New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335267	A. BUILDING ______ B. WING ______	C 08/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRONDACK MEDICAL CENTER UIHLEIN	**185 OLD MILITARY ROAD** **LAKE PLACID, NY 12946**

(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) COMPLETE DATE
I200	415.18 Pharmacy Services This Regulation is not met as evidenced by: The facility failed to provide pharmacy services, and develop and implement policies and procedures that assure the accurate acquisition, receipt, dispensing and administering of all drugs and biologicals required to meet the needs of each resident. The facility did not provide or obtain routine and emergency drugs and biologicals directly to its residents under a contract as described in section 400.4 of Part 400 of this Subchapter. The facility's contract with the provider of pharmaceutical services did not require compliance with all pertinent provisions of this Chapter; and did not include the following language: "Notwithstanding any other provision in this contract, the facility remains responsible for ensuring that any service provided pursuant to this contract complies with all pertinent provisions of Federal, State and local statutes, rules and regulations." 415.18	I200		9/29/08

Office of Health Systems Management / Office of Long Term Care

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335267	A. Building B. Wing	10/9/2008

Name of Facility	Street Address, City, State, Zip Code
ADIRONDACK MEDICAL CENTER UIHLEIN	185 OLD MILITARY ROAD LAKE PLACID, NY 12946

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0156 Reg. # 483.10(b)(5) - (10), 483.10(b)(1) LSC	10/09/2008	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	10/09/2008	ID Prefix F0329 Reg. # 483.25(l) LSC	10/09/2008
ID Prefix F0333 Reg. # 483.25(m)(2) LSC	10/09/2008	ID Prefix F0353 Reg. # 483.30(a) LSC	10/09/2008	ID Prefix F0425 Reg. # 483.60(a),(b) LSC	10/09/2008
ID Prefix F0490 Reg. # 483.75 LSC	10/09/2008	ID Prefix F0493 Reg. # 483.75(d)(1)-(2) LSC	10/09/2008	ID Prefix F0514 Reg. # 483.75(l)(1) LSC	10/09/2008
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/8/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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{F 281} SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility did not ensure that services provided met professional standards of quality for one (# 91) of five newly admitted residents reviewed during a post survey review and two complaint investigations (Case #'s NY00060638 and NY00061055). The facility did not ensure that physician orders for a narcotic pain medication were written to include parameters according to accepted standards of practice. Specifically, multiple orders for a pain medication had the potential to be administered with an unsafe level of acetaminophen and a narcotic. Additionally, professional staff did not question the unsafe orders. This is a repeat deficiency from the partial extended survey conducted on 8/8/08. This resulted in no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy. This is evidenced by the following: Resident #91 The resident was admitted to the facility on 9/30/08 with the diagnoses of fractured right knee, diabetes mellitis and hypertension. The Minimum Data Set (MDS) was not available. The Admission Nursing Assessment form, dated 9/30/08, assessed the resident as being alert and oriented. This same assessment, assessed the resident with an ongoing pain management problem in the right knee and assessed the pain level as a "5" (on a pain scale of 0-10, with 10	{F 281}		9/29/08

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

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

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{F 281}	Continued From page 1	{F 281}		

being the most severe level of pain).

The physician admission and standing orders dated 9/30/08, identified that the resident could receive one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 2 hours by mouth as needed for pain and acetaminophen 650 mg every 4 hours by mouth as needed for pain. These same orders, also noted that the initial orders written by the the Registered Nurse Manager (RNM) for the physician to sign (which had a line through them, discontinuing the orders), had indicated that hydrocodone 5 mg and acetaminophen 500 mg could be given 1 tablet every 4 hours and 2 tablets every 4 hours.

In a 24 hour period, the total dosage of hydrocodone that could have been administered to the resident was 18 tablets. The total dosage of acetaminophen, if the resident had received the prescribed doses as ordered by the physician, was 12.9 grams in a 24 hour period.

The hydrocodone 5 mg and acetaminophen 500 mg Pharmaceutical reference, provided to the facility by the vendor pharmacy, dated 3/07, documented that hydrocodone 5 mg and acetaminophen 500 mg tablets at high doses may produce dose-related respiratory depression and should be administered with caution for patients with liver or kidney disease. Additionally, it documented that the medication can cause confusion and over sedation in the elderly and they should be started on low doses of hydrocodone and acetaminophen. This same reference documented that the total daily dosage

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{F 281}	Continued From page 2	{F 281}		

for hydrocodone should not exceed 8 tablets in a 24 hour period. It further noted that, the toxic dose for adults for acetaminophen is 10 grams in a 24 hour period.

The nursing note dated 10/1/08 at 9:02 am, documented that the resident received acetaminophen 650 mg for right knee pain with effectiveness and noted that the resident refused hydrocodone and acetaminophen for pain and stated "it makes me constipated".

The Medication Administration Record (MAR) not dated, indicated that the resident did not receive hydrocodone 5 mg and acetaminophen 500 mg until 10/3/08.

During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the Director of Nursing (DON), the physician stated that during review of the multiple orders for hydrocodone and acetaminophen, he realized what problems could arise if the resident was given the medications as ordered and discontinued the hydrocodone 5 mg and acetaminophen 500 mg 1 tablet every 2 hours by mouth as needed on 10/2/08. He confirmed that a maximum dosage that could be provided to the resident should have been included in the order.

During an interview on 10/9/08 at 3:20 pm, the Registered Nurse Manager (RNM), she stated that she wrote both orders for the hydrocodone 5 mg and acetaminophen 500 mg and was aware that acetaminophen was a standing order on the admission orders and signed off the orders after the physician had written them. She further stated that she had questions about the multiple orders but wrote the orders for the physician to sign. She

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{F 281}	Continued From page 3 stated that she followed facility policy that indicated that the medication orders from the hospital needed to be reconciled exactly as written. She stated she followed the policy and wrote the orders for hydrocodone 5 mg and acetaminophen 500 mg to be given 1 tablet every 4 hours and 2 tablets every 4 hours as needed. She stated she did not see the physician, but did see that he had changed the hydrocodone 5 mg and acetaminophen 500 mg orders to one tablet of hydrocodone 5 mg and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 mg and acetaminophen 500 mg every 2 hours by mouth as needed for pain and therefore must have addressed the concern. She confirmed she was aware that there should be a maximum dosage for both medications but did not further question the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg tablets and plain acetaminophen tablets. During an interview on 10/9/08 at 3:25 pm, the Registered Nurse Supervisor (RNS) stated that she did have concerns about the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg and acetaminophen. She stated that she knew the physician was aware of the orders because he clarified the orders when he rewrote them. She stated that the physician did not write the prescriptions for the hydrocodone 5 mg and acetaminophen 500 mg as required, but confirmed that the emergency kit could have been accessed for the medication if the resident had requested the hydrocodone 5 mg and acetaminophen 500 mg for pain. During an interview on 10/10/08 at 8:45 am, the supervising Registered Pharmacist (RPH), he	{F 281}		

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{F 281}	Continued From page 4 stated that the initial RPH did not fill the orders for hydrocodone 5 mg and acetaminophen 500 mg and sent the orders to Health Direct Services for verification due to the irregular orders. The RPH stated that a "red flag would go up to any RPH" in regards to the acetaminophen levels. He stated that a maximum dosage not to exceed 4 grams should have been written and that multiple orders for hydrocodone 5 mg and acetaminophen 500 mg did not make sense. He stated that the maximum dosage for acetaminophen should be 4 grams and the maximum tablets of hydrocodone 5 mg and acetaminophen 500 mg should be 8 tablets, each in a 24 hour period. 10 NYCRR415.11(c)(3)(i)	{F 281}		
{F 385} SS=D	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility did not ensure that appropriate medical management was provided and did not ensure that another physician supervised the medical care of residents, when their attending physician was unavailable for two	{F 385}		9/29/08

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{F 385}	Continued From page 5 (Residents #'91 and 32) of five newly admitted residents reviewed, during a post partial extended survey and complaint investigations (Case #'s NY00060638 and NY00061055). The facility did not ensure that physician orders for a narcotic pain medication and acetaminophen were written to include parameters, according to accepted standards of practice and did not sign physician admission orders within 48 hours. Specifically, multiple orders for a pain medication had the potential to be administered with an unsafe level of acetaminophen and a narcotic medication for Resident #91 and did not sign Resident #32's admission orders within 48 hours. This is a repeat deficiency from the partial extended survey conducted on 8/8/08. This resulted in no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy. This is evidenced by the following: Resident #91 The resident was admitted to the facility on 9/30/08 with the diagnoses of fractured right knee, diabetes mellitis and hypertension. The Minimum Data Set (MDS) was not available. The Admission Nursing Assessment form dated 9/30/08, assessed the resident as being alert and oriented. This same assessment, assessed the resident with an ongoing pain management problem in the right knee and assessed the pain level as a "5" (on a pain scale of 0-10, with 10 being the most severe level of pain). The physician admission and standing orders, dated 9/30/08, identified that the resident could receive one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 milligrams (mg) and	{F 385}		

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{F 385}	Continued From page 6 acetaminophen 500 mg every 2 hours by mouth as needed for pain and acetaminophen 650 mg every 4 hours by mouth as needed for pain. These same orders, also noted that the initial orders written by the the Registered Nurse Manager (RNM) for the physician to sign (which had a line through them, discontinuing the orders), had indicated that hydrocodone and acetaminophen could be given, 1 tablet every 4 hours and 2 tablets every 4 hours. In a 24 hour period, the total dosage of hydrocodone that could have been administered to the resident was 18 tablets. The total dosage of acetaminophen, if the resident had received the prescribed doses as ordered by the physician, was 12.9 grams in a 24 hour period. The hydrocodone 5 mg and acetaminophen 500 mg Pharmaceutical reference, provided to the facility by the vendor pharmacy, dated 3/07, documented that hydrocodone 5 mg and acetaminophen 500 mg tablets at high doses may produce dose-related respiratory depression and should be administered with caution for patients with liver or kidney disease. Additionally, it documented that the medication can cause confusion and over sedation in the elderly and they should be started on low doses of hydrocodone and acetaminophen. This same reference documented that the total daily dosage for hydrocodone should not exceed 8 tablets in a 24 hour period. It further noted that, the toxic dose for adults for acetaminophen is 10 grams in a 24 hour period. The nursing note dated 10/1/08 at 9:02 am, documented that the resident received acetaminophen 650 mg for right knee pain with	{F 385}		

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{F 385}	Continued From page 7 effectiveness and noted that the resident refused hydrocodone 5 mg and acetaminophen 500 mg for pain and stated "it makes me constipated". During review of the Medication Administration Record (MAR) not dated, indicated that the resident did not receive hydrocodone 5 mg and acetaminophen 500 mg until 10/3/08. During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the Director of Nursing (DON), the physician stated that during review of the multiple orders for hydrocodone and acetaminophen, he realized problems could arise if the resident was given the medications as ordered and discontinued the hydrocodone 5 mg and acetaminophen 500 mg 1 tablet every 2 hours by mouth as needed on 10/2/08. He confirmed that a maximum dosage that could be provided to the resident should have been included in the order. During an interview on 10/9/08 at 3:25 pm, the Registered Nurse Supervisor (RNS) stated that she did have concerns about the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg and acetaminophen. She stated that she knew the physician was aware of the orders because he clarified the orders when he rewrote them. She stated that the physician did not write the prescriptions for the hydrocodone and acetaminophen,, but confirmed that the emergency kit could have been accessed for the medication if the resident had requested the hydrocodone 5 mg and acetaminophen 500 mg for pain. During an interview on 10/10/08 at 9:10 am, the physician stated that he did put a maximum daily	{F 385}		

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{F 385}	Continued From page 8	{F 385}		

dosage on prescriptions and had started to place a maximum daily dosage in his orders.

During an interview on 10/10/08 at 8:45 am, the supervising Registered Pharmacist (RPH) stated that the initial RPH did not fill the orders for hydrocodone 5 mg and acetaminophen 500 mg and sent the orders to Health Direct Services for verification due to the irregular orders. The RPH stated that a "red flag would go up to any RPH" in regards to the acetaminophen levels. He stated that a maximum dosage not to exceed 4 grams should have been written and that multiple orders for Vicodin did not make sense. He stated that the maximum dosage for acetaminophen should be 4 grams and the maximum tablets of hydrocodone 5 mg and acetaminophen 500 mg should be 8 tablets, each in a 24 hour period.

During an interview on 10/10/08 at 12:30 pm, the DON stated that she had noted that the admission orders were not signed by the physician during an audit she had performed. She stated that she did try to contact the physician within the 48 hour time frame for admission orders but was not able to do so.

Resident #32
The resident was admitted to the facility on 9/25/08 with the diagnoses of status post fall with multiple contusions, fractured right shoulder and atrial fibrillation. The MDS dated 9/30/08 assessed the resident with intact short and long term memory with independent decision making skills.

The the Admission orders dated 9/25/08, obtained by verbal order, were noted to have been signed by the physician on 10/1/08. The

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{F 385}	Continued From page 9 verbal orders were not signed by the physician for 6 days. In review of the facility's plan of correction, dated 9/14/08, by the Administrator of the facility, documented that the "MD to sign new admission orders within 48 hours." During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all new admission orders were to be signed within 48 hours by the physician. The Administrator confirmed during this same interview, that the physician had been away during this period. It was confirmed that the Physician Assistant is supposed to cover for the physician when he was not available. During an interview on 10/10/08 at 12:30 pm, the DON stated that she had noted that the admission orders were not signed by the physician during an audit she had performed. She stated that she did try to contact the physician within the 48 hour time frame for admission orders but was not able to do so. She stated that the physician had needed sign the admission orders because he was the medical provider who had given the admission orders. 10 NYCRR415.15(b)(l)(i)(ii)	{F 385}		
{F 501} SS=E	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility.	{F 501}		9/29/08

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{F 501}	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility did not ensure that the Medical Director (MD) implemented resident care policies and appropriately coordinated the medical care provided for two (#'s 91 and 32) of five newly admitted residents reviewed during a post partial extended survey and two complaint investigations (Case#'s NY00060638 and NY00061055). The facility did not ensure that physician orders for a narcotic pain medication and acetaminophen were written to include parameters according to accepted standards of practice and did not sign physician admission orders within 48 hours. Specifically, multiple orders for a pain medication had the potential to be administered with an unsafe level of acetaminophen and a narcotic medication for resident #91 and did not sign resident #32's admission orders within 48 hours as per the policy incorporated into the facility's plan of correction (POC). This is a repeat deficiency from the partial extended survey conducted on 8/8/08. This resulted in no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy. This is evidenced by the following: Resident #91 The resident was admitted to the facility on 9/30/08 with the diagnoses of fractured right knee, diabetes mellitis and hypertension. The Minimum Data Set (MDS) was not available. The Admission Nursing Assessment form, dated 9/30/08 assessed the resident as being alert and oriented. This same assessment, assessed the resident with an ongoing pain management problem in the right knee and assessed the pain	{F 501}		

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	335267	A. BUILDING ____ B. WING ____	R-C **10/09/2008**

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{F 501}	Continued From page 11 level as a "5" (on a pain scale of 0-10, with 10 being the most severe level of pain). The MD admission and standing orders dated 9/30/08, identified that the resident could receive one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 2 hours by mouth as needed for pain and acetaminophen 650 mg every 4 hours by mouth as needed for pain. These same orders, also noted that the initial orders written by the the Registered Nurse Manager (RNM) for the MD to sign (which had a line through them, discontinuing the orders), had indicated that hydrocodone 5 mg and acetaminophen 500 mg could be given 1 tablet every 4 hours and 2 tablets every 4 hours. In a 24 hour period, the total dosage of hydrocodone that could have been administered to the resident was 18 tablets. The total dosage of acetaminophen, if the resident had received the prescribed doses as ordered by the MD, was 12.9 grams in a 24 hour period. The hydrocodone 5 mg and acetaminophen 500 mg Pharmaceutical reference, provided to the facility by the vendor pharmacy, dated 3/07, documented that hydrocodone 5 mg and acetaminophen 500 mg tablets at high doses may produce dose related respiratory depression and should be administered with caution for patients with liver or kidney disease. Additionally, it documented that the medication can cause confusion and over sedation in the elderly and they should be started on low doses of hydrocodone and acetaminophen. This same	{F 501}		

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{F 501}	Continued From page 12	{F 501}		

reference documented that the total daily dosage for hydrocodone should not exceed 8 tablets in a 24 hour period. It further noted that, the toxic dose for adults for acetaminophen is 10 grams in a 24 hour period.

The nursing note dated 10/1/08 at 9:02 am, documented that the resident received acetaminophen 650 mg for right knee pain with effectiveness and noted that the resident refused hydrocodone 5 mg and acetaminophen 500 mg for pain and stated "it makes me constipated".

During review of the Medication Administration Record (MAR) not dated, indicated that the resident did not receive hydrocodone 5 mg and acetaminophen 500 mg until 10/3/08.

During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the Director of Nursing (DON), the MD stated that during review of the multiple orders for hydrocodone and acetaminophen, he realized what problems could arise if the resident was given the medications as ordered and discontinued the hydrocodone 5 mg and acetaminophen 500 mg tablet every 2 hours by mouth as needed on 10/2/08. He confirmed that a maximum dosage that could be provided to the resident should have been included in the order.

During an interview on 10/9/08 at 3:25 pm, the Registered Nurse Supervisor (RNS) stated that she did have concerns about the multiple orders for Vicodin and Acetaminophen. She stated that she knew the physician was aware of the orders because he clarified the orders when he rewrote them. She stated that the physician did not write the prescriptions for the Vicodin as required, but

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{F 501}	Continued From page 13	{F 501}		

confirmed that the emergency kit could have been accessed for the medication if the resident had requested the Vicodin for pain.

During an interview on 10/10/08 at 9:10 am, the MD stated that he did put a maximum daily dosage on prescriptions and had started to place a maximum daily dosage in his orders.

During an interview on 10/10/08 at 8:45 am, the supervising Registered Pharmacist (RPH) stated that the initial RPH did not fill the orders for hydrocodone 5 mg and acetaminophen 500 mg and sent the orders to Health Direct Services for verification due to the irregular orders. The RPH stated that a "red flag would go up to any RPH" in regards to the acetaminophen levels. He stated that a maximum dosage not to exceed 4 grams should have been written and that multiple orders for hydrocodone 5 mg and acetaminophen 500 mg did not make sense. He stated that the maximum dosage for acetaminophen should be 4 grams and the maximum tablets of hydrocodone 5 mg and acetaminophen 500 mg should be 8 tablets, each in a 24 hour period.

During an interview on 10/10/08 at 12:30 pm, the DON stated that she had noted that the admission orders were not signed by the physician during an audit she had performed. She stated that she did try to contact the physician within the 48 hour time frame for admission orders but was not able to do so.

During an interview on 10/10/08 at 12:40 pm, the Administrator confirmed that the physician who gave the verbal admission orders was also the MD of the facility.

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Resident #32
The resident was admitted to the facility on 9/25/08 with the diagnoses of status post fall with multiple contusions and fractured right shoulder and atrial fibrillation. The MDS dated 9/30/08 assessed the resident with intact short and long term memory with independent decision making skills.

The admission orders dated 9/25/08, obtained by verbal order, were noted to have been signed by the physician on 10/1/08. The verbal orders were not signed by the MD for 6 days.

During an interview on 10/9/08 at 11:20 am, the Administrator and the Director of Nursing (DON) confirmed that the MD had been involved in all aspects of developing and implementing the POC.

During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all new admission orders were to be signed within 48 hours by the physician. The Administrator confirmed during this same interview, that the MD had been away during this period. It was confirmed that the physician assistant is supposed to cover for the physician when he was not available. The MD confirmed that the policy and procedure for signing physician admission orders was not followed.

During an interview on 10/10/08 at 12:30 pm, the DON stated that she had noted that the admission orders were not signed by the physician during an audit she had performed. She stated that she did try to contact the physician

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{F 501}	Continued From page 15 within the 48 hour time frame for admission orders but was not able to do so. She stated that the physician had needed sign the admission orders because he was the medical provider who had given the admission orders. During an interview on 10/10/08 at 12:40 pm, the Administrator confirmed that the physician who gave the verbal admission orders was also the MD of the facility. 10 NYCRR 415.15(a)	{F 501}		
{F 520} SS=E	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}		9/29/08

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{F 520}	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, it was determined that the facility failed to have a Quality Assurance (QA) program which effectively identified problems and established corrective actions to ensure that each resident was provided services that met professional standards of quality and had appropriate medical management during a post partial extended survey and complaint investigations (Cases # NY00060638 and # NY00061055). Specifically, the facility failed to have a Quality Assurance (QA) program which effectively identified problems and established corrective actions to ensure that residents did not have multiple orders for a pain medication that had the potential to be administered with an unsafe level of acetaminophen and a narcotic. Additionally, professional staff did not question the unsafe orders and the MD failed to ensure that a resident's admission orders were signed within a 48 hour time period as per the facilities Plan of Correction (POC). This is a repeat deficiency from the partial extended survey conducted on 8/8/08. This resulted in no actual harm with a potential for more than minimal harm that is not Immediate Jeopardy. This is evidenced by the following: Resident #91: The physician admission and standing orders dated 9/30/08, identified that the resident could receive one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 milligrams (mg) and acetaminophen 500 mg every 2 hours by mouth	{F 520}		

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{F 520}	Continued From page 17	{F 520}		

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as needed for pain and acetaminophen 650 mg every 4 hours by mouth as needed for pain. These same orders, also noted that the initial orders written by the the Registered Nurse Manager (RNM) for the physician to sign (which had a line through them, discontinuing the orders), had indicated that hydrocodone 5 mg and acetaminophen 500 mg could be given 1 tablet every 4 hours and 2 tablets every 4 hours.

In a 24 hour period, the total dosage of hydrocodone that could have been administered to the resident was 18 tablets. The total dosage of acetaminophen, if the resident had received the prescribed doses as ordered by the physician, was 12.9 grams in a 24 hour period.

The hydrocodone 5 mg and acetaminophen 500 mg Pharmaceutical reference, provided to the facility by the vendor pharmacy, dated 3/07, documented that hydrocodone 5 mg and acetaminophen 500 mg tablets at high doses may produce dose-related respiratory depression and should be administered with caution for patients with liver or kidney disease. Additionally, it documented that the medication can cause confusion and over sedation in the elderly and they should be started on low doses of hydrocodone and acetaminophen. This same reference documented that the total daily dosage for hydrocodone should not exceed 8 tablets in a 24 hour period. It further noted that, the toxic dose for adults for acetaminophen is 10 grams in a 24 hour period.

The nursing note dated 10/1/08 at 9:02 am, documented that the resident received acetaminophen 650 mg for right knee pain with effectiveness and noted that the resident refused

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{F 520}	Continued From page 18 hydrocodone 5 mg and acetaminophen 500 mg for pain and stated "it makes me constipated". During review of the Medication Administration Record (MAR) not dated, indicated that the resident did not receive hydrocodone 5 mg and acetaminophen 500 mg until 10/3/08. During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the Director of Nursing (DON), the physician stated that during review of the multiple orders for hydrocodone and acetaminophen, he realized what problems could arise if the resident was given the medications as ordered and discontinued the hydrocodone 5 mg and acetaminophen 500 mg tablet every 2 hours by mouth as needed on 10/2/08. He confirmed that a maximum dosage that could be provided to the resident should have been included in the order. During an interview on 10/9/08 at 3:20 pm, the Registered Nurse Manager (RNM) stated that she wrote both orders for the hydrocodone 5 mg and acetaminophen 500 mg and was aware that Acetaminophen was a standing order on the Admission orders and signed off the orders after the physician had written them. She further stated that she had questions about the multiple orders but wrote the orders for the physician to sign. She stated that she followed facility policy that indicated that the medication orders from the hospital needed to be reconciled exactly as written. She stated she followed the policy and wrote the orders for hydrocodone 5 mg and acetaminophen 500 mg to be given 1 tablet every 4 hours and 2 tablets every 4 hours as needed. She stated she did not see the physician but did see that he had changed the hydrocodone 5 mg	{F 520}		

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{F 520}	Continued From page 19 and acetaminophen 500 mg orders to one tablet of hydrocodone 5 mg and acetaminophen 500 mg every 4 hours by mouth as needed for pain, one tablet of hydrocodone 5 mg and acetaminophen 500 mg every 2 hours by mouth as needed for pain and therefore must have addressed the concern. She confirmed she was aware that there should be a maximum dosage for both medications but did not further question the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg and Acetaminophen. During an interview on 10/9/08 at 3:25 pm, the Registered Nurse Supervisor (RNS) stated that she did have concerns about the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg and Acetaminophen. She stated that she knew the physician was aware of the orders because he clarified the orders when he rewrote them. She stated that the physician did not write the prescriptions for the hydrocodone 5 mg and acetaminophen 500 mg as required, but confirmed that the emergency kit could have been accessed for the medication if the resident had requested the Vicodin for pain. During an interview on 10/10/08 at 8:45 am, the supervising Registered Pharmacist (RPH) stated that the initial RPH did not fill the orders for hydrocodone 5 mg and acetaminophen 500 mg and sent the orders to Health Direct Services for verification due to the irregular orders. The RPH stated that a "red flag would go up to any RPH" in regards to the acetaminophen levels. He stated that a maximum dosage not to exceed 4 grams should have been written and that multiple orders for hydrocodone 5 mg and acetaminophen 500 mg did not make sense. He stated that the maximum dosage for acetaminophen should be 4	{F 520}		

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{F 520}	Continued From page 20 grams and the maximum tablets of hydrocodone 5 mg and acetaminophen 500 mg should be 8 tablets, each in a 24 hour period. The RPH, that initially had questioned the multiple orders for hydrocodone 5 mg and acetaminophen 500 mg was not available for interview. During an interview on 10/10/08 at 12:30 pm, the DON and the Administrator confirmed that all nursing staff had been inserviced on medication administration. Policy and procedures were implemented as part of the POC. The MD had been involved in all aspects of the POC. They confirmed that the QA program that had been instituted did not have effective corrective actions in place to ensure that residents did not have multiple orders for medications. Resident #32: During review of the the Admission orders dated 9/25/08, obtained by verbal order, were noted to have been signed by the physician on 10/1/08. The verbal orders were not signed by the physician for 6 days. In review of the POC dated 9/14/08 by the Administrator of the facility, documented that the "MD to sign new admission orders within 48 hours." During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all new admission orders were to be signed within 48 hours by the physician. The Administrator confirmed during this same interview, that the physician had been away during this period. It was confirmed that the Physician Assistant is supposed to cover for the	{F 520}		

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{F 520}	Continued From page 21 physician when he was not available. During an interview on 10/10/08 at 12:30 pm, the DON confirmed that she had noted that the admission orders were not signed by the physician during an audit she had performed. She stated that she did try to contact the physician within the 48 hour time frame for admission orders but was not able to do so. She stated that the physician had needed sign the admission orders because he was the medical provider who had given the admission orders. During this same interview the Administrator and the DON confirmed that the QA program they had established in the POC had not been effective 10NYCRR415.27(a-c)	{F 520}		

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{I200}	415.18 Pharmacy Services This Regulation is not met as evidenced by: Effective Date: 04/17/96 Title: Section 415.18 - Pharmacy services (i)Verbal orders: All medications administered to residents shall be ordered in writing by a legally authorized practitioner unless unusual circumstances justify a verbal order, in which case the verbal order shall be given to a licensed nurse, or to a licensed pharmacist, immediately reduced to writing, authenticated by the nurse or registered pharmacist and countersigned by the prescriber within 48 hours. In the event a verbal order is not signed by the prescriber or a legally designated alternate practitioner within 48 hours, the order shall be terminated and the facility shall ensure that the residents medication needs are promptly evaluated by the medical director or another legally authorized prescribing practitioner. The facility did not ensure that the prescribing practitioner countersigned verbal orders within 48 hours for seven (#'s 15, 32, 41, 49, 76, 91 and 114) of 14 residents reviewed during the post partial extended survey and complaint investigations #'s NY00060638 and NY00061055. This resulted in no actual harm with the potential for minimal harm that is not immediate jeopardy. This is evidenced by: Resident #41 The resident was admitted to the facility on 9/24/08 with diagnoses of elective left hip replacement, osteoarthritis and hypertension. A physician's verbal order dated 9/30/08 to discontinue coumadin on 10/18/08 was not countersigned until 10/7/08 and was not within the 48 hours requirement.	{I200}		9/29/08

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{I200}	Continued From page 1 During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all verbal orders should have been signed within 48 hours by the physician. Resident #15 The facility did not ensure that verbal orders were countersigned within 48 hours for this resident. The resident was admitted to the facility on 3/11/03 with diagnoses of depression, neurogenic bladder and anemia. A physician verbal order dated 10/2/08 to empty and document drainage from a nephrostomy tube every shift was not countersigned until 10/7/08, not within 48 hours. During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all verbal orders should have been signed within 48 hours by the physician. Resident #114 The resident was admitted to the facility on 5/27/08 with diagnoses of right lower lobe pneumonia, MRSA in the sputum and non small cell lung cancer. Physician verbal orders dated 10/3/08 for comfort care, a verbal order dated 10/4/08 to hold coumadin unit 10/7/08, start Omeprazole 40 milligrams (mg) by mouth daily and to start Tylenol 650 mg by mouth every eight hours and a verbal order dated 10/5/08 for a Hospice consult were not countersigned until 10/8/08. All the orders were not within the 48 hours requirement.	{I200}		

New York State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335267	A. BUILDING ______ B. WING ______	R-C **10/09/2008**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRONDACK MEDICAL CENTER UIHLEIN	**185 OLD MILITARY ROAD LAKE PLACID, NY 12946**

(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) COMPLETE DATE
{I200}	Continued From page 2 During an interview on 10/9/08 at 11:38 am with the physician, the Administrator and the DON, it was confirmed that all verbal orders should have been signed within 48 hours by the physician.	{I200}		

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F 156 SS=E	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting	F 156		9/29/08

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

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

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F 156	Continued From page 1 personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and	F 156		

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F 156	Continued From page 2	F 156		

applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview during a complaint investigation (Case #NY00060638) and partial extended survey, the facility did not ensure the resident's advance directives, as indicated by the resident's surrogate, were completed thoroughly and in a timely manner for six (Resident #'s 6, 7, 10, 13, 18 and 31) of seven residents without the capacity to consent to a Do Not Resuscitate (DNR) determination on all three nursing units. Specifically, the facility's written DNR determination forms for a resident without capacity to consent and with a surrogate, were not signed by all three required parties (the surrogate, the attending physician and a concurring physician) prior to writing a DNR order. This was a pattern of deficient practice that was not actual harm with the potential for more than minimal harm that was not immediate jeopardy. This was evidenced by the following examples:

Resident #6:

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The facility did not fully complete the DNR determination papers for this resident in a timely manner, yet had a written DNR order. The facility transferred this resident to the hospital and identified her with a DNR status on 7/25/08.

The resident was admitted to the facility on 6/24/08 with diagnoses including hypertension, atrial fibrillation, and osteoarthritis. The initial Minimum Data Set (MDS) assessment tool, dated 7/7/08, assessed the resident to have short and long term memory problems, delirium indicators of periods of restlessness, lethargy and mental status function varied over the course of the day. This resident was usually understood and able to understand others.

The consent for a DNR paperwork, for a resident without capacity, was not completed prior to the written DNR order. The facility's admission orders, dated 6/24/08, were check marked DNR order and were not signed by the physician. The DNR consent forms for a resident without capacity and with a surrogate, had the attending physician signature dated 6/26/08. The concurring physician signed on 8/4/08 and the resident's surrogate signature was dated 8/4/08.

The hospital history and physical, dated 7/25/08, documented the resident was a DNR based on the nursing home's paperwork.

Resident #7:
The facility did not have DNR consent paperwork completed prior to the order being written for DNR on 7/16/08. The facility had initiated the DNR papers for a resident without capacity and with a surrogate, and had one undated physician signature on the form. The facility did not obtain

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F 156	Continued From page 4 signatures by resident's surrogate nor a concurring physician. The resident was admitted to the facility on 7/16/08 with diagnoses including chronic subdural hematoma, poorly controlled diabetes and dementia. The 5-day MDS, dated 7/28/08, assessed the resident to have short and long term memory problems, and severely impaired decision making skills; and the resident was assessed to sometimes be understood and sometimes understands other people. The Admission Orders dated 7/16/08, contained a DNR order and were not signed by the attending physician. Resident #31: The facility did not have the DNR paperwork completed prior to writing a DNR order, and on 8/4/08 following identification of the incomplete DNR paperwork the DNR order was rescinded with the resident changed to a resuscitate status. The resident was admitted to the facility on 3/25/04 with diagnoses of anemia, gastroparesis and dementia. The full printed physician's orders signed on 7/3/08 read "DNR". The facility had initiated DNR forms for a resident without capacity and with a surrogate on 3/1/04. The attending physician signed the form on 3/1/04 and a concurring physician signed the form on 3/2/04, yet the form did not have any surrogate consent as of 8/4/08. On 8/4/08, a written physician's order read "resuscitate order in place". The facility's written policy and procedure titled "Advance Directives", dated 9/05, identified three staff had responsibility for the completion of the	F 156		

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F 156	Continued From page 5 facility's paperwork. The Admissions Coordinator was to obtain the signature of the resident or representative and provide the copy to the unit Nurse Manager. The Nurse Manager was to ensure all the forms were completed and then share them with the physician for the order to written promptly. The physician was to review the documents, discuss the advance directives with the resident or representative, complete the paperwork and write the orders. This policy additionally stated the interdisciplinary team would review the advance directives at least quarterly during the resident's care conference. 10NYCRR 415.3(e)(2)(iii)	F 156		
F 157 SS=G	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as	F 157		9/29/08

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Continued From page 6

specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on medical record review and staff interview during complaint investigations (#'s NY00060638 and NY00061055) and a partial extended survey, the facility did not ensure the physician was consulted when there was a significant change in the resident's physical, mental or psychosocial status for four (Residents # 1, 17, 18 and 20) of six residents reviewed on two units. Specifically, the facility did not notify the physician when, Resident #1 was noted to have a change in condition, when staff were unable to arouse the resident on 7/25/08 for more than 5 hours; when Resident #17's pressure ulcer increased in size and developed tunneling to the right and left sides of the wound; when the Resident #18's left toe was red and swollen and the resident stated she could not feel her toe and did not even know if she had a toe. This was actual harm that was not Immediate Jeopardy.
This was evidenced by:

Resident # 1
The facility failed to notify the resident's physician of a significant change in the resident's condition when the staff were unable to arouse the newly admitted resident with verbal or physical stimuli for more than 5 hours. This resulted in actual

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F 157	Continued From page 7 harm to the resident who was admitted to the hospital with a diagnosis of benodiazepine overdose. The resident was admitted to the facility on 7/24/08 at approximately 1:00 pm with diagnoses of MRSA (methicillin resistant staphylococcus aureus) of the left elbow, neurogenic bladder, pacemaker implantation and anxiety disorder. The facility nursing admission assessment form dated 7/24/08, assessed the resident to be alert and oriented times 3 (oriented to person, place and time) and documents that the resident responds to voice and touch. A nurse's note written by the RN Nurse Manager (RNNM #1) and dated 7/26/08 at 8:33 am, titled "Late Entry from 7/25/08 at 8:00 am "documented a CNA reported the resident was not waking up for breakfast. RN #1 attempted to wake the resident with no success. RNNM #1 had been informed that the resident had been administered two doses of Xanax 1.25 mg, one dose on 7/24/08 at 10:30 pm and a second dose on 7/25/08 at 12:30 am . The resident's vital signs (VS) on 7/25/08 at 8:00 am were blood pressure 128/70 heart rate 68, respirations 18 oxygen saturation on 3 liters of oxygen by nasal cannula 93%. RNNM # 1 advised staff that Resident # 1 may be tired from being up until 2:00 AM and to notify writer (RNNM#1) if the resident did not wake up in an hour or two. The writer (RNNM# 1) and charge nurse were alerted at 11:00 am with a slight drop in VS 102/64, 60, 14 and oxygen saturation on 3 liters of oxygen by nasal cannula 96%. A call was then made to the physician's assistant and the resident was transferred to the emergency room for an evaluation for a non-responsive episode at 11:30 am.	F 157		

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During an interview with a Certified Nurse Assistant (CNA#1), (who was on duty for part of the evening shift on 7/24/08 and the 11:00 pm-7:00 am shift for 7/25/08), was interviewed on 8/4/08 at 10:00 am, and stated around 6:00 am on 7/25/08, she was asked by the LPN charge nurse to help stand the resident so he could be catheterized. At that time the resident did not respond and the charge nurse and CNA #1 shook him and called him by name (attempted to arouse him) "but he didn't wake up. The LPN charge nurse told me to get the stand lift and try to get the resident to stand on the lift and pull his pants down for the catheterization but he wasn't responding and we couldn't get him to stand,even in the lift. I went and told the nurse manager (RN# 1) that we couldn't get him to stand in the lift and she said to let him sleep that he was probably tired."

CNA # 2 was interviewed on 7/29/08 at approximately 2:40 pm, she was on duty 7/25/08, 7:00 am-3:00 pm shift. CNA #2 stated, "I started my shift at 7:00 am and saw the resident (Resident #1) in his room. I called his name. I shook him and I lifted his head with both of my hands. He didn't wake up. When his eyes were opened they stayed fixed (staring). The charge nurse (LPN# 1) told me this Resident (# 1) had been like that since he had medication around midnight. I told LPN #1 that something was wrong, it was like he was in a coma. I couldn't wake him up for breakfast. I didn't even try to put food in his mouth. I got the nurse manager (RNNM #1) and they took his vital signs. He felt cold to me. The nurse manager said he was okay. The charge nurse (LPN #1) told the nurse manager that after he had his medicine (at 12:30

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F 157	Continued From page 9 am) nobody could wake him up. I spoke to the charge nurse about him again later in the morning but no one did anything. I told the charge nurse (LPN #1) I think he's in a coma." During an interview with the Charge Nurse (LPN # 1) on 7/30/08 at approximately 10:00 am LPN#1 stated, "...on 7/25/08 around 6:30 am - 7:00 am the resident was still sitting in his chair and I had to stand him. I tried standing him alone but wasn't able to stand him up. I got the CNA and we tried together and we couldn't stand him. He was in and out of it. I told the CNAs to use the stand lift (mechanical lift) and stand him and get his pants pulled down so I could catheterize him and then I went on a break. When I came back from break the nurse manager (RN#1) told me the CNAs couldn't use the stand lift with him because he couldn't hold onto the lift. I catheterized (the resident) in the chair. He was pretty out of it. He might have lifted his head but he didn't speak. Later I went in the resident's room with the CNA (CNA #2) and the nurse manager (RNNM #1) maybe around 8:00 am. We got vital signs and tried to wake him. I tapped his shoulder, called his name loudly, moved his arms but there was no response. The nurse manager (RNNM #1) thought he had had a busy day (previous 24 hours) and was awake a lot and we should let him sleep. Somewhere between 10:00 am and 11:00 am the nurse manager (RNNM #1) called to me and told me to get vital signs on the resident. They were not much different from the earlier set of vital signs." The nurse manager (RNNM #1) was interviewed on 7/29/08 at approximately 3:15 pm. RNNM #1 stated, "I came on duty around 6:30am. The CNA (CNA # 2) told me she couldn't arouse	F 157		

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F 157	Continued From page 10 (awaken) the resident for breakfast. The night nurse had said in report that the resident was awake until around 2:00 am after his second dose of Xanax (Alprazolam). We went in the room and the resident's vital signs were okay. I told the CNA (CNA # 2) to let me know if he didn't wake up in an hour or two. Around 11:00 am I was called to the room again to look at the resident. His vital signs had changed a little. I didn't do neuro (neurological) checks then and hadn't done them earlier. I moved his shoulders and gently shook him and called his name but he didn't respond to any of that. He wasn't warm anymore. He was cold. I called the PA (physician's assistant) and we sent him to the ER (emergency room)." The resident was admitted to the hospital with a diagnosis of benzodiazepine. Resident # 17 The facility did not ensure that the physician was consulted when there was a significant change in the resident's physical status. The physician was not notified when the resident's (Resident # 17) pressure ulcer increased in size and developed tunneling to the right and left sides of the wound. The resident was admitted to the facility on 05/23/03 with diagnoses of multiple sclerosis, congestive heart failure (CHF) and low blood pressure. The minimum data set (MDS) dated 05/07/08 assessed the resident as having intact long and short-term memory and independent with decision-making. A nurses note dated 07/30/08 timed at 08:28:01(electronic medical record) and subtitled "Late entry skin rounds 7/24/08: Inner aspect of coccyx wound measures 3.5 x 4 with entire wound measuring 4.3 x 5. Entire wound depth	F 157		

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F 157	Continued From page 11 0.7, left tunneling, right tunneling 1.5. (This nurses' note did not include what measurement scale was used for these numbers). A physician progress note dated 7/22/08 documented, "she does have a sore on her coccyx area which was developed presumably from pressure from a bedpan." During an observation of dressing change to the coccyx pressure ulcer wound on 08/06/08 at approximately 11:00 am the treatment nurse stated the resident's dressing change was done while she was on the commode as this is the resident's preference. The dressing change was stopped, by the investigator, when the treatment was attempting to pack the wound with a wet to dry dressing while previous packing was still in place. During an interview with the facility physician on 08/08/08 at approximately 9:30 am, he stated he was aware of the resident's pressure ulcer on the coccyx area but that he was not aware that " tunneling" had developed in the coccyx wound. Resident # 18 The facility did not ensure that the physician was consulted when there was a significant change in the resident's physical status. The physician was not notified when the resident's (Resident # 18) toe became red swollen and the resident had complained that she could not feel her toe. The resident was admitted to the facility on 01/24/06 with diagnoses of heart failure, hypertension and osteoarthritis. The Minimum Data Set (MDS) dated 05/09/08 assessed the resident as having intact long and short-term	F 157		

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F 157	Continued From page 12 memory with moderately impaired decision-making. During an observation of the resident's wound care on 08/07/08 at 10:45 am, the resident's left fifth toe was very red and swollen with a loose crust over a pressure sore. When the treatment nurse questioned if the resident was having pain the resident replied, "I don't feel it (referring to her left fifth toe). I don't even know I have a toe." During an interview with a facility physician on 08/08/08 at approximately 9:30 am the physician stated he had not been informed by staff that this resident's toe was red, and swollen, or that the resident had expressed she could not feel her toe, but that he would check it out (evaluate). 10NYCRR 415.3(e)(2)(ii)(b)	F 157		
F 281 SS=K	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview during complaint investigations (Case #'s NY00060638, NY00061055) and a partial extended survey, the facility failed to ensure that services provided met professional standards of quality for fifteen (Resident's #1, 4, 5, 6, 7, 8, 12, 17, 18, 20, 27, 29, 30, 32 and 34) of thirty-four residents reviewed. Specifically, the facility failed to assess Resident #1's neurological function in a timely manner when the resident was noted to be unresponsive; failed to follow the physician's order to catheterize Resident # 1 every six hours;	F 281		9/29/08

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failed to adequately and accurately assess Resident # 5 who was found on the floor after an unwitnessed fall and when the resident began having changes in her condition a few days after the fall; failed to assess Resident # 6, who was admitted to the hospital for rectal bleeding after two days duration. The facility failed to follow the physician assistant's order to send Resident # 20 to the hospital if the resident still had a fever in an hour and failed to provide an adequate assessment for Resident # 20, who was admitted to the hospital on 7/9/08. This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care. This is evidenced by the following examples:

Resident # 1
The facility failed to conduct an accurate and timely assessment of this resident's change in condition (physical functioning and level of responsiveness); notify the physician in a timely manner or timely transfer the resident to an acute care facility for treatment when the resident was unresponsive.

The resident was admitted to the facility for rehabilitation on 7/24/08 at 1:30 pm with diagnoses of methicillin resistant staphylococcus aureus (MRSA) of the left elbow, neurogenic bladder, pacemaker implantation and anxiety disorder. The facility nursing admission assessment form, dated 7/24/08, assessed the resident to be alert and oriented to person, place and time, and states that the resident responds to voice and touch.

A nurse's note written by the RN Nurse Manager (RN#1), dated 7/26/08 at 8:33 am, titled "Late Entry from 7/25/08 at 8:00 am " documented that

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F 281	Continued From page 14 the CNA stated the resident was not waking up for breakfast. RN #1 attempted to wake the resident without success. RN#1 was informed that the resident had been administered two doses of Xanax 1.25 mg., one dose at 10:30 pm 7/24/08 and a second dose at 12:30 am, on 7/25/08. (Xanax is an anti-anxiety medication). Vital signs were blood pressure 120/70, heart rate 68 (beats per minute) respirations 18 (per minute) and oxygen saturation (on 3 liters of oxygen per minute) was 93% was withing normal limits. RN #1 advises staff he (Resident # 1) may be tired from being up until 2:00 am, and to let her know if he did not wake up in an hour or two. RN#1 and charge nurse were alerted at 11:00 am that Resident #1 had a slight drop in vital signs. (vital signs not documented) The physician assistant was notified and ordered the resident to be transferred to the emergency department for an evaluation due to being non-responsive. On 7/25/08 at approximately 5:45 am the resident was noted to be unresponsive to the unit nurse's (LPN#1) verbal and tactile stimuli. A Registered Nurse (RN) was not notified by the unit nurse at the time of the resident's change in function and level of responsiveness. The RN Nurse Manager (RN#1) was informed at 6:30 am, when she arrived on the unit, that two CNA's had difficulty attempting to stand the resident. At 8:00 am, a CNA reported an inability to arouse the resident to the unit LPN (LPN#1) and RN#1. The LPN obtained vital signs and the RN#1 believed the resident to be tired and sleeping. RN#1 instructed the staff to notify her in an hour or two if staff was still unable to arouse the resident. At 11:00 am, the Facility Administrator and RN, were asked to "look at the resident because he was unresponsive." The administrator stated she	F 281		

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F 281	Continued From page 15 thought he was "apneic at first" and called for the unit nurses. When RN#1 assessed the resident at that time "he was unarousable, his skin was cool and his color was different." A call was placed to the Physician's Assistant and transfer to the hospital Emergency Room (ER) was ordered. The resident was assessed at the ER with a temperature of 89 degrees Fahrenheit (normal 98.6 degrees). The resident was diagnosed at the ER to have had a benzodiazepine overdose with coma. During an interview on 8/4/08 at approximately 10:00 am CNA#1 stated, "I was assigned to work from 11:00 pm, 7/24/08 to 7:00 am, 7/25/08 but came in a few hours early. I had a conversation with the resident (Resident # 1) during the evening and he was anxious but, alert and oriented. I spoke with him for about 45 minutes at that time. I didn't speak with him again until after 12:30 am-1:00 am on 7/25/08. I was asked around 6:00 am on 7/25/08 by the LPN charge nurse (LPN#1) to help stand the resident so he could be catheterized. At that time the resident didn't respond. LPN#1 and I shook him and called him by name but he didn't wake up. LPN#1 told me to get the stand lift (a device used to transfer) and try to get the resident to stand on the lift and pull his pants down for the catheterization. We tried but the resident wasn't responding and we couldn't get him to stand even in the lift. I went and told the nurse manager (RN#1) that we couldn't get him to stand and she said to let him sleep that he was probably tired. I went back and covered him up and let him sleep. I told the CNA that came on for the day shift about him and that we couldn't wake him up and then I went home." An interview was conducted with CNA# 2 on	F 281		

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F 281	Continued From page 16 7/29/08 at approximately 2:40 pm. who stated, "I started my shift at 7:00 am and made rounds and went in and saw the resident (Resident # 1). I called his name, I shook him, and I lifted his head with both of my hands but he didn't wake up. His eyes were open and they stayed fixed (staring). The charge nurse (LPN #1) told me the resident had been like that since he had medication around midnight. I told LPN #1 that something was wrong. It was like he was in a coma. I couldn't wake him up for breakfast. I didn't even try to put food in his mouth. I got the nurse manager (RN#1) and we took his vital signs. He felt cold to me. The nurse manager said he's okay. The charge nurse (LPN# 1) told the nurse manager that after he had his medicine (at 12:30 am) nobody could wake him up. I was in the room 4 or 5 times through the morning and I spoke to the charge nurse about him again but no one did anything. I told (LPN #1) during the morning. I think he's in a coma. Then the administrative aide (AA) came on the unit and I asked her to look at the resident. I knew she could get something done for the resident. The AA went and got the facility administrator. The Administrator had someone call the ambulance." The nurse manager (RN#1) was interviewed on 7/29/08 at approximately 3:15 pm. In the interview she stated, "I came on duty around 6:30 am. Around 8:00 am the CNA (CNA#2) told me she couldn't arouse the resident for breakfast. The night nurse had said in report that the resident was awake until around 2:00 am and that he had a second dose of Xanax at 12:30 am. We (CNA#1, LPN#1 and RN#1) went into the room and the resident's vital signs were okay. I told (CNA# 2) to let me know if the resident didn't wake up in an hour or two. Around 11:00 am I	F 281		

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was called to the room again to look at the resident. At that time he felt cold to me. His vital signs had changed a little. I didn't do neuro (neurological) checks then or hadn't done them earlier. I moved his shoulders and gently shook him and called his name but he didn't respond to any of that. I called the PA (physician's assistant) and we sent him to the ER. After he was at the hospital for an hour or so a nurse called from the hospital and asked about the dose of his Xanax. Then there was a second call from a nurse at the hospital and she said that he had been given an excessive dose of Xanax at the nursing home. That's when the charge nurse and I looked at the chart and saw that he received Xanax 1.25 mg at 10:30 pm and 12:30 am but the dose should have been Xanax 0.125 mg."

The LPN charge nurse (LPN#1) was interviewed on 7/30/08 at approximately 10:00 am. LPN#1 stated he came to work at 11:30 pm on 7/24/08 and was told by the evening LPN that the resident was anxious and she had given him a dose of Xanax at 10:30 pm. When I saw the resident I didn't think his color looked good. I checked his O2 sat (oxygen saturation, a measure of amount of oxygen in the blood) and it was around 60% (normal being over 90%). I switched him from the oxygen concentrator to the oxygen tank and his O2 sat went up to the 90's (normal). I told the CNA's to put him in his chair because he said he slept better in the chair. I gave him another dose of Xanax around 12:30 am. Around 6:30 am he was still in the chair and I tried to stand him to pull his pants down so I could catheterize him. I wasn't able to get him to stand so I got the CNA and we tried together. We couldn't stand him up and he was in and out of it. I told the CNA's to use the stand lift (mechanical

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lift) and stand him and get his pants down so I could catheterize him and then I went on a break. When I came back from break the nurse manager told me the CNA's couldn't stand him with the lift because he couldn't hold on to it. I catheterized him then in the chair. He was pretty out of it. He might have lifted his head but he didn't speak. Later, around 8:00 am I went to the resident's room with the CNA (CNA# 2) and the nurse manager (RN#1). We got vital signs and they were okay. I tried to wake him by tapping his shoulder and I called his name loudly and moved his arms but there was no response. The nurse manager thought he had a busy day (previous 24 hours) and was awake a lot and said we should let him sleep. Between 10:00 am and 11:00 am the nurse manager (RN#1) called me and told me to get vital signs on the resident again. They were not much different from the earlier set of vital signs."

The "Pre Hospital Care Report" (ambulance record) " dated 7/25/08, under the "objective assessment " section documented the resident was found sitting in a chair, slumped over, airway patent, breathing regular, labored, shallow breathing. The resident was unresponsive and a secure airway intubated with a 7.5mm tube placed.

The "Record of Emergency Room Visit ", dated 7/25/08 documented that the resident was transferred from the facility after being found unresponsive but breathing. The resident was intubated by EMS en route per paramedic protocol. Under the Emergency Room Course section of the summary it states, " the patient was given multiple doses of Romazicon (a drug used to reverse symptoms of sedation from

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benzodiazepines (alprazolam) of which initially patient became much more arousable and restless and agitated. He was given additional doses of Romazicon and was eventually started on a Romazicon drip. The patient did become more awake and was eventually extubated". Under the A (assessment) section of this form, the document states, "Benzodiazepine overdose with subsequent coma."

The hospital death summary states, "after admission, he (Resident #1) was noted to be hypothermic with a low temperature of 89.0 degrees AF."

The facility admission orders, dated 7/24/08 under the "treatment section" documented "straight cath (catheterize) q6h (every six hours)." The facility treatment sheet in the treatment section documented "straight cath q6h"(every six hours) to be done at 12:00 midnight, 6:00 am, 12:00 noon and 6:00 pm.

During an interview with the charge nurse LPN (LPN#1) on duty at 12:00 midnight and 6:00 am for 7/25/08, LPN #1 stated he catheterized the resident around 6:30 am on 7/25/08 and got about 300cc of urine from the resident's bladder. LPN#1 stated I didn't catheterize the resident for the 12:00 midnight catheterization. I'm not sure why I didn't, but I didn't."

Resident # 5
The facility failed to conduct an accurate and timely assessment of this resident's condition (physical functioning and level of responsiveness) after being found on the floor.
The resident was found on the floor on a crash pad alongside her bed on 7/27/08 at

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approximately 9:30 pm after an unwitnessed fall out of bed. Neuro (neurological) checks were not initiated on the resident after the fall. Per RN#1 neuro checks were not done because there was no way to tell if the resident hit her head during the fall. RN#1 stated that the resident had experienced vomiting, mental status changes and unresponsiveness since the fall but that she (RN#1) had not really thought about placing the resident on neuro checks.

The resident was admitted to the facility on 7/02/08 with diagnoses of CVA (cerebral vascular accident) with aphasia, fractured right patella and PVD (peripheral vascular disease). The most recent Minimum Data Set (MDS) dated 07/14/08 assessed the resident as having short term memory impairment and long term memory intact with modified independence with decision-making.

A physician's order dated 7/29/08 documented "initiate Lap Buddy in w/c. MD to evaluate for extreme restlessness."

The nurse's note dated 07/27/08 at 22:20:25 read "At 9:30 pm writer called to room, resident lying on right side on crash pad. Resident denies any pain or discomfort ,+ ROM (range of motion) in all extremities, body check revealed no red areas. Resident assisted BTB (back to bed). VS (vital signs) to be taken by LPN. Family notified." A review of nurse's notes from 7/27/08 to 8/2/08 reveals there are no vital signs documented from 7/27/08 until 8/1/08 and there is no indication that neuro (neurological) checks were done at the time of the fall on 7/27/08 or again until after a second fall on 8/2/08.

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During an interview with the RN nurse manager (RN#1) on 8/2/08 at approximately 12:45 pm, RN#1 stated that neuro checks would be done on a resident if the resident hit their head during a fall. RN#1 was asked if neuro checks were done on Resident #5 after her fall from bed on 7/27/08. RN#1 responded that neuro checks were not done because there was no way to tell if the resident hit her head during the fall. RN#1 stated that the resident experienced vomiting, mental status changes and unresponsiveness since the fall but that she (RN#1) "hadn't really thought about placing her (Resident # 5) on neuro checks but now that you mention it, it's probably a good idea."

During an interview on 8/2/08 at approximately 11:30 am, LPN #1 stated the resident (Resident #5) had fallen out of bed earlier that morning but he did not know if she hit her head during the fall. LPN#1 stated he would start neuro checks now (at the time of the interview) but the resident had not had neuro checks done prior to the fall of 7/27/08. "I'm just starting them (neuro checks) now."

Resident # 6
The facility failed to assess the resident for rectal bleeding and the medical record does not provide documentation that the resident was experiencing rectal bleeding. On 7/25/08 the resident was transported to the local emergency room (ER) and subsequently admitted to the hospital. ER notes documented the resident had rectal bleeding of two days duration prior to transfer to the hospital.

The resident was admitted to the facility on 06/24/08 with diagnoses of atrial fibrillation,

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hypertension and osteoarthritis. The most recent Minimum Data Set (MDS) dated 07/01/08 assessed the resident as having long and short term memory impairment and modified independence with decision-making.

A review of nurse's notes from the medical record for Resident # 6 from 7/23/08 to 7/28/08 revealed there was no indication the resident had rectal bleeding nor was there an assessment of the resident for rectal bleeding. A note dated 7/29/08 states "readmitted from AMC/SL. S/P (status post) rectal bleed."

A hospital emergency department record for Resident #6, dated 7/25/08 at 16:40 hours (4:40 pm), documented in the "physician's notes" section of the form "patient sent from Uihlein after 2 day Hx (history) of rectal bleeding with clots." On the same form under the "working diagnosis" section the physician writes, "GI (gastrointestinal) Bleed-lower, Admit." A hospital physician progress note dated 7/25/08 at 8:34 pm documented "88 year old lady with dementia has BRRB (bright red rectal bleeding) x 2 days."

Resident # 20
On 7/6/08 at approximately 11:50 pm the resident developed a rash and a temperature of 102.3 F (normal temperature is 98.6). The physician was notified and ordered the resident be sent to the emergency room (ER) if the fever persisted in an hour. According to the resident's medical record, the resident continued to run a temperature between 100.3F and 101F and at 6:00 am on 7/8/08 the residents temperature was 101.6 F. The resident was not sent to the ER and there is no indication that the physician was notified again of the resident's persistent fever until 7/9/08 when

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F 281	Continued From page 23 an order was obtained to send the resident to the ER. The resident was admitted to the facility on 04/06/06 with diagnoses of depression, seizure disorder and and neurogenic bladder. The Minimum Data Set (MDS) dated 5/15/08 assessed the resident as having intact long and short term memory and independent in decision-making. A nurse's note dated 7/6/08 at 23:53 hours (11:53 pm) documented a body temperature of 102.3 F; a rash on the resident's right buttocks and right thigh and "that the rash was warm to the touch. RN assessed, PA notified, give 1gm APAP (acetaminophen) p.o.(by mouth) now, benadryl 50mg po/IM (intramuscular) now. If fever persists in one hour send to ER, send to ER if rash persists, per telephone order of PA." The physician order dated 7/6/06 documented, "If fever persists in one hour send to ER (emergency room). Send to ER in AM (morning) if rash persists." A handwritten LPN nurse's note dated 7/7/08, not timed, documented, "Resident ran a low grade temperature that would fluctuate between 101 F and 100.3 F. He was given Tylenol A UA (urinalysis) was taken and he tested positive for a UTI (urinary tract infection) and blood in the urine." A physician's order dated 7/7/08 was written to start resident on Cipro 250 mg Bid X 10 days. A handwritten nurses note dated 7/8/08 , not timed, documented, "temp continued to fluctuate	F 281		

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F 281	Continued From page 24 between 100.1- 100.6. now at 6 :00 am temp 101.6 F. gave APAP. no c/o(complaints). no s/s (signs or symptoms) of pain or discomfort." A physician's order dated 7/9/08 was written to "send (resident) to ER for evaluation." The next nurse's note in the medical record documented, when the resident returned to the facility from the hospital at 12:05 pm on 7/15/08, is a readmission note and documented the resident was readmitted to the facility from the hospital at 11:30 am. A review of the medical record revealed from 7/7/08 to 7/25/08 there was no RN assessment documented and/or nurse's note written that indicated the need for hospitalization and subsequent readmission to the nursing home. 10NYCRR 415.11.(c)(3)(i)	F 281		
F 329 SS=K	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		9/29/08

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F 329	Continued From page 25 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and interview during a complaint investigation (Case # NY00060638) and partial extended survey, the facility failed to ensure that each resident's drug regimen is free from unnecessary drugs, excessive dosages, including duplicative medications, and for excessive duration for seven (Resident #'s 1, 4, 6, 8, 10, 12 and 32) of eight residents. The facility failed to adequately monitor residents receiving psychoactive medication, and anti-hypertensive medication. Specifically, Resident #1, who had a documented sensitivity to an anxiolytic (benzodiazepine drug), Xanax (generic name-alprazolam), was administered two doses of Xanax 1.25 mg within a two hour time frame, experienced significant sedation and ultimately became unresponsive. The facility failed to monitor Resident #8 for adverse medication effects following the reduction of her Xanax on 7/30/08. The resident was administered Xanax XR 2.0 mg, twice a day, since admission on 5/8/08 to 7/29/08. The facility failed to prevent administration of duplicate antihypertensive medications for Resident #32 when the same medication was ordered and administered both as the trade name (Altace) and the generic (Ramipril). This resulted in actual harm to	F 329		

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F 329	Continued From page 26 Resident #1 and potential for more than minimal harm to the health and safety of six additional residents that is Immediate Jeopardy and Substandard Quality of Care. This is evidenced by the following examples: Resident # 1 The facility failed to ensure that each resident's drug regimen is free from unnecessary drugs and excessive dosages, and failed to adequately monitor Resident #1 who was administered alprazolam, an anti-anxiety medication. Resident #1, an 81 year old, male was administered alprazolam at a dose that caused sedation. The resident had a known sensitivity to alprazolam as documented in the hospital discharge summary's transfer to swing bed, based on a psychiatric consult. The resident received two doses of alprazolam 1.25 mg. (milligram) within two hours, at 10:30 pm (7/24/08) and 12:30 am (7/25/08). The resident was noted to be unresponsive (did not respond to verbal stimuli or shaking of the shoulders, five and a half hours after the second dose of alprazolam was administered). The resident remained unresponsive and was transferred to the hospital approximately 11 hours after the second dose of alprazolam was administered. The resident was transferred to the hospital emergency department where he was diagnosed (emergency room records) with benzodiazepine overdose with coma on 7/25/08 at 12:20 pm, and subsequently admitted. The Clinical Pharmacology report for Alprazolam copyright date 2008, provided to the facility by vendor pharmacy on 7/31/08, documented the treatment of anxiety disorder oral doses in the "elderly not exceed 0.75mg/day unless higher doses are necessary for functional status." The resident was admitted on 7/24/08 at 1:30 pm	F 329		

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F 329	Continued From page 27 for rehabilitation with a plan to be discharged to home. His admission diagnoses included methicillin resistant staphylococcus aureus (MRSA) septicemia of the left olecranon (elbow region) bursitis with surgical intervention, anxiety disorder-depression and neurogenic bladder. The facility's Admission Nursing Assessment, dated 7/24/08, documented the resident was alert and oriented to person, place and time. Additionally, the resident was assessed to respond to voice and touch. The written progress note by the Registered Nurse (RN), dated 7/24/08, documented the resident was able to ambulate with assistance and a walker and had an unsteady gait pattern. The resident was transferred from the hospital to the nursing home and arrived with two discharge summaries, dictated by two hospital physicians. A third document, titled "Discharge Orders & Instructions" that contained a handwritten list of medications also accompanied the resident. Each of these three documents listed different medication dosing instructions. The hospital's "discharge summary transfer to swing bed" form, dated 7/3/08, documented Zyprexa 2.5 mg. as needed and 5 mg. as needed, and Xanax or alprazolam 0.0625 mg. three times a day as needed. The hospital "discharge summary", dated 7/24/08, documented Xanax 0.125 mg. every two hours as needed, and Zyprexa 2.5 mg. every eight hours as needed and 5mg. every night (HS). The"Discharge Orders & Instructions" form, not dated, written by a hospital RN, listed Xanax 1.25 mg. every two hours, as needed, and Zyprexa 2.5	F 329		

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F 329	Continued From page 28	F 329		

mg by mouth use before Xanax (without any additional timeframe for administration specified). The hospital RN incorrectly transcribed the order for Xanax as1.25 mg. (ten times greater than the intended Xanax dose ordered being 0.125 mg.).

The facility's "Admission and Standing Orders" form, dated 7/24/08 at 4:00 pm, medication listed "Xanax 1.25 mg. every two hours as needed." Zyprexa was written "2.5 mg. tab, use (to be given) before Xanax", the frequency of this medication was not specified in the physician's order. The Admission and Standing Orders were not signed by the facility physician.

The facility physician wrote, on 7/24/08, two separate prescriptions, one for Xanax 1 mg. tablets and another prescription for Xanax 0.25 mg. tablets, to be administered every two hours as needed for anxiety with a maximum daily dose (MDD) of 12 mg.

A hospital psychiatric consult conducted on 6/30/08, untimed, documented the resident had a history of anxiety and depression. During this consultation, the resident was documented as "not at all anxious on examination". The consulting psychiatrist documented discussion of this resident's case with the hospital physician, specifically, that the resident "has had difficulty with significant sedation and desaturation. I do think that using extremely small doses of Alprazolam is probably the best idea, or to continue to use the Olanzapine." The psychiatric consultant's written plan was to "speak with the pharmacy to attempt to get alprazolam in even smaller doses" (lower than 0.125 mg).

A review of the facility Medication Administration

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F 329	Continued From page 29 Record (MAR) for July 2008 listed Zyprexa and Xanax. The Zyprexa directions were written for "2.5 mg. use before Xanax" with a planned administration time written for 8:00 am to begin on 7/25/08. The Xanax directions were written for "1.25 mg. every two hours as needed, see routine Zyprexa". The Zyprexa was not administered on 7/24/08 and 7/25/08. The Xanax was administered on 7/24/08 by a Licensed Practical Nurse (LPN), LPN #1 at 10:30 pm and by LPN #2 on 7/25/08 at 12:30 am. A Medication Error Report, dated 7/25/08 at 1:45 pm, identified the error as a "transcription error" and "incorrect dosage administered." This form identified the medication order as "Xanax 1.25 mg. every two hours as needed for anxiety". The error was not detected by the facility until after receiving two calls from the hospital asking what dose of Xanax the resident was given. There were no nurse's progress notes that documented the rationale for administration or the effects of the Xanax dose administered on 7/24/08 at 10:30 pm. The LPN #2's nursing progress note, dated 7/25/08 at 10:50:44 (10:50 am), documented the resident "at the start of the shift" had an oxygen saturation level of 60% (normal desired level is above 90%) while receiving oxygen therapy, and improved to 96% with a change in the oxygen delivery method (changed from concentrator to oxygen tank). This note documented the "resident was up for awhile through the night. Fell asleep in room chair around 2 :00 am. Resting comfortably the rest of the night." This note did not document a rationale for the administration of the Xanax dose administered on 7/25/08 at 12:30 am.	F 329		

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F 329	Continued From page 30 During an interview on 7/29/08 at 1:00 pm, the attending physician stated to have only "looked at" the psychiatric consultation of 6/30/08, and the nursing home's admission orders prior to writing the prescriptions for Xanax on 7/24/08. He stated he used the nursing home admission orders as a reference to write the Xanax prescription. He stated that he noted the resident had a history of anxiety, a recent psychiatric hospital stay and thought that (1.25 mg, Xanax) was the hospital dose. He stated he wrote Xanax 1.25 mg every two hours as needed because of the resident's history of anxiety and it's use in the hospital. He stated he did not review the hospital dictated discharge summary, dated 7/24/08. He stated seeing the handwritten summary that listed a Xanax 1.25 mg. order. He said he usually looked at a list of medications from the hospital with a check off box (medication reconciliation form) for the discharge but this form was not available for this admission. During an interview on 7/29/08 at 3:30 pm, the Registered Nurse Nurse Manager (RNNM) #1 stated she copied the nursing home admission orders off the (hospital's) "Discharge Orders and Instructions" dated 7/24/08, and left them for the physician to review and sign. She stated she then called the physician to notify him that a prescription would need to be written for Xanax, and did not review all of the orders with the physician at that time. RNNM #1 stated she was unaware that the hospital's "Discharge Orders and Instructions" form contain an error in the dose of Xanax until LPN #2 reported the transcription error to her after he received a phone call from the hospital on 7/25/08 questioning doses of Xanax administered at the nursing home.	F 329		

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During an interview on 7/30/08 at 10:10 am, LPN #2 stated he administered the 12:30 am dose of Xanax and thought it was greater than what he customarily has seen in the past for residents. This LPN described the resident as sitting at the edge of the bed and short of breath prior to giving that dose of Xanax. LPN #2 stated on 7/25/08, he had received two phone calls from the hospital ER that morning questioning the dose of Xanax administered and the times Xanax was administered. Following the second call from the ER, LPN #2 checked the resident's chart and discovered the "discharge summary" documented the dose for Xanax as 0.125 mg every two hours as needed, (not 1.25 mg.) and then he informed the RNNM #1.

During an interview on 7/30/08 at approximately 4:25 pm with the hospital registered nurse (RN #2), who wrote the hospital "Discharge Orders and Instructions" form, stated he discharged the resident to the nursing home on 7/24/08. He stated, it is hospital protocol that the discharging nurse copy the medications to be continued after discharge from the medication reconciliation form (which is reviewed and signed by the physician) onto the "Discharge Orders & Instructions" form. He stated he remembered the medication reconciliation form specified to give Zyprexa before Xanax and both medications were ordered in low doses. He stated he was informed by the hospital Nurse Manager recently of his transcription error. He stated he copied the Xanax dose as 1.25 mg, not 0.125 mg every two hours as needed. Additionally, he stated the physicians used to complete the "Discharge Order & Instructions" forms, but the doctors were too busy, so the process was changed to the

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F 329	Continued From page 32 physician checking the Medication Reconciliation List to continue or discontinue each medication listed, then the nurse copies the medications to be continued onto the Discharge Orders & Instructions form. Resident #8 The facility failed to ensure the resident was free from unnecessary drugs at an excessive dose and for an excessive duration; and did not attempt to reduce the dose of Xanax from the time of her admission on 5/8/08 until 7/30/08. The facility failed to monitor Resident #8 for adverse medication effects following the reduction of Xanax on 7/30/08. Prior to that time the resident was administered Xanax XR 2.0 mg, twice a day, since admission on 5/8/08 to 7/29/08, with no attempt to reduce the dosage. The resident was admitted on 5/8/08 with diagnoses including Parkinson's disease, anxiety, depression and hypertension. The initial Minimum Data Set (MDS), dated 5/19/08, assessed the resident to have intact short and long term memory, no delirium indicators, was able to make herself understood and usually was able to understand others. The written medical summary from the resident's community physician, dated 3/21/08, listed the resident's medications with doses and administration schedules. Her medications included, Xanax XR 2 mg. twice a day (total of 4 mg) and Effexor XR 150 mg. daily. Both of these medications were extended release forms. Upon admission to the facility on 5/8/08, Xanax XR 2 mg. twice daily and Effexor XR 150 mg.	F 329		

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F 329	Continued From page 33 daily were ordered by the facility physician. The physician's review of the resident's total program of care on both 6/11/08 and 7/22/08, documented the continuation of these medications. No physician's orders were written in an attempt to reduce the psychoactive medications between 5/8/08 and 7/30/08. On 7/30/08, new medical orders were written to "change to Xanax 0.5 mg twice a day" and monitor the resident's level of agitation and vital signs, twice a day, for five days. There were no nurse progress notes between 7/27/08 at 8:27 am, until 8/5/08 8:14 am which documented that the resident had no complaint of discomfort, slept well." The Director of Nursing Services (DNS) and the facility Administrator, on 7/31/08 at 4:30 pm asked about recent Xanax dose reductions, each stated the physician was writing psychoactive medication orders with ordered staff monitoring included. There was no evidence to support that staff monitored for changes in resident's health/medical conditions related to adjustments in Xanax dosages administered. They both provided and stated the Clinical Pharmacology report for Alprazolam, copyright 2008, provided to the facility by the pharmacy vendor, was being utilized for the dosing standards. They stated the facility did not have written psychoactive medication policies. During an interview on 8/6/08 at 1:00 pm, the resident stated, within the last week having experiencing symptoms described as flu-like of "not feeling well, very shaky, but not Parkinson's shaking, really sweating a lot but having very cold feet, and feeling very anxious." When she discussed these symptoms with a "female nurse from my cluster," the resident was informed of the	F 329		

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F 329	Continued From page 34 decrease in the Xanax dose. She stated "then I realized I'm going through Xanax withdrawal and need to fight off the panic." The resident stated she had taken Xanax a total of at least 3 mg. a day and the Effexor XR "for years now." Resident #32 The facility failed to ensure the resident's admission orders were correct and without duplicative orders for an antihypertensive medication, Altace and Ramipril (the generic name). The resident was admitted to the facility for rehabilitation on 7/30/08, with diagnosis including hypertension, diabetes mellitus (DM) and status post total hip arthroplasty (hip replacement). The resident was assessed on admission as alert and oriented. The Admission Orders dated 7/30/08 listed separate orders for the same medication twice using two different names, one order read Ramipril 10 mg; another order read Altace 10 mg by mouth. These orders were signed by the attending physician and signed as "noted" (reviewed by) two RNs, in accordance with the facility's written transcription of physician's orders policy. The resident was administered duplicative doses of the antihypertensive medication for seven consecutive days. The MAR documented administration of Altace 10 mg daily at 6:00 am from 8/1/08 through 8/7/08. The medication administration record (MAR) documented Ramipril 10 mg. was administered daily at 10:00 am from 8/1/08 through 8/7/08. There were no documented blood pressures on the MAR prior to	F 329		

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F 329	Continued From page 35 the administration of the duplicative antihypertensive medications. The nursing interdisciplinary notes between 7/30/08 and 8/8/08 recorded 4 blood pressure (BP) readings. The BP readings were: on 8/5/08, morning (untimed), 118/60; on 8/7/08, morning (not timed), 90/50; on 8/7/08, following an untimed unresponsive episode, 102/52; and 8/7/08, evening shift, 133/65. The vital signs obtained 8/8/08, night shift, did not include a BP. A Medication Error Report, dated 8/7/08 at 12:00 pm, documented the error was "incorrect dosage administered" (the actual error is not identified on the Medication Error Report form used) and listed the medication order "Altace 10 mg. every day." An additional note on the Medication Error Report reads "Altace 10 mg. given at 6:00 am and 10:00 am." This error had not been detected in the dispensing of the medication on 7/30/08. During an interview on 8/8/08 at 10:00 am, with the RNNM stated this error had just been found and the medications were scheduled to be administered on different shifts. 10 NYCRR 415.12(l) (1)	F 329		
F 333 SS=J	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview during a complaint investigation (Case # NY00060638)	F 333		9/29/08

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F 333	Continued From page 36 and a partial extended survey, the facility failed to ensure significant medication errors did not occur for five (Resident #'s 1, 6, 21, 22 and 32) of eight residents reviewed for medication regimens. Specifically, the facility failed to ensure that the correct dose of medication was ordered and administered; failed to ensure that duplicated medications were not ordered; and failed to ensure that the ordered intravenous solution was administered. Resident #1 was given two excessive doses of Xanax (a benzodiazepine, generically named alprazolam) within two hours. The resident became unresponsive at the facility and was transferred to the hospital where he was diagnosed with a benzodiazepine overdose with coma. This resulted in actual harm for Resident #1 that was Immediate Jeopardy and Substandard Quality of Care. This is evidenced by the following examples: Resident #1 Resident #1 was given two excessive doses of Xanax (a benzodiazepine, generically named alprazolam) within two hours. The resident became unresponsive at the facility and was transferred to the hospital where he was diagnosed with a benzodiazepine overdose with coma. The resident had a known and documented sensitivity to alprazolam (Hospital Discharge Summary). The Clinical Pharmacology report for Alprazolam, copyright date 2008, provided to the facility by the vendor pharmacy, documented the treatment of anxiety disorder oral doses in the "elderly not exceed 0.75mg/day unless higher doses are necessary for functional status." This resident received two doses of alprazolam 1.25 mg. within two hours, at 10:30 pm (7/24/08) and 12:30 am (7/25/08). The resident was noted to be unresponsive (did not	F 333		

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respond to verbal stimuli or shaking of the shoulders, five and a half hours after the second dose of alprazolam was administered). The resident remained unresponsive and was transferred to the hospital approximately 11 hours after the second dose of alprazolam was administered. The resident was transferred to the hospital emergency department record documented the admitting diagnosis as benzodiazepine overdose with coma on 7/25/08 at 12:20 pm. The resident died at the hospital on 7/26/08.

The resident was admitted on 7/24/08 at 1:30 pm for rehabilitation with a plan to be discharged to home. His admission diagnoses included methicillin resistant staphylococcus aureus (MRSA), septicemia of the left olecranon (elbow region) bursitis with surgical intervention, anxiety disorder-depression, and neurogenic bladder. The facility's Admission Nursing Assessment, dated 7/24/08, documented the resident was alert and oriented to person, place and time. Additionally, the resident was assessed to respond to voice and touch. The written progress note by the Registered Nurse Nurse Manager (RNNM), dated 7/24/08, documented the resident was able to ambulate with assistance and a walker and had an unsteady gait pattern.

The "discharge summary transfer to swing bed", dated 7/3/08, documented Zyprexa 2.5 mg. as needed and 5 mg. as needed, and Xanax or alprazolam 0.0625 mg. three times a day as needed.

The "discharge summary", dated 7/24/08, documented Zyprexa 2.5 mg. to be administered every eight hours as needed and 5 mg. at

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bedtime, and Xanax 0.125 mg. every two hours as needed.

The "Discharge Orders & Instructions" form, not dated, written by a hospital RN, listed Zyprexa 2.5 mg. use (to be administered) before Xanax, and Xanax 1.25 mg. every two hours, as needed.

The facility's "Admission and Standing Orders" form, dated 7/24/08 at 4:00 pm, medication list included "Zyprexa 2.5 mg. use before Xanax" and "Xanax 1.25 mg. every two hours as needed." These orders were not signed by the facility physician. The physician did write two prescriptions, on 7/24/08, for Xanax 1 mg. tablets and Xanax 0.25 mg. tablets to be administered every two hours as needed for anxiety with a maximum daily dose (MDD) of 12 mg.

A psychiatric consult conducted on 6/30/08, untimed, at the hospital documented the resident had a history of anxiety and depression. During this consultation, the resident was documented as "not at all anxious on examination". The consulting psychiatrist documented discussion of this resident's case with the hospital physician, specifically, that the resident "has had difficulty with significant sedation and desaturation. I do think that using extremely small doses of Alprazolam is probably the best idea, or to continue to use the Olanzapine." The psychiatric consultant's written plan was to "speak with the pharmacy to attempt to get alprazolam in even smaller doses" (lower than 0.125 mg).

A review of the facility Medication Administration Record (MAR) for July 2008 listed Zyprexa and Xanax. The Zyprexa directions were written for "2.5 mg. use (to be given) before Xanax" with a

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planned administration time written for 8:00 am to begin on 7/25/08. The Xanax directions were written for "1.25 mg. every two hours as needed, see routine Zyprexa". The Zyprexa was not administered on 7/24/08 and 7/25/08. The Xanax was administered on 7/24/08 by a Licensed Practical Nurse (LPN #1) at 10:30 pm and by a different LPN #2 on 7/25/08 at 12:30 am.

A Medication Error Report, dated 7/25/08 at 1:45 pm, identified the error as a "transcription error" and "incorrect dosage (was) administered." This form identified the medication order as "Xanax 1.25 mg. every two hours as needed for anxiety." The error was not detected by the facility until after receiving two calls from the hospital asking what dose of Xanax the resident was given. The Zyprexa order was without clear administration directions and the failure to administer it prior to administering a dose of Xanax, was not included in this error report.

During an interview on 7/30/08 at 10:10 am, LPN #2 stated he administered the 12:30 am dose of Xanax and thought it was greater than what he customarily has seen in the past for residents. LPN #2 stated on 7/25/08, he had received two phone calls from the hospital ER that morning questioning the dose of Xanax administered and the times Xanax was administered. Following the second call from the ER, LPN #2 checked the resident's chart and discovered the "discharge summary" documented the dose for Xanax as 0.125 mg every two hours as needed, (not 1.25 mg.) and then informed the RNNM #1.

During an interview on 7/29/08 at 3:30 pm, the RNNM #1 stated she copied the orders from the "Discharge Orders and Instructions" and left them

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F 333	Continued From page 40 for the physician to review and sign. She stated she called the physician to notify him that a prescription would need to be written for Xanax but did not review the orders with the physician at that time. She stated LPN #2 had reported the transcription error to her after he received a phone call from the hospital about the Xanax dose given. During an interview on 7/30/08 at approximately 4:25 pm with the hospital registered nurse (RN #2), who wrote the "Discharge Orders and Instructions" form, stated having discharged the resident to the nursing home on 7/24/08. It is hospital protocol that the discharging nurse copy the medications to be continued after discharge from the medication reconciliation form (which is reviewed and signed by the physician) onto the "Discharge Orders & Instructions" form. He stated he remembered the medication reconciliation form specified to give Zyprexa before Xanax and both medications were ordered in low doses. He stated he was informed by the hospital Nurse Manager recently of his transcription error. He stated he copied the Xanax dose as 1.25 mg, not 0.125 mg every two hours as needed. Additionally, he stated the physicians used to complete the "Discharge Order & Instructions" forms, but the doctors were too busy so the process was changed to the physician checking the Medication Reconciliation List to continue or discontinue each medication listed, then the nurse copies the medications to be continued onto the Discharge Orders & Instructions form. During an interview on 7/29/08 at 1:00 pm, the attending physician stated to have only "looked at" the psychiatric consultation not the discharge	F 333		

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summaries, and the nursing home's admission orders prior to writing the prescriptions for Xanax on 7/24/08. He stated he transcribed the Xanax 1.25 mg. every two hours as needed, onto the prescription because the resident had a history of anxiety, a recent psychiatric hospital stay and thought that was the hospital dose. He stated he wrote Xanax 1.25 mg every two hours as needed because of the resident's history of anxiety and it's use in the hospital. He stated he did not review the dictated discharge summary, dated 7/24/08. He stated seeing the handwritten summary that listed Xanax 1.25 mg. order. He said he usually looked at a list of medications from the hospital with a check off box (medication reconciliation form) for the discharge but this form was not available for this admission. He stated there were no written parameters for the administration of the "as needed" Zyprexa or Xanax.

Resident # 22
The facility failed to administer the intravenous (IV) solution ordered by the physician to this resident for several hours.

The resident was admitted to the facility on 08/11/05 with diagnoses of dementia, cerebral vascular accident (CVA) and diabetes mellitus. The most recent Minimum Data Set (MDS) for the resident dated 05/13/08 assessed the resident as having impaired long and short term memory and severely impaired ability for decision making.

A Medication Error form dated 8/10/08 at 7:30 am identified the error (incorrect IV solution being hung) as "incorrect medication administered". The Medication Error form did not identify that a pharmacy error had occurred. This report

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documented the error occurred on 8/9/08 at 4:40 pm and the report was filled out at 7:30 am on 8/10/08. The written order, dated 8/8/08, was for an IV solution of 5% Dextrose (sugar) with half-strength Normal Saline (salt) (D5 1/2 NS) at a rate of 75 cubic centimeters (cc) per hour. The resident was found with the wrong IV solution of 5% Dextrose in 0.9% Sodium Chloride (D5 0.9% NaCl) infusing, when the IV infiltrated (the solution was no longer going into the vein).

A written RN progress note, dated 08/08/08 at 16:22 (4:22 pm), documented "D 5 1/2 NS @ 75 cc an hour", was ordered by the physician and IV fluids were administered as ordered.

The RN progress note, dated 8/10/08 at 6:09 am, documented the IV had infiltrated in the resident's left arm. The physician's assistant was informed that the facility had no supply of D 5 1/2 NS, and the resident received D 5 NS from 4:40 pm (8/9/08) until approximately 3:40 am (8/10/08). New physician orders for the resident's care were then received. These orders included administration of 0.9% saline solution IV at 75 cc per hour, change the blood glucose monitoring to every six (6) hours with (insulin) coverage, and follow-up in the morning with the attending physician.

During an interview on 8/10/08 at approximately 3:15 pm, with the facility's RN Administrator, stated she discovered a pharmacy dispensing error related to the IV solution. The physician's written order, dated 8/8/08, for the IV solution was faxed to the pharmacy at 6:30 pm. The RN Administrator contacted the pharmacy operations manager on 8/10/08 and he stated the fax had been received at the pharmacy on 8/8/08 at 6:28

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F 333	Continued From page 43 pm, but was not dispensed (filled), but could not explain the rationale for not filling the order. Resident # 32 The facility did not identify duplicative medication (Altace and Ramipril) administrated daily for 8 days, between admission on 7/30/08 to 8/7/08, when the medication error was discovered. The resident was admitted to the facility for rehabilitation on 7/30/08 with diagnosis of hypertension, diabetes mellitus and status post total hip arthroplasty (hip replacement). The resident was assessed on admission note as alert and oriented. The Admission Orders, dated 7/30/08, listed separate items for the same medication. One order written read Ramipril (generic name for Altace)10 mg by mouth daily. A separate order written read Altace (a trade name for the generic form of Ramipril) 10 mg by mouth every morning. These orders were signed by the attending physician and signed as "noted" (reviewed by) two RNs on 7/30/08. The August 2008 medication administration record (MAR) documented Ramipril 10 mg. was administered once a day at 10:00 am, from 8/1/08 through 8/7/08. The MAR documented administration of Altace 10 mg once a day at 6:00 am from 8/1/08 through 6:00 am 8/7/08. The nursing interdisciplinary notes between 7/30/08 and 8/8/08 recorded 4 blood pressure (BP) readings. The BP readings were: 8/5/08, morning (not otherwise defined), 118/60; 8/7/08, morning (not otherwise defined), 90/50; 8/7/08, following an untimed unresponsive episode, 102/52; and 8/7/08, evening shift, 133/65. The vital signs	F 333		

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F 333	Continued From page 44 obtained 8/8/08, night shift, did not include a BP. A Medication Error Report, dated 8/7/08 at 12:00 pm, documented the error as "incorrect dosage administered" and listed the medication order "Altace 10 mg. every day." An additional note on this Medication Error Report form reads "Altace 10 mg. given at 6:00 am and 10:00 am." This Medication Error Report did not identify a pharmacy error occurrence for the duplicative therapy. The RN who completed the medication error report stated on 8/8/08 at 10:00 am, the error had probably not been noticed as the medications were scheduled for administration on different shifts. The RN designated on the medication error report form as responsible for the error was the RNNM #1 who resigned from the facility on 8/4/08, and the error was discovered on 8/7/08. 10NYCRR 415.12(m)	F 333		
F 353 SS=F	483.30(a) NURSING SERVICES - SUFFICIENT STAFF The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this	F 353		9/29/08

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section, licensed nurses and other nursing personnel.

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview during complaint investigations (Case #'s NY00053143, NY00054760, NY00056988, NY00060638, and NY00061055) and a partial extended survey, the facility did not ensure a sufficient quantity of staff were available to meet the needs of the residents in response to call bell activation, toileting needs, incontinence care, ambulation and positioning as directed in the individualized resident care plans. This deficient practice resulted in no actual harm with the potential for more than minimal harm that is not Immediate Jeopardy but is Substandard Quality of Care. This was evidenced by the following examples:

Finding #1
The facility did not have sufficient qualified staff available on the residential unit to meet/ provide direct resident care as directed in written resident care plans, on a 48-bed residential unit. The unit design had three "clusters" of residential rooms, one with 18 residents and two with 15 residents. One certified nursing assistant (CNA) was scheduled for each of three clusters and had responsibility for the rendering hands-on direct care to the residents of the cluster.

During the observations on residential Unit 1 on

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F 353	Continued From page 46 8/13/08 at 5:20 pm, two resident call bells rang continuously for more than ten minutes, without any staff response. The actual staffing on this unit at the time was one Licensed Practical Nurse (LPN), 2 unit CNA's and a "float" CNA from another unit. During interviews conducted with the direct care staff assigned to this unit between 7/29/08 and 8/17/08, the staff stated that with the current staffing schedule, the residents' care was not performed despite their best efforts to render care as care planned. Staff additionally stated the RNNM had instructed them to initial all care as completed and the "NA' and "0" were not acceptable on the care documentation forms in use at the facility. Specifically, as not done as planned were; two hour toileting or incontinence care as planned; residents needed ambulation at the distance or frequency planned had not occurred and repositioning of residents who required staff assistance was not implemented, as care planned. Staff identified residents who were incontinent because the residents waited for assistance or were not provided toileting assistance as planned. During interviews conducted with resident's and resident designated representatives of this unit between 7/29/08 and 8/17/08, they stated the staff "work very hard", "are so busy, try not to bother them too much, other people need them more", "try to manage without help or ask for everything at once". Residents stated call bell response was "slow", which was further defined as 30 minutes or more. The residents stated a "need to plan ahead to get assistance to attempt to prevent incontinence." Three residents stated they experienced bowel and bladder incontinence	F 353		

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while waiting for staff assistance. These residents asked to remain anonymous because they were afraid their comments would cause trouble/problems for the direct care staff.

As stated during an interview with visitors to the facility between 8/5/07 and 8/14/08, when these visitors, found a resident lying in bed in a dark room soiled with bowel incontinence on 8/9/08 at 10:30 am, care was provided by the visitors with staff assistance after "finding staff and asking for assistance". Resident representatives stated they frequently responded to resident safety alarms in the cluster common area as no staff are present in the area and the alarm had sounded as a resident was "getting up unsafely".

Finding #2
The facility did not have sufficient qualified staff available on the residential unit to meet/ provide direct resident care as directed in written resident care plans on a 48-bed residential unit. The unit design had three "clusters" of residential rooms, one with 18 residents and two with fifteen residents. One CNA was scheduled for each of these clusters and responsible for the provision of the hands-on direct care of the residents of the cluster.

During the observations on residential Unit 2 on 8/7/08 at 12:10 pm, multiple resident call bells were continuously ringing for more than 12 minutes, without any staff response. Following the response to two of the ringing resident call bells, the responding unlicensed staff person stated both of those residents had requested bathroom privileges (toileting) and had "started to go" already (been incontinent of urine). This unit's actual staffing on this shift was the Registered

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ADIRONDACK MEDICAL CENTER UIHLEIN	**185 OLD MILITARY ROAD** **LAKE PLACID, NY 12946**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 48 Nurse Nurse Manager (RNNM), 2 LPN's, 4 CNA's, a Resident Assistant (RA), and one "limited duty person", who was not doing direct care, as reported by the RNNM at 12:30 pm. During interviews conducted of the direct care staff assigned to this unit between 7/29/08 and 8/17/08, the staff members stated with the current staffing schedules, the care was not performed despite their best efforts as care planned. Staff additionally stated the RNNM had instructed them to initial all care as completed and that "NA' and "0" or blank codes were not acceptable on the care documentation forms in use at the facility. Specifically, tasks not done as planned are; the every two hour toileting or incontinence care, ambulation of residents at the distance and/or frequency planned, and the repositioning of residents who required staff assistance. The staff identified residents who had been incontinent during the wait for assistance or were not provided toileting assistance as planned. Staff stated the "team leaders" are frequently assigned as a staff CNA to the care of all residents in a cluster and then the duties normally assigned to the team leaders revert to the cluster CNA leaving the 'team leader's" duties not completed. RA's are assigned to a cluster as the CNA but their responsibilities are limited to assist only residents who require the assistance of one staff. Hospitality aides are assigned to the unit but do not provide direct care (hands-on care), and were at times the only staff person assigned to "manage" a cluster. During interviews conducted with residents of this unit between 7/29/08 and 8/17/08, they stated the staff "work very hard", "are so busy, try not to bother them too much other people need them	F 353		

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F 353	Continued From page 49 more", "try to manage without help or ask for everything at once." Residents stated call bell response was "slow", which was further defined as 30 minutes or more. The residents stated a "need to plan ahead to get assistance". Three residents, who requested their identity remain confidential, stated they have experienced bowel and bladder incontinence while waiting for staff assistance. A review of the facility nursing "daily staffing" sheets documented unfilled positions, and scheduled RA hours end at 6:00 pm. During an interview with the Director of Nursing Services (DNS), on 8/6/08 at 3:15 pm, stated the facility had no written protocols or policy for nursing staffing patterns. When specifically asked if the resident care could be provided as care planned, she stated "yes, I think it is when they have the help". The DNS defined "the help" as a CNA per cluster, a RA (who can feed residents and assist with care of residents needing one person assistance), a Hospitality Aide (HA) (who does not provide hands-on care to residents), and a "team leader" who is a CNA responsible for the care of 3 residents on the unit, ensures turning and positioning is done every two hours on the unit, unit ambulation and range of motion (ROM). 10NYCRR 415.13(a)(1)(i-iii)ng Seursin Services (DNS), on 8/6/08 at 3:15 pm, stated the facility had no written protocols or policy for nursing unit staffing patterns. When specifically asked if the resident care could be delivered as care planned, she stated "yes, I think it is, when they have the help". The DNS defined "the help" as a CNA per cluster, a RA (who can feed residents and assist with care residents needing	F 353		

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F 353	Continued From page 50 1 person assistance), a Hospitality Aide (HA) (who does not provide hand-on care to residents), and a "team leader" who is a CNA responsible for the care of 3 residents on the unit, ensures turning and repositioning is done every 2 hours on the unit, unit ambulation and range of motion (ROM). 10NYCRR 415.13(a)	F 353		
F 385 SS=K	483.40(a) PHYSICIAN SERVICES A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on record review and interview during a complaint investigation (NY00060638) and a partial extended survey, the facility failed to: ensure for seven (Residents # 1,2,5,7,8, 17 and 32) of fourteen residents reviewed, that the physician provided medical management for residents on antihypertensives and benzodiazepines; ensure that the physician signed the admission orders. Specifically, Resident # 1 was administered the wrong medication dose when a transcription error changed the dose of Xanax from 0.125mg to 1.25mg and the error was perpetuated when the facility physician copied the incorrectly transcribed	F 385		9/29/08

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F 385	Continued From page 51 dose when he wrote a prescription for the drug. Also,there was no written acceptance of a resident's admission when the physician failed to sign admitting orders for Resident #1. Resident # 32 was administered duplicate medications when two orders were written for the same drug. One included the trade name Altace; the other order included the generic name Ramipril. Resident #17 did not have timely medical assessment and intervention of a changing pressure sore at the coccyx. This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care. This is evidenced by the following examples: Resident #1 The resident with a documented sensitivity to Alprazolam (brand name-Xanax) was administered the drug at an excessive dose when a prescription was written by the physician for Xanax 1.25mg every two hours (q2h) as needed (prn) and the maximum daily dose (MDD) of the medication was written as 2mg. The resident received two doses of Xanax 1.25mg within two hours of each other (on 7/24/08 at 10:30 pm and 7/25/08 at 12:30 am). The resident became oversedated, and unresponsive to verbal stimuli and/or the physical shaking of the shoulders five and a half hours after the second dose was administered. The resident remained unresponsive and was transferred to the hospital Emergency Room (ER) approximately 11 hours after the second dose of Alprazolam was administered. The resident was admitted on 7/24/08 at 1:30 pm for rehabilitation with a plan to be discharged to home. His admission diagnosis included methicillin resistant staph aureus (MRSA),	F 385		

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F 385	Continued From page 52 septicemia of the left olecranon (elbow region) bursitis with surgical intervention, anxiety disorder, depression, and neurogenic bladder. The facility's Admission Nursing Assessment, dated 7/24/08, documented the resident was alert and oriented to person, place and time. Additionally, the resident was assessed to respond to voice and touch. The written progress note by the Registered Nurse (RN) documented the resident was able to ambulate with assistance and a walker with an unsteady gait pattern. Two dictated discharge summaries came with the resident from the hospital and also a handwritten "discharge orders and instructions" form each of these three documents listed different medication dosing instructions for the psychoactive medications. The "discharge summary transfer to swing bed", dated 7/3/08, listed Zyprexa 2.5 milligram (mg.) as needed and 5 mg. as needed; and Xanax or Alprazolam 0.0625 mg. three times a day as needed. The "discharge summary", dated 7/24/08, listed Zyprexa 2.5 mg. every eight hours as needed and 5 mg. at bedtime; and Xanax 0.125 mg. every two hours as needed. The "Discharge orders & instructions" form, not dated, listed Zyprexa 2.5 mg. use before Xanax and Xanax 1.25 mg. every two hours as needed. None of these orders had parameters (indications) for the administration of the "as needed" medications. The facility's "Admission and Standing Orders" form, dated 7/24/08 at 4:00 pm, medication list included "Zyprexa 2.5 mg. use before Xanax" and "Xanax 1.25 mg. every two hours as needed". These orders did not contain parameters for the administration of the as needed doses. These	F 385		

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orders were not identified as "telephone ordered" by the physician and were not signed by the physician. The physician did write prescriptions for Xanax 1 mg. tablets and Xanax 0.25 mg. tablets to be administered every two hours as needed for anxiety with a maximum daily dose (MDD) of 12 mg., which was above the accepted MDD for use in the elderly of 0.75mg.

A psychiatric consult conducted on 6/30/08 at the hospital documented the resident had a history of anxiety and depression. During this consultation, the resident was documented as "not at all anxious on examination" and "that using extremely small doses of Alprazolam is probably the best idea or to continue Olanzapine". The consulting physician documented discussion of this resident's case with the medical physician, specifically that the resident "has had difficulty with significant sedation and desaturation". The consultant's written plan was to speak with the pharmacy to attempt to get Alprazolam in even smaller doses.

A review of the Medication Administration Record (MAR) for July 2008 listed Zyprexa and Xanax. The Zyprexa directions were written " Zyprexa 2.5 mg PO (by mouth) use before Xanax" with a planned administration time written for 8:00 am to begin on 7/25/08. The Xanax directions were written " Xanax 1.25 mg., po, Q2hrs (every two hours) PRN (as needed) see routine Zyprexa." The Zyprexa was not administered at all on 7/25/08. The Xanax was administered on 7/24/08 at 10:30 pm and 7/25/08 at 12:30 am by two Licensed Practical Nurse (LPN) medication.

During an interview on 7/29/08 at 3:30 pm, the RNM stated she copied the orders from the

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F 385	Continued From page 54 "Discharge Orders and Instructions" and left them for the physician to review and sign. She stated she called the physician to notify him that a prescription would need to be written for Xanax, but did not review the orders with the physician at that time. She stated the physician came in to the facility, wrote the prescription for the Xanax and the LPN faxed the prescription to the pharmacy. During an interview on 7/29/08 at 1:00 pm, the attending physician stated to have only "looked at" the psychiatric consultation not the discharge summaries, and the nursing homes admission orders prior to writing the prescriptions for Xanax on 7/24/08. He stated he transcribed the Xanax 1.25mg. every two hours as needed onto the prescription because the resident had a history of anxiety, a recent psychiatric hospital stay and thought that was the hospital dose. He stated he wrote Xanax 1.25mg every two hours as needed because of the resident's history of anxiety and it's use in the hospital. He stated not seeing the dictated discharge summary, dated 7/24/08. He stated seeing the handwritten summary that listed Xanax 1.25 mg order. He said he usually looked at a list of medications from the hospital with a check off box (medication reconciliation form) for the discharge but there wasn't one. He stated there were no written parameters for the administration of the as needed Zyprexa and/or Xanax. Resident #32 Admission orders signed by the physician documented duplicate medications (Altace and Ramipril) were ordered for daily administration. The drugs were each administered to the resident for 8 days, from admission on 7/30/08 and until the medication error was discovered on 8/7/08.	F 385		

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F 385	Continued From page 55 The resident was admitted to the facility for rehabilitation on 7/30/08 with diagnosis of hypertension, diabetes mellitus (DM) and status post total hip arthroplasty (hip replacement). The resident was assessed on admission as alert and oriented. The Admission Orders, dated 7/30/08, listed separate items for the same medication. One order written read Ramipril (generic name for Altace)10 mg by mouth daily. A separate order written read Altace (a trade name for the generic form of Ramipril)10 mg by mouth every morning. These orders were signed by the attending physician and signed as "noted" (reviewed by) two RNs. The medication administration record (MAR) documented Ramipril 10 mg. was administered daily at 10:00 am from 8/1/08 through 8/7/08. The MAR documented administration of Altace 10 mg daily at 6:00 am from 8/1/08 through 8/7/08. There were no documented blood pressures on the MAR prior to the administration of these antihypertensives. A Medication Error Report, dated 8/7/08 at 12:00 pm, documented the error was "incorrect dosage administered" and listed the medication order "Altace 10 mg. every day". An additional note on this Medication Error Report form reads "Altace 10 mg. given at 6:00 am and 10:00 am". This Medication Error Report did not identify a pharmacy error occurrence for the duplicative therapy. Resident # 17 The facility did not ensure timely medical	F 385		

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F 385	Continued From page 56	F 385		

assessment of a facility acquired pressure sore as the status of the pressure sore changed in depth and tunnelling developed as documented during the skin rounds of 7/24/08.

The resident was admitted to the facility on 05/23/03 with diagnoses of multiple sclerosis, congestive heart failure (CHF) and low blood pressure. The Minimum Data Set (MDS) dated 05/07/08 assessed the resident as having intact long and short-term memory and independent with decision-making.

A nurse's note dated 07/30/08 timed at 08:28:01 and subtitled "Late entry skin rounds 7/24/08: Inner aspect of coccyx wound measures 3.5 x 4, with entire wound measuring 4.3 x 5. Entire wound depth 0.7, left tunneling, right tunneling 1.5. (This note does not include what measurement scale was used for these numbers).

An MD progress note dated 7/22/08 notes, "She does have a sore on her coccyx area which was developed presumably from pressure from a bedpan."

During an observation of the dressing change to the coccyx pressure ulcer wound on 08/06/08 at approximately 11:00 am, the treatment nurse stated the resident's dressing change was done while she was on the commode as this is the resident's preference. The dressing change was stopped, by the investigator, when the treatment nurse was attempting to pack the wound with a wet to dry dressing while previous packing was still in place.

During an interview with the facility physician on

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F 385	Continued From page 57 08/08/08 at approximately 9:30 am, he stated he was aware of the resident's pressure ulcer on the coccyx area but that he was not aware that " tunneling" had developed in the coccyx wound. He stated he was not aware that the resident's wound care was performed while she sat on the commode or that the staff stated the dressing was changed while the resident sat on the commode because that was the resident's preference. 10NYCRR 415.12(m)	F 385		
F 425 SS=L	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview during a	F 425		9/29/08

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F 425	Continued From page 58 complaint investigation (Case # NY00060638) and partial extended survey, the facility failed to provide, for eight (Residents #'s 1, 4, 6, 8, 10, 12, 22 and 32) of 11 residents reviewed, pharmacy services that provided accurate acquiring, receiving, dispensing and administering of all drugs to meet the needs of each resident. The facility failed to ensure that each resident's drug regimen was free from medications ordered in excessive doses and an acceptable frequency; and that medications ordered were written with parameters (indications) for administration; failed to detect that aresident's medication orders were duplicative orders; and failed to ensure that medications were dispensed by the pharmacy to the facility when ordered by the physician to be administered to a resident. Specifically, for Resident #1, the physician prescribed and the pharmacy dispensed single administration doses and maximum daily doses (MDD) for a drug, alprazolam (Xanax), that were above the recommended doses for use in the elderly. Also, the pharmacy vendor dispensed duplicate antihypertensive medications as the trade name(Altace) and also in the generic form (Ramipril) for the same resident (Resident #32); and the pharmacy vendor did not dispense intravenous solutions that were ordered by the physician for Resident # 22. This deficient practice resulted in Immediate Jeopardy to resident health and safety. This is evidenced by the following examples: Resident # 1 The resident was admitted on 7/24/08 at 1:30 pm for rehabilitation with a plan to be discharged to home. His admission diagnoses included methicillin resistant staph aureus (MRSA) septicemia of the left olecranon (elbow region)	F 425		

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F 425	Continued From page 59 bursitis with surgical intervention, severe anxiety disorder,depression, and neurogenic bladder. The facility's Admission Nursing Assessment, dated 7/24/08, documented the resident was alert and oriented to person, place and time. Additionally, the resident was assessed to respond to voice and touch. The written progress note by the Registered Nurse (RN) documented the resident was able to ambulate with assistance and a walker with an unsteady gait pattern. A medication transcription error for Xanax (generic name-alprazolam) occurred at the hospital and resulted in Resident #1's dose of Xanax/alprazolam being documented incorrectly as 1.25 milligram (mg) every 2 hours as needed. The correct order was for 0.125 mg, Xanax. On admission to the nursing home, the Registered Nurse-Nurse Manager (RNNM#1) transcribed the admission medication orders for Resident #1 from the list of hospital medications which contained the transcription error. The facility physician wrote prescriptions for Xanax from that list, as Xanax 1.25 mg, every two hours as needed and specified a MDD of 12 mg. daily. The Total Daily Threshold for Anxiolytics for Alprazolam in the elderly is 0.75 mg. daily (Federal OBRA guidelines). Resident #1 received two doses of Alprazolam 1.25 mg within two hours (10:30 pm on 7/24/08, and 12:30 am on 7/25/08). The resident became oversedated. The resident was first noted to be unresponsive at approximately 5:45 am, on 7/25/08. He remained unresponsive, was transferred to the hospital emergency department at approximately 11:30 am, and arrived at the emergency department at 12:14 pm where he was diagnosed with benzodiazepine overdose and coma on 7/25/08 at 12:20 pm. and ultimately admitted to the hospital.	F 425		

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F 425	Continued From page 60	F 425		

Two dictated discharge summaries came with the resident from the hospital and also a handwritten "discharge orders and instructions" form. Each of these three documents listed different medication dosing instructions. The "discharge summary transfer to swing bed", dated 7/3/08, listed Zyprexa 2.5 mg. as needed and 5 mg. as needed; and Xanax or Alprazolam 0.0625 mg. three times a day as needed. The "discharge summary", dated 7/24/08, listed Zyprexa 2.5 mg. every eight hours as needed and 5 mg. at bedtime; and Xanax 0.125 mg. every two hours as needed. The"Discharge orders & instructions" form, not dated, listed Zyprexa 2.5 mg. use before Xanax, and Xanax 1.25 mg., every two hours as needed. None of these orders had parameters (indications) for the administration of the as needed medications.

The facility's "Admission and Standing Orders" form, dated 7/24/08 at 4:00 pm, listed medications included "Zyprexa 2.5 mg. use before Xanax" and "Xanax 1.25 mg. every two hours as needed". These orders did not contain parameters for the administration of the, as needed doses. These orders were not signed by the physician. The physician did write prescriptions for Xanax 1 mg. tablets and Xanax 0.25 mg. tablets, MDD 12mg, to be administered every two hours as needed for anxiety.

A review of the Medication Administration Record (MAR) for July 2008 listed Zyprexa and Xanax. The Zyprexa directions were written as "2.5 mg. use before Xanax" with a planned administration time written for 8:00 am to begin on 7/25/08. The Xanax directions were written "1.25 mg. every two hours as needed see routine Zyprexa." The

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F 425	Continued From page 61 Zyprexa was never administered at the nursing home. The Xanax was administered on 7/24/08 at 10:30 pm and again on 7/25/08 at 12:30 am. A different Licensed Practical Nurse (LPN) administered the Xanax medication each time. During an interview on 7/30/08 at 10:10 am, the Licensed Practical Nurse (LPN) administering the medication at 12:30 am 7/25/08 stated, the dose and frequency of the Xanax were larger than he'd seen before but had not questioned the orders. During an interview on 7/29/08 at 3:30 pm, the Registered Nurse Manager (RNM) stated she copied the orders from the "Discharge Orders and Instructions" and left them for the physician to review and sign. She stated to have called the physician to notify him that a prescription would need to be written for Xanax, but did not review the orders with the physician at that time. She stated, "if there is a question about a prescription the pharmacy will call for us for clarification and occasionally they ask for the doctors phone number so they can contact the doctor. I worked late at the desk that day and there wasn't a phone call from the pharmacy." During an interview on 7/29/08 at 1:00 pm, the attending physician stated to have only "looked at" the psychiatric consultation not the discharge summaries, and the nursing homes admission orders prior to writing the prescriptions for Xanax on 7/24/08. He stated he transcribed the Xanax 1.25mg. every two hours, as needed, onto the prescription because the resident had a history of anxiety and thought that was the hospital dose. He stated there were no written parameters for the administration of the as needed Zyprexa and/or Xanax.	F 425		

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The blister pack card of Alprazolam 0.25mg tablets dispensed and delivered by the pharmacy, revealed the directions for the administration of this medication as, "1 by mouth every 2 hours as needed along with one 1mg tab (TD + 1.25mg) (MDD=12mg)"

The blister pack card of Alprazolam 1mg tablets dispensed and delivered by the pharmacy, reveals the directions for the administration of this medication as, "1 by mouth every 2 hours as needed along with one 0.25mg tab (TD+1.25mg) (MDD=12mg) (anxiety)."

Resident #22
The resident was admitted to the facility on 08/11/05 with diagnoses of dementia, cerebral vascular accident (CVA) and diabetes mellitus. The most recent Minimum Data Set (MDS) for the resident dated 05/13/08 assessed the resident as having impaired long and short term memory and severely impaired ability for decision making.

A physician's order for infusion of an intravenous (IV) solution of D5 1/2 NS at 75 cc/hour (Dextrose and half-strength Normal Saline to infuse at 75 cc every hour) was written on 08/08/08 and faxed to the pharmacy at 6:30PM. When the pharmacy failed to deliver the intravenous solution, the staff at the facility started an IV and hung a bag of IV solution taken from the facility stock. On 8/10/08, at approximately 4:00 am it was noted that the bag of intravenous solution (D5 NS) infusing into the resident at that time (the bag taken from the facility stock) was the incorrect solution and not the solution ordered by the physician.

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F 425	Continued From page 63 A Medication Error form dated 8/10/08 at 7:30 am documented an intravenous (IV) solution of D5 1/2 NS at 75cc/hour was ordered by the physician but the incorrect medication of D5NS was found infusing into the resident since 8/9/08 at 4:40PM. The wrong solution had infused for 12 hours. A nurse's note dated 08/08/08 at 16:22 hours states D 5 1/2 NS @ 75 cc /hour was ordered and administered. A nurse's note dated 8/10/08 at 6:09 am states MD informed there is no supply of D5 1/2 NS and resident received D5 NS from 4:40 pm to about 3:40 am. When the attending physician was notified of the medication (IV solution) error, he ordered an infusion of 0.9%NS at 75cc/hr with monitoring of the residents blood sugars with insulin coverage every 6 hours. During an interview with the facility registered nurse RN/Administrator on 8/10/08 at approximately 3:15 pm the administrator stated there was a pharmacy error with an IV solution. An order was received and then faxed to Royal Care Pharmacy on 08/08/08 at approximately 6:30 pm for an IV solution. The operations manager at Royal Care Pharmacy told the facility Administrator the fax was received at 6:28 pm, but the order was never filled and he was not sure why it was not filled. The RN/Administrator stated, maybe our error would not have occurred if the order had been filled by the pharmacy. We didn't have the correct solution on hand. Resident #32: The resident was admitted to the facility for rehabilitation on 7/30/08 with diagnosis including	F 425		

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hypertension, diabetes mellitus (DM) and status post total hip arthroplasty (hip replacement). The resident was assessed on admission as alert and oriented.

The resident's admission orders instructed to administer Altace 10 mg every morning (Q AM) and Ramipril 10 mg by mouth every day (po qd). Ramipril is the generic name for the drug Altace. The pharmacy delivered and the resident received both drugs (Altace and Ramipril), a double dose, for seven days from 8/1/08 to 8/7/08.

The Admission Orders dated 7/30/08 listed separate items for the same medication. One order written read Ramipril (generic name for Altace)10 mg by mouth daily. A separate order written read, Altace 10 mg by mouth every morning. The antihypertensive medication orders did not include any parameters for not administering the medications, such as a specific low blood pressure reading. These orders were signed by the attending physician and signed as "noted" (reviewed by) two RN's.

The medication administration record (MAR) documented Ramipril 10 mg. was administered daily at 10:00 am from 8/1/08 through 8/7/08. The MAR documented administration of Altace 10 mg daily at 6:00 am from 8/1/08 through 8/7/08. There were no blood pressures documented on the MAR prior to the administration of these antihypertensives.

A Medication Error Report, dated 8/7/08 at 12:00 pm, documented the error as "incorrect dosage administered" and listed the medication order "Altace 10 mg. every day". An additional note on

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F 425	Continued From page 65 this Medication Error Report form reads "Altace 10 mg. given at 6:00 am and 10:00 am." 10 NYCRR 415.18(a)	F 425		
F 490 SS=L	483.75 ADMINISTRATION A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview during the investigation of a complaint case (NY#00060638) it was determined the Administrator failed to: ensure that residents' medication regimens were effectively managed and monitored; ensure residents were free of significant medication errors; arrange for provision of adequate pharmacy services; and provide adequate supervision of medical personnel. The facility failed to develop policies and procedures in accordance with federal and state requirements and generally accepted professional standards and practices that are complete, accurately documented, and readily accessible. This resulted in Immediate Jeopardy to Resident Health and Safety and Substandard Quality of Care. The findings are: The facility failed to have an acceptable contract with a pharmacy services vendor to provide pharmacy services in accordance with federal and state requirements. A medication order was incorrectly transcribed from hospital discharge	F 490		9/29/08

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F 490	Continued From page 66 orders for Resident #1. The incorrectly transcribed discharge order was perpetuated when the facility physician prescribed alprazolam at a dose and frequency exceeding recommended guidelines. The facility's pharmacy services reviewed the medication order and dispensed the medication without identifying that the dosage was excessive and/or unusual (two separate tablets for Xanax, 1 mg and 0.25 mg were dispensed); and nursing services administered two doses to Resident #1 who was subsequently transferred to an acute care facility emergency department, was admitted for evaluation with a diagnosis of benzodiazepine overdose with coma and core body temperature of 89.7 F (normal body temperature is 98.6 F). The facility's pharmacy vendor failed to dispense the physician ordered intravenous (IV) solution on 8/8/08. The facility failed to identify the incorrect IV solution was stocked at the facility and the wrong IV solution was administered to the resident for 12 hours between 8/9/08 at 3:40 pm and 8/10/08 at 4:00 am. The facility failed to adequately and accurately assess resident's with a change in condition in a timely manner. Resident #1's neurological function was not assessed in a timely manner when the resident was observed to be unresponsive. Resident #5 was not adequately or accurately assessed after being found on the floor, an unwitnessed fall, and began having changes in her condition a few days later. Resident #6 was admitted to the hospital for rectal bleeding after two days duration, and no assessment was documented in the medical record prior to the hospital transfer.	F 490		

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F 490	Continued From page 67 The facility staff failed to follow the written physician's order to catheterize Resident #1 every six hours. Resident #20, who had temperature elevations for three days, was not adequately assessed nor transferred to the hospital for evaluation as ordered by the physician's assistant. 10NYCRR 415.26	F 490		
F 493 SS=L	483.75(d)(1)-(2) GOVERNING BODY The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview during a complaint investigation (Case #NY00060638) the governing body failed to establish and implement resident care policies and procedures regarding management and operation of the facility. Specifically, physician services ordered anti-anxiety medications in doses considered excessive for use with the elderly; failed to ensure that nursing services provided accurate and timely resident assessments when residents' experienced changes in health status; and failed to ensure that adequate pharmacy services for dispensing of medications and review of residents' medication regimens were provided. This resulted in	F 493		9/29/08

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F 493	Continued From page 68 Immediate Jeopardy to residents' health and safety and Substandard Quality of Care for all residents. This is evidenced by: F281 Comprehensive Care Plans s/s K F329 Unnecessary Drugs s/s K F333 Medication Errors s/s J F385 Physician Services s/s K F425 Pharmacy Services s/s L F490 Administration s/s L F501 Medical Director s/s L F520 Quality Assessment and Assurance s/s L 10NYCRR 415.26(b)(3)(1)	F 493		
F 501 SS=L	483.75(i) MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and resident interviews, and review of the facility policies and procedures, it was determined that the medical director failed to assume responsibility for implementation of resident care policies and the coordination of medical care in the facility. Specifically, the medical director failed to ensure that policies were developed and/or implemented for physician orders, medication administration, pharmacy services, assessment of residents, staffing and overall quality of care. The medical director failed to coordinate medical care for Resident's # 1 and 32 who were on	F 501		9/29/08

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F 501	Continued From page 69 benzodiazepines and antihypertensives and for Resident #1's admission to the facility. There was no written acceptance of the resident's admission when the physician failed to sign the resident's admitting orders. The facility failed to provide adequate assessment and intervention for Resident # 17 with a pressure ulcer, who experienced a significant change (deterioration) in medical status. The Medical Director failed to assure that the facility provided care as directed in the resident's care plan when there was not sufficient qualified staff available on the residential unit. Specifically, Resident # 1 was administered the wrong medication dose when a transcription error changed the dose of Xanax from 0.125mg to 1.25mg and the error was perpetuated when physician copied the inaccurate dose as he wrote a prescription for the drug and when there was no written acceptance of Resident #1's admission and when the physician failed to sign the resident's admitting orders; Resident # 32 was administered duplicative medications when two separate orders were written for the same drug using the trade name Altace in one order and the generic name Ramipril in the second order; Resident # 17's medical regimen was not updated when the physician was not aware of the change in status and dimensions of the resident's pressure ulcer. This resulted in actual harm that was Immediate Jeopardy and Substandard Quality of Care. This is evidenced by the following examples: Finding # 1 Resident #1 with a documented sensitivity to Alprazolam was administered the drug at an excessive dose when a prescription was written by the physician for Xanax 1.25mg every two hours (q2h) as needed, and the maximum daily	F 501		

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F 501	Continued From page 70 dose (MDD) of the medication was written as 12mg. This resident received two doses of 1.25mg within two hours of each other (on 7/24/08 at 10:30 pm and 7/25/08 at 12:30 am). The pharmacy vendor delivered the medication to the facility without questioning or consulting with the physician prior to dispensing the Xanax, and staff administered the medication without question to dosage or frequency. A review of the medical record revealed there was no personal written approval by the physician for Resident #1 to be admitted to the facility. The resident's admission orders were not signed by the physician. Finding # 2 Resident # 32 admission orders were signed by the physician-medical director and listed duplicate medications orders in the generic name and the trade name (Ramipril and Altace, respectively), for daily administration. The drugs were each administered to Resident #32 for 7 days, from his admission on 7/30/08 until the day the medication error was discovered on 8/7/08. There was no evidence that the duplication of orders was questioned by staff or by the pharmacy. Finding #3 During an interview with the facility physician-medical director, on 08/08/08 at approximately 9:30 am, he stated he was aware of Resident #17's pressure ulcer on the coccyx area, but he was not aware that "tunneling" had developed in the wound. He stated he was not aware that the resident's wound care was performed while she sat on the commode or that the staff stated the dressing was changed while the resident sat on the commode because that	F 501		

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F 501	Continued From page 71 was the resident's preference. Finding #4. The facility did not have sufficient qualified staff available on the residential unit to provide direct resident care as directed in written resident care plans on the 48-bed residential units. During the observations on residential Unit 1 on 8/13/08 at 5:20 pm, multiple resident call bells rang continuously for more than ten minutes without any staff response. During interviews conducted of the direct care staff assigned to these units between 7/29/08 and 8/17/08, the staff members state with the current staff scheduled the care was not performed as care planned despite their best efforts. Specifically, tasks not done as planned are: the every two hour toileting or incontinence care, the ambulation at the distance or frequency planned, and the repositioning of resident's who require staff assistance. The staff identified residents who became incontinent while waiting for assistance or were not provided toileting assistance as planned. During interviews conducted with residents of Units 1 and 2, between 7/29/08 and 8/17/08, they stated the staff "work very hard", "are so busy, try not to bother them too much... other people need them more", "try to manage without help or ask for everything at once." Residents stated call bell responses to provide needed assistance were "slow", which was further described by residents who waited 30 minutes or more for assistance from staff. The residents stated they "need to plan ahead (anticipate) to get assistance." Residents reported they experienced bowel and	F 501		

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F 501	Continued From page 72 bladder incontinence while waiting for staff assistance. Residents requested to not be identified due to concerns they could be blamed for impacting staffs' employment or perceived as "complainers." Finding #5 The facility Administrator was interviewed on 8/4/08 at 3:45 pm, and stated the facility currently uses the hospital's policies and procedures and is in the process of updating those to reflect facility operations. The facility was unable to provide policies and procedures requested on 7/29/08 until 8/8/08. 10NYCRR 415.15(a)	F 501		
F 514 SS=E	483.75(l)(1) CLINICAL RECORDS The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record reviews and interview during an investigation of a complaint (Case # NY00060638) it cannot be ensured that resident medical records were complete, accurate, current and readily accessible. Two staff nurses	F 514		9/29/08

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lacked access to the electronic (computer) medical records for residents under their care. Each of two nurses reported they entered information regarding treatments, resident observations/ concerns in residents' medical records by handwritten notes because neither nurse was able to access the residents' electronic medical record used by other staff until granted access rights. The attending physician/Medical Director did not have access to the interdisciplinary computerized medical records.

Licensed Practical Nurse (LPN#3) was interviewed on 7/30/08 at approximately 1:30 pm and stated her first day of employment at the facility "as an LPN" was on 05/26/08. As off 7/30/08, the LPN did not have computer access to residents medical records.

LPN#4 was interviewed on 7/30/08 at approximately 1:50 pm and stated she was employed at the facility for one month and did not have access to the electronic medical record. LPN#4 stated she entered a nurses note in long hand but could not access medical records using the computer or view nurses notes from other nursing staff in the electronic medical record. LPN #4 stated that thought nurses notes are printed out once a week, then filed in the medical chart keep on the residential units.

The Administrator was interviewed on 8/11/08 at approximately 4:45 pm and stated the LPN (LPN #2) had just received computer access that day and would be educated that evening on how to navigate the medical record in the computer. The Administrator further stated the attending physician, who is the Medical Director, did not have access rights for interdisciplinary notes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335267	A. BUILDING ____ B. WING ____	C 08/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRONDACK MEDICAL CENTER UIHLEIN	185 OLD MILITARY ROAD LAKE PLACID, NY 12946

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 74 the resident's electronic medical records as of 8/11/08. 10NYCRR 415.22 (a)(1-4)	F 514		
F 520 SS=L	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on staff interview, observation and record reviews conducted during a complaint investigation (Case # NY00060638) and a partial extended survey, it was determined that the facility failed to have a Quality Assurance	F 520		9/29/08

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335267	A. BUILDING ______ B. WING ______	C 08/08/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ADIRONDACK MEDICAL CENTER UIHLEIN	**185 OLD MILITARY ROAD** **LAKE PLACID, NY 12946**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 75 Program that readily identified unsafe practices to ensure effective services, actions and interventions were in place. Specifically, the facility failed to ensure residents with the potential for adverse medication reactions were monitored, failed to recognize an adverse medication reaction, failed to ensure that residents' drug regimen were free from unnecessary drugs, failed to monitor and assess a resident who experienced excessive sedation, failed to ensure the facility's physician's services to supervise resident's medical treatment, and failed to ensure that the pharmacy had a system in place to identify medication dosages which exceed the recommended daily dose, failed to ensure that the pharmacy had a system to inform the physician of questionable dosages and failed to ensure that the pharmacy had a system to notify the facility of questionable dosages. This resulted in Immediate Jeopardy to residents' health and safety and Substandard Quality of Care for all residents. 415.27(a-c)	F 520		

AH Form Approved

11/14/2008

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
335267	A. Building B. Wing	11/6/2008

Name of Facility	Street Address, City, State, Zip Code
ADIRONDACK MEDICAL CENTER UIHLEIN	185 OLD MILITARY ROAD LAKE PLACID, NY 12946

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix I200 Reg. # 415.18 LSC	11/05/2008	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 8/8/2008

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO