadin order of 7.5mg to be given every day at 8:00pm. Pharmacist Staff B indicated this would be an unsafe dosage of Coumadin.	A 395		

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- Pharmacist Staff B provided a fax sent on 6/13/14 at 10:59pm to nursing staff on patient #24's unit requesting clarification of the Coumadin dose. Fax indicated that "this is a significant dosage increase. Order is not adequate for entry. Entered at approximately 200% of written dose". The medical record lacked evidence that nursing staff responded to the request for clarification.

- ADON staff A, interviewed on 10/30/14 at 9:10am indicated faxes are used for communication between nursing staff and pharmacy for order clarification. Nursing is to follow up with the doctor after receiving a request for clarification request fax from the pharmacist.

- Patient #24's nursing care plan dated 6/14/14 directed "...Patient will have therapeutic lab values for Coumadin therapy within three days..." Interventions included: "Follow up with labs as ordered. Administer anti-coagulant as ordered. Monitor patient for increase bleeding, bruising".

- Patient #24's Treatment Plan dated 6/14/14 directed "Patient will have no complications associated with DVT/PE during hospitalization". Interventions included: "will evaluate health status and monitor symptoms as needed to treat DVT/PE: prescribe and monitor response to coumadin..."

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A 395	Continued From page 24 - Nursing progress note on 6/14/14/ at 8:49pm indicated that patient #24 refused 08:00am and 08:00pm medications (including the Coumadin). The medical record lacked documentation nursing staff notified the physician at the time of the patient's medication refusal. Nursing documentation lacked an assessment of patient #24's lower extremities. - Coumadin did not appear on the Medication Administration record (MAR) after 6/14/14. However, patient #24's medical record failed to contain a discontinue order for Coumadin The medical record lacked evidence the nursing staff were aware of the Coumadin missing from the MAR. - Assistant Director of Nursing (ADON) staff A interviewed on 10/29/14 at 1:50pm acknowledged patient #24's chart lacked evidence of a discontinue order for Coumadin. - Nursing progress note on 6/15/14 at 10:20pm indicated the patient refused all nighttime medications. The medical record lacked documentation nursing staff notified the physician at the time of the patient's refusal to take their medications and lacked nursing documentation of an assessment of the patient's lower extremities. - Pharmacist Staff B reported a follow up phone call and an additional fax dated 6/16/14 to the nursing unit to clarify the coumadin dosage as nursing staff failed to respond to the initial	A 395		

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A 395	Continued From page 25 request. Note attached to the fax stated "Warfarin(Coumadin) needs to be reviewed- pharmacy's 2nd request pt (patient) has missed 2 doses." Staff B revealed nursing staff failed to respond to the second request to clarify the order. Staff B indicated patient #24 " fell through the cracks after the third or fourth day " . - Pharmacist staff B interviewed 10/30/14 at 10:05am indicated they did not have a good process for clarification of medication orders. Pharmacist Staff B revealed failure to receive timely clarifications from the units. Pharmacist Staff B indicated there needs to be a different procedure; " the fax system does not adequately address medication orders needing timely clarification, entry or administration and they do not have a systems of checks and balances since alterations can take place at any point of entry in the current system " . Staff B revealed there is no way to know if anyone received the fax unless someone calls the pharmacy back. Staff B revealed on 6/16/14 they filled out a variance (incident) report on 6/16/14. - Investigative notes of the incident completed by the hospital ' s risk manager staff W reviewed on 10/30/14 revealed a failure to transcribe an order involving nursing service. The notes confirmed nursing incorrectly entered Coumadin order. The notes lacked evidence of any other follow-up including any new policy ' s or procedures for clarification of medication orders, or education to the nursing staff or pharmacy staff regarding the expectations for clarifying medication orders.	A 395		

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A 395	Continued From page 26 - Nursing progress note on 6/16/14 at 5:37pm indicated patient has been non-compliant with treatment and medications and lab work. The medical record failed to contain any documentation of further attempts by nursing staff to ensure lab work necessary to monitor the patient's medical conditions was performed and lacked nursing documentation of an assessment of the patient's lower extremities. The medical record lacked evidence of any lab specimens received for testing during the patient's admission. - Nursing progress note on 6/17/14 at 10:09am indicated the patient refused all their morning medications. The medical record lacked documentation nursing staff notified the physician at the time of the patient's refusal to take their medications and lacked nursing documentation of an assessment of the patient's lower extremities. - Nursing progress note on 6/17/14 at 9:54pm indicated the patient refused all their nighttime medications. The medical record lacked documentation nursing staff notified the physician at the time of the patient's refusal to take their medications and lacked nursing documentation of an assessment of the patient's lower extremities. - Nursing progress note on 6/18/14 at 10:36am indicated the patient refused all their morning medications. The medical record lacked documentation nursing staff notified the physician at the time of the patient's refusal to take their medications and lacked nursing documentation of an assessment of the patient's lower extremities.	A 395		

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A 395	Continued From page 27	A 395		
	-Nursing progress notes on 6/19/14 lacked any assessment of the patient's lower extremities.			
	- Nursing staff documentation at 6/20/14 at 5:34am indicated that patient cried out loudly for thirty minutes and the patient's legs were swollen but patient refused further assessment. The medical record lacked evidence nursing staff notified the physician of the change in condition.			
	- Patient advocate staff V interviewed on 10/23/14 provided personal notes that indicated on 6/20/14 patient #24 's legs were very red and swollen with sores or spots.			
	- Progress notes dated 6/20/14 at 3:16pm revealed notification to the unit nurse of "excessive body fluids " coming from patient #24's mouth and nose as well as crying and choking noises. Nursing notes revealed patient was drooling with difficulty swallowing, was crying out as if in pain, and had a large amount of edema (swelling) to both legs. Patient #24 refused nursing assessment. Nursing staff notified patient #24's psychiatric doctor of their condition and they notified the medical doctor. Medical staff H's progress notes 6/20/14 at 3:26pm revealed patient was "drooling and gasping " , refused medical exam, and the patient required transfer to a local hospital to rule out aspiration (breathing a foreign object such as			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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A 395	Continued From page 28 food or liquid into your nose, mouth, or respiratory tract). - Nursing notes dated 6/20/14 at revealed patient #24 required admission to an Intensive Care Unit at another hospital with a diagnosis of a DVT from ankle to groin in right leg. - The Nursing staff failed to correctly transcribe a critical medication and failed to respond to fax requests from pharmacy clarifying the medication dosage. Nursing staff failed to notify the physician after missed doses of medications, failed to follow the care plan regarding the patient's DVT including administering medication as ordered and ensuring the labs were completed as ordered and failed to perform ongoing assessments the patient's lower extremities. Nursing staff failures to supervise and evaluate the care of a patient contributed to the deterioration of a patient's physical condition requiring admission to an intensive care unit.	A 395		
A 490	482.25 PHARMACEUTICAL SERVICES The hospital must have pharmaceutical services that meet the needs of the patients. The institution must have a pharmacy directed by a registered pharmacist or a drug storage area under competent supervision. The medical staff is responsible for developing policies and procedures that minimize drug errors. This function may be delegated to the hospital's organized pharmaceutical service.	A 490		

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A 490	Continued From page 29 This CONDITION is not met as evidenced by: Based on medical record review, document review, and staff interview the hospital's pharmacy failed to develop a tracking system for clarification of medication orders, failed to monitor the effectiveness of medications, and failed to coordinate medication needs for patients (refer to A-0500). The lack of an effective pharmacy tracking system for clarification of medication orders and failure to monitor medication therapy and coordinate medication needs for patients resulted in an immediate jeopardy identified by the Centers for Medicare/Medicaid services on 10/30/14. The cumulative effect of the pharmacy's systemic failure to develop a tracking system for clarification of medication orders, to monitor the effectiveness of medication therapy and coordinate medication needs for patients and failure to ensure outdated drugs and biologicals were not available for patient use resulted in the hospital's inability to provide care in a safe and effective manner.	A 490	**To address A490 and A500** Pharmacy, medical, nursing and laboratory staff will increase their consultations with the team approach in regards to high risk medications, laboratory results and risk management activities to ensure patient safety and quality of care. The hospital hired a new Director of Pharmacy in order to meet this objective and ensure the standards of practice are in accordance with Federal and State laws. **Transcribing and Clarifying Orders** The process for clarification of medication orders was changed to require a pharmacist to contact by phone the prescriber or attending physician if questions or concerns arise that would prohibit the pharmacist from processing a medication order. The pharmacist will contact the Medical Director or designee if no response is received from the attending or covering physician.	
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: The hospital reported a census of 258 patients with a bed capacity of 206 beds. Based on medical record review, document review, and staff interview the hospital pharmacy lacked a	A 500		

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Continued From page 30

tracking system for clarification of medication orders and failed to complete a thorough investigation of a medication event for three of twenty five sampled patients (patient's #9, #24 and #25). The hospital's pharmacy's failure to supervise and coordinate all the activities of pharmacy services resulted in deterioration of a patient's medical condition and medication errors/omissions.

Findings include:

- The American Society of Health-System Pharmacists (ASHP) Guidelines: Minimum Standard for Pharmacies in Hospitals directs: "...A. Reviewing Patient Responses to Medication Therapy ...Medication therapy monitoring includes a proactive assessment of patient problems and an assessment of a. The therapeutic appropriateness of the patient ' s medication regimen...d. Patient adherence to the prescribed medication regimen... j. Assessment of the effectiveness of the patient ' s medication. ...Antimicrobial Stewardship and Infection Prevention and Control. Pharmacists should monitor patients' laboratory reports of microbial sensitivities or applicable diagnostic markers and advise prescribers.

- Patient #9's closed medical record review on 10/27/14 revealed an admission date of 8/24/14 with a psychiatric diagnosis of major depressive disorder with severe psychotic features and medical diagnosis of diabetes mellitus. Physician staff G assessed patient #9 on 8/26/14 for medical issues. Physical examination indicated

A 500

If an order can be processed but requires further action by the physician (i.e. clarify indication / diagnosis), the pharmacist will enter the order, notify the nurse, fax a copy of the clarification request to the unit, and follow-up within 72 hours to ensure resolution. If unsuccessful, the pharmacist will contact the Medical Director or designee.

Pharmacy will include the Risk Management in all requests for clarification in order to track patterns and trends of medication events. The Risk Manager and / or designee will investigate each report. The Risk Manager and / or designee will request the Medical Director, Director of Nursing, or other clinical manager to address any issues identified. Reports will be presented to Pharmacy and Therapeutics Committee and Risk Management Committee.

Clinical Reviews

High risk medications (as identified in the hospital formulary) or those

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A 500	Continued From page 31 patient #9 had swelling of the legs and a superficial ulcer on the tip of the second toe left foot. Physician staff G ordered clindamycin (an antibiotic) 150mg (milligrams) three times a day by mouth, physical therapy for hydrotherapy (whirlpool baths), and a pain medication. - Physician staff H did not assess patient #9 again until 9/10/14 (two weeks later) for left foot pain. Staff H indicated patient #9's left foot up to mid leg swollen, tender and left second toe has open ulcer, tender, no active bleeding, swelling and erythematous. Patient #9 currently used a pain medication and clindamycin. - Physician staff H did not assess patient #9 again until 9/18/14 (8 days later) for a follow up for their left foot pain. Assessment revealed left second toe tender, erythematous, no discharge, plantar surface of the second toe gangrene, dryness and ingrown nails. Patient #9 continued on the antibiotic clindamycin. Physician staff H ordered a wound culture of the left second toe. Patient #9's medical record lacked evidence of wound culture results and the hospital pharmacy was monitoring the effectiveness of the antibiotic the patient had been on for 23 days. - Assistant Director of Nursing staff A interviewed on 10/30/14 at 12:00pm acknowledged nursing staff failed to obtain the wound culture ordered on 9/18/14 to determine if patient #9 received the appropriate antibiotic. - Nursing progress notes on 9/25/14 at 1:40am indicated patient #9 's entire foot is red with flaking dry skin. The end of the second toe is black with white flaking skin around the tip. Nursing documentation indicated patient #9	A 500	medications in which a review is determined clinically necessary will be reviewed by a pharmacist in an ongoing manner. Consultations and contacts will be documented in the PCS. A pharmacist will perform a comprehensive clinical pharmacology review and consult with the physician for any recommendations monthly. The Pharmacy Department will provide a report to Pharmacy and Therapeutics Committee regarding clinical interventions. **Investigation of Medication Events** The process for investigating medication events was revised. All medication events will be thoroughly investigated by the Risk Manager or designee and reported on at Risk Management Committee at least monthly to endorse the findings or determine need for additional investigation.	

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A 500 Continued From page 32
refused their antibiotic 30% of the time. Medical record lacked evidence the hospital pharmacy addressed the patient's adherence to the antibiotic drug regimen.

- Physician staff H did not assess patient #9 again until 9/25/14 at 10:49am and documented left leg erythematous, tender, warm, swollen, left first toe tender, plantar surface gangrene, Patient has known history of diabetes mellitus and patient is noncompliant with the antibiotic treatment. Patient required transfer to an acute care hospital for left leg cellulitis and first toe gangrene and required amputation of the left second toe. Patient #9's medical record revealed patient #9 remained on the antibiotic clindamycin for 31 days and their wound continued to deteriorate.

- Patient #9's medical record lacked evidence the hospital's pharmacist tracked the antibiotic use and its effectiveness, addressed patient's compliance with their drug regimen, and monitored for labs (cultures or other diagnostic marker).

- Patient #24 ' s closed medical record reviewed on 10/29/14 revealed a transfer date of 6/13/14 from a community hospital with a psychiatric diagnosis of schizoaffective disorder, depressive type and medical diagnosis of deep vein thrombosis (DVT).The medical record failed to indicate the location of the lower extremity DVT.

- Admission evaluation notes on 6/14/14 revealed Physician staff J's knowledge that patient #24's history included a DVT diagnosed approximately three to four months ago. A lab test

A 500

Procedure for Implementing the Plan

In-service training has been initiated and is ongoing for nursing, medical and pharmacy staff. Staff who are not on duty prior to November 18, 2014, will be trained upon their return to work. Ongoing training will be provided as opportunities for improvement are identified through the monitoring process.

Quality Assurance Measure

There will not be any serious adverse outcomes due to standard of care failures. Any opportunities for improvement will be addressed and corrected promptly upon identification.

The title of the person responsible for implementing the acceptable plan of correction

The Director of Pharmacy is responsible for implementing the acceptable plan of correction.

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A 500	Continued From page 33 completed on 6/13/14 at the hospital the patient transferred from showed a non-therapeutic Protime International Normalized Ratio (PT/INR-test to measure the time it takes for blood to clot) results of 1.1 (Therapeutic PT/INR level is 2-3). Physician staff J ordered lab tests including a PT/INR, comprehensive metabolic panel (CMP) and a complete blood count (CBC) to be completed on 6/16/14. The medical record revealed the facility failed to complete the ordered lab tests. Patient #24's medical record failed to reveal any lab tests (PT/INR) completed to test the patient's clotting time from admission to discharge. - Physician orders dated 6/13/14 required Coumadin (medication used to prevent harmful blood clots from forming or growing larger) 5mg by mouth every other day and Coumadin 7.5mg by mouth every other day. Physician orders directed staff to begin Coumadin 7.5mg on 6/14/14 and Coumading 5.0 mg on 6/15/14. - Pharmacist staff B indicated they faxed a clarification request of the Coumadin order to the Nurses ' station on patient #24 ' s unit on 6/13/14 because nursing staff entered the Coumadin order as 5mg to be given every day at 8:00pm and 7.5mg to be given every day at 8:00pm. Pharmacist staff B provided the printed page of patient #24 ' s medication order received by the pharmacy verifying the incorrect order entry by the nursing staff and indicated that this would be an unsafe dosage of Coumadin. - Patient #24's Medication Administration Record (MAR) revealed they refused the 7.5mg	A 500	The Risk Manager is responsible for ensuring compliance with the investigative process. **The date when the hospital will be in full compliance by November 18, 2014** The hospital will be in compliance by Tuesday, November 18, 2014.	

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A 500	Continued From page 34 Coumadin dose on 6/14/14. The medical record lacked evidence patient #24 received any dose of Coumadin during their admission. - Pharmacist staff B indicated pharmacy staff failed to receive a response from nursing staff after the clarification fax sent on 6/13/14 prompting a " follow up phone call " and an additional clarification fax to the nursing unit on 6/16/14. Note attached to the fax stated "Warfarin (Coumadin) needs to be reviewed-pharmacy's 2nd request pt (patient) has missed 2 doses." Pharmacist staff B revealed nursing staff failed to respond to the fax and clarify the order. Pharmacist Staff B indicated that they put the medication on hold. Pharmacist staff B indicated patient #24 "fell through the cracks after the third or fourth day ". - Patient #24's medical record failed to contain a discontinue order for Coumadin. However, Coumadin did not appear on the MAR after 6/14/14. The patient did not receive any Coumadin from 6/14/14-6/20/14. - Assistant Director of Nursing (ADON) staff A interviewed on 10/29/14 at 1:50pm acknowledged patient #24's chart lacked evidence of a discontinue order for Coumadin. - ADON staff A interviewed on 10/30/14 at 9:10am indicated nursing is to follow up with the doctor after receiving a request for clarification fax from pharmacy. Staff A indicated faxes are	A 500		

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A 500	Continued From page 35 used for communication between nursing staff and pharmacy for order clarification. - Medical Director Staff C interviewed on 10/29/14 at 3:55pm revealed pharmacy is supposed to make sure an RN or doctor knows about the issue so clarification can be given. Staff C acknowledged a fax to the units' nurses' station would not be proper procedure. - Pharmacist staff B interviewed 10/30/14 at 10:05am indicated the facility did not have a good process for clarification of medication orders. Pharmacist Staff B revealed failure to receive timely clarifications from the units. Pharmacist Staff B further indicated there needs to be a different procedure; " the fax system does not adequately address medication orders needing timely clarification, entry or administration and they do not have a system of checks and balances since alterations can take place at any point of entry in the current system ' . Pharmacist Staff B revealed there is no way to know if anyone received the fax unless someone calls the pharmacy back. Pharmacist Staff B revealed they filled out an incident report on 6/16/14. - Medical Director staff C interviewed on 10/30/14 at 10:30am indicated they had no knowledge of patient #24 not receiving Coumadin as ordered by a physician. - Investigative notes of the incident completed by the risk manager staff W reviewed on 10/30/14 at	A 500		

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A 500	Continued From page 36 9:05am revealed a failure to transcribe an order involving nursing service. The notes confirmed nursing incorrectly entered Coumadin order. - Review of the hospital's policies on 10/29/14 revealed the hospital pharmacy failed to develop new policies and procedures for medication clarification requests since this incident in June. - Nursing notes dated 6/20/14 at 9:09pm revealed patient #24 required admission to an Intensive Care Unit at another hospital with a diagnosis of a DVT from ankle to groin in right leg. - The hospital's pharmacy's failure to provide a tracking system for clarification of medications and their practice to place a medication on hold without consultation with a physician contributed to a patient not receiving medications necessary to treat the patient's medical condition and led to deterioration of a patient's physical condition requiring admission to an intensive care unit. - Patient #25's closed medical record reviewed on 10/30/14 revealed an admission date of 6/19/2014 with a psychiatric diagnosis of schizoaffective disorder, and medical diagnosis of cardiac arrhythmias (irregular heart rate).	A 500		

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A 500	Continued From page 37 - Physician orders on 6/20/14 at 0830 directed the patient to receive digoxin (a medication used to treat irregular heart rates by making the heart beat slower and stronger) .125mg every morning and a digoxin level lab test. - Patient #25's medical record reviewed on 10/30/14 revealed a medication reconciliation form completed on 6/20/14 at 0830 including a digoxin order of .125 mg every Monday Wednesday and Friday. The medical record and MAR lacked evidence the reconciliation form was received in pharmacy with the change in frequency. - Pharmacist staff B interviewed on 10/29/14 at 2:45pm revealed the medication order for patient #25 lacked the correct frequency-patient #25 was taking the medication three times a week at home not daily as ordered. Pharmacist Staff B indicated they faxed a clarification to the nurse ' s station on patient #25 ' s unit on 6/20/14 for the digoxin and a laboratory request for digoxin level as this is a high risk medication. The medical record lacked evidence the nursing staff responded to the clarification order. - Medication administration record (MAR) revealed nursing staff documented patient refused digoxin 0.125mg on Saturday 6/21/14, received digoxin 0.125mg on Sunday 6/22/14, and received digoxin 0.125mg on Monday 6/23/14.	A 500		

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A 500	Continued From page 38 - Laboratory results sheet revealed the patient had digoxin level drawn on 6/20/14 at 12:30pm and the results were available for review 6/21/14 at 6:12am. The patient's digoxin level was low- <0.5 mcg/L (normal range 0.8-2.0 mcg/L). The medical record lacked evidence pharmacy was aware of the lab result. - Pharmacist staff B interviewed on 10/29/14 at 2:45pm revealed pharmacy staff failed to receive a response from nursing staff from the fax sent on 6/20/14 prompting a follow up fax dated 6/23/14 stating "...Pharmacy is discontinuing this med, due to high risk. Med w/o (without) obtaining sufficient lab values for safe use..." - The medical record lacked evidence of a discontinue order for the digoxin. However, the medication Digoxin did not appear on the MAR on 6/24/14. - Physician's order dated 6/23/14 at 10:40am requested digoxin level at 1400. The medical record lacked evidence pharmacist staff B was notified or aware of the ordered digoxin level. - Physician ' s order dated 6/25/14 revealed an order for digoxin .125mg to be given every Monday, Wednesday, and Friday. - The MAR revealed patient #25 was given digoxin .125mg on Thursday 6/26/14 and Friday 6/27/14.	A 500		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OSAWATOMIE STATE HOSPITAL PSYCHIATRIC	**500 STATE HOSPITAL DRIVE OSAWATOMIE, KS 66064**

(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
A 500	Continued From page 39 - Pharmacist staff B interviewed 10/30/14 at 10:05am indicated patient #25 would have received a week's worth of digoxin in three days if the patient had not refused the dose on Saturday 6/21/14 and they were not aware of the digoxin level ordered on 6/20/14 or 6/23/14 or their results. Pharmacist Staff B revealed they filled out an incident report on 6/24/14. - Investigative notes of the incident report completed by the risk manager staff W reviewed on 10/30/14 at 12:00pm revealed pharmacy failed to obtain an order prior to discontinuing ordered digoxin. - Review of hospital policies on 10/29/14 failed to reveal the hospital pharmacy developed any new policies and procedures for medication clarification requests since this incident in June. - The hospital's pharmacy lacked a tracking system for clarification of medication orders. The hospital's pharmacy's practice of discontinuing medications without obtaining an order in consultation with the physician or nursing staff contributed to a patient not receiving medications necessary to treat the patient's medical condition.	A 500		

Attachment 1: Design Template for new PCS Wound Care Assessment form

Wound Care Assessment

Time of Assessment ▇ hours

New wound? ▇ No ▇ Yes, describe how wound occurred

Location of Wound(s)-- (exact anatomical location)

Size of Wound(s) – (exact dimensions of width, length, depth at widest / deepest area)

Color ▇ Red ▇ Pink ▇ Tan ▇ Yellow ▇ Brown ▇ Gray ▇ Black

▇ Other

Temperature ▇ Normal ▇ Warm ▇ Cold

Edema

Odor

Moisture, exudate and drainage

Appearance of Skin around the wound

If decubitus ulcer, specify stage [redacted]

Wound Stage	Description
1	P serum-filled blister. Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and / or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue.
2	Partial-thickness loss. Dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open / ruptured serum-billed blister. Presents as a shiny or dry shallow ulcer without slough or bruising.
3	Full-thickness skin loss. Subcutaneous fat may be visible but bone, tendon, or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling.
4	Full-thickness skin loss with exposed bone, tendon, or muscle. Slough or eschar may be on present on some parts of the wound bed. Often includes undermining and tunneling.
Unstageable	Full-thickness tissue loss in which the bed of the ulcer is covered by slough (yellow, tan, gray, brown, or black).

Pressure-relieving devices used [redacted]

Treatment and / or Dressings (Describe irrigation solutions used, medications applied, and / or dressing applied)

[redacted]

Physician notified for change in condition and / or non compliance with assessment or treatment?

[redacted] Yes, Time [redacted] hours Physician(s) [redacted]

[redacted] No, Wound is improving

Instructions from physician

[redacted]

Attachment 2: Design Template for new PCS Peripheral Edema Assessment form

Peripheral Edema Assessment

Time of Assessment

New onset of edema? No Yes

Type of Edema
- None
- Non pitting edema
- 1+ = Trace (Mild pitting, slight indentation, no perceptible swelling of the leg)
- 2+ = Moderate (Moderate pitting, indentation subsides rapidly)
- 3+ = Deep (Deep pitting, indentation remains for a short time, leg looks swollen)
- 4+ = Very deep (Very deep pitting, indentation lasts a long time, leg is very swollen)

Location of Edema and Measurement (circumference may be measured using a cloth or paper measuring tape)

Temperature Normal Warm Cold

Moisture, drainage and exudate

Appearance of Skin (check all that apply)

Red Pink Tan Yellow Black

Petechiae Wheeping Scaling skin Bruised Erythematous

Other:

Treatment Patient Receives for Edema and Compliance

Physician notified for change in condition and / or non compliance with assessment or treatment?

Yes, Time hours Physician(s)

No, edema is stable or improving

Instructions from physician

Attachment 3: Design Template for new PCS Refusal of Treatment(s) / Tests form

Refusal of Treatment(s) / Tests

Patient refused the following:

- Medication(s) at ______ hours. The specific medications refused included:
- Blood draw for laboratory tests
- To provide urine specimen
- Wound culture
- Physical therapy
- Dental appointment
- Podiatry appointment
- Off grounds appointment with
- Other, specify

Steps taken to encourage patient compliance

Physician notified for non compliance with assessment or treatment

Time ______ hours Physician(s)

Instructions from physician