Exhibit 1

From:	Leland Dempsey
To:	Anna Lee (07foiarf@cms.hhs.gov)
Subject:	FOI Request - Travis Claussen - Blue Valley Hospital
Date:	Tuesday, April 21, 2020 8:10:17 PM
Attachments:	CMS - Third FOI Request - Letter seeking Travis Claussen material - 4-21-20.pdf Death Certificate - Travis Claussen.pdf Letters of Administration.pdf CMS Authorization - UPDATED & Signed by Deb (filled out).pdf 2. CMS - Statement of Deficiencies (without Plan of Correction yet filled in by BVH) - 4-25-20 (37 pages).pdf 4. CMS - Statement of Deficiecies and Plan of Correction - 6-14-18 (49 pages).pdf

***Via Mail & Email:* 07foiarf@cms.hhs.gov**

Anna Lee
CMS
601 E. 12th St., Room 355
Kansas City, MO 64106

RE: Our client: Family of Travis Claussen/Estate of Travis Claussen (deceased)
Facility: Blue Valley Hospital, Inc. & Blue Valley Surgical Associates, LLC
DOB: [redacted]
SSN: [redacted]
Subject: **RECORDS/REPORTS CONCERNING PATIENT TRAVIS CLAUSSEN**

Dear Ms. Lee:

Our office represents Debra L. Claussen and Herm Claussen in a wrongful death action as parents of patient Travis Claussen, deceased. We also represent Debra L. Claussen in her capacity as personal representative of the Estate of Travis Claussen.

(This e-mail version of the request is also being sent in hard-copy fashion by U.S. Mail).

Pursuant to the Freedom of Information Act and the Privacy Act of 1974, we hereby request access to, and copies of, all records maintained by your agency that reference Mr. Claussen, including but not limited to:

1. The complete contents of any investigative file(s) discussing Mr. Claussen's death, which occurred on or about April 11, 2018 at Blue Valley Hospital/Blue Valley Surgical Associates.

2. All medical records referencing Mr. Claussen.

3. A complete copy of any Statement of Deficiencies referencing Mr. Claussen, along with any supporting documentation that references Mr. Claussen, including but not limited to surveyor notes, witness statements, meeting minutes, nurse notes, medication orders, and medication administration records.

4. A complete copy of any Plan of Correction, or any supporting document submitted therewith, which references Mr. Claussen.

5. Any correspondence that references Mr. Claussen.

6. Any documents gathered by CMS but not yet produced pursuant to our previous FOI requests of October 26, 2018 and January 9, 2019. It is believed that this comprised a "large volume" of records gathered by the Kansas Department of Health & Environment and that concern Travis Claussen.

7. Any documents provided to CMS by the Kansas Department of Health & Environment referencing Travis Claussen.

To assist you in your research, please note that we have previously obtained various documents which redact information about Mr. Claussen, identifying him only as "Patient #10". (See CMS 'Statement of Deficiencies' dated 4/25/18 a copy with redactions is attached hereto as "Exhibit A" at pp. 5, 6, 12 & 13; and CMS 'Statement of Deficiencies' dated 6/14/18 a copy with redactions is attached hereto as "Exhibit B" at pp. 1, 2, 3,11, 12, 13, 14, 16, 17, 18, 19, 20, 22, 30 and 35). With this request we seek access to the above-described categories of documents discussing Mr. Claussen ***with any references shown in full and without redactions***.

I am willing to pay reasonable fees for actual expenses incurred in the fulfillment of this request up to a maximum of $2,000.00. If you estimate that the fees will exceed this limit, please inform me first. I have enclosed a copy of the signed Medicare Authorization to Disclose Personal Health Information by his mother, Debra Claussen, Letters of Administration, and a copy of Mr. Claussen's death certificate.

To the extent that any record you identify as potentially responsive to this request contains information that you believe to be exempt from disclosure, please provide all segregable portions of otherwise exempt material.

Please let me know if you need any additional information and thank you for your attention to this matter.

Leland Dempsey
Dempsey & Kingsland, P.C.
City Center Square, Suite 1860
1100 Main Street
Kansas City, Missouri 64105
Phone: (816) 421-6868
Fax: (816) 421-2610
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Staff

April 21, 2020

Via Mail & Email: **07foiarf@cms.hhs.gov**
Anna Lee
CMS
601 E. 12th St., Room 355
Kansas City, MO 64106

RE: Our client: Family of Travis Claussen/Estate of Travis Claussen (deceased)
Facility: Blue Valley Hospital, Inc. & Blue Valley Surgical Associates, LLC
DOB: [redacted]
SSN:
Subject: **RECORDS/REPORTS CONCERNING PATIENT TRAVIS CLAUSSEN**

Dear Ms. Lee:

Our office represents Debra L. Claussen and Herm Claussen in a wrongful death action as parents of patient Travis Claussen, deceased. We also represent Debra L. Claussen in her capacity as personal representative of the Estate of Travis Claussen.

Pursuant to the Freedom of Information Act and the Privacy Act of 1974, we hereby request access to, and copies of, all records maintained by your agency that reference Mr. Claussen, including but not limited to:

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I am willing to pay reasonable fees for actual expenses incurred in the fulfillment of this request up to a maximum of $2,000.00. If you estimate that the fees will exceed this limit, please inform me first. I have enclosed a copy of the signed Medicare Authorization to Disclose Personal Health Information by his mother, Debra Claussen, Letters of Administration, and a copy of Mr. Claussen's death certificate.

To the extent that any record you identify as potentially responsive to this request contains information that you believe to be exempt from disclosure, please provide all segregable portions of otherwise exempt material.

Please let me know if you need any additional information and thank you for your attention to this matter.

Sincerely yours,

LELAND DEMPSEY
Attorney at law
leland@dandklaw.com

LFD/lfd
Enclosures

Kansas Department of Health and Environment
Office of Vital Statistics
CERTIFICATE OF DEATH

115-2018-09240
AMENDED-05/17/2018 — State File Number

1. Decedent's Legal Name (First, Middle, Last)	2. Sex	3. Date Of Death (Month, Day, Year)	4. Social Security Number	5. Date Filed By State Registrar
TRAVIS WILLIAM CLAUSSEN	MALE	04/11/2018	[redacted]	05/04/2018

6. Last Name Prior to First Marriage	7a. Date Of Birth	7b. Age	8. Place Of Birth (City And State Or Foreign Country)	9. Decedent Ever In U.S. Armed Forces
	[redacted]	40 YEAR(S)	KANSAS CITY, MISSOURI	NO

10a. Place Of Death	10b. Facility Name (If Not Institution, Street And Number)	10c. County Of Death	10d. Zip Code
ER/OUTPATIENT	SAINT LUKE'S SOUTH HOSPITAL	JOHNSON	66213

10e. City or Town Of Death	11. Marital Status	12. Surviving Spouse (Name Prior to First Marriage)	13a. Residence – Street Address
OVERLAND PARK	NEVER MARRIED		18125 BAXTER ROAD

13b. State or Foreign Country	13c. County or Province	13d. City or Town	13e. Zip Code	13f. Inside City Limits
MISSOURI	CLAY	LIBERTY	64068	NO

14. Decedent's Ancestry	15. Decedent's Race
AMERICAN	WHITE

16. Decedent's Hispanic Origin
NOT SPANISH, HISPANIC, LATINO

17. Decedent's Education	18. Decedent's Occupation	19. Decedent's Industry
SOME COLLEGE CREDIT, BUT NO DEGREE	SALES/MECHANIC	MOTOCROSS

20. Father/Parent Birth Name (First, Middle, Last)	21. Mother/Parent Birth Name (First, Middle, Last)
HERMAN PETER CLAUSSEN	DEBRA LEE FOX

22a. Informant's Name (First, Middle, Last)	22b. Mailing Address (Street, Number, City, State, And Zip Code)	22c. Relationship To Decedent
HERMAN PETER CLAUSSEN	18125 BAXTER ROAD, LAWSON, MISSOURI, 64062	FATHER

23. Method Of Disposition	24a. Place Of Disposition	24b. Location
CREMATION	PORTER CREMATORY	LENEXA, KANSAS

25. Funeral Service Licensee And License Number	26. Name Of Embalmer And License Number
/e/JON M DALE - 2151	NOT EMBALMED - 9999

27. Name And Address Of Firm CREMATION SOCIETY OF KS AND MO-KANSAS CITY, 5561 NW BARRY RD, KANSAS CITY, MISSOURI, 64154

28. Cause Of Death Part I. Events (diseases, injuries, or complications) that directly caused the death.

		Approximate Interval: Onset To Death
IMMEDIATE CAUSE (Final Disease Or Condition Resulting In Death)	A) INTRUSIVE CORONARY ARTERY DISEASE	A)
	B)	B)
Conditions, if any, leading To cause listed on line A)	C)	C)
UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LISTED LAST	D)	D)

Part II. Other Significant Conditions Contributing To Death But Not Resulting In The Underlying Cause Given In Part I.	29a. Autopsy	29b. Autopsy Findings Available To Complete The Cause Of Death	29c. Coroner Contacted
FENTANYL INTOXICATION	YES	YES	YES

30. Did Tobacco Use Contribute To Death?	31. If Female:	32. Manner Of Death
UNKNOWN		ACCIDENT

33a. Date Of Injury	33b. Time Of Injury	33c. Injury At Work	33d. How Injury Occurred
04/10/2018	UNKNOWN	NO	EXCESSIVE INGESTION OF FENTANYL

33e. Place Of Injury	33f. Location (Street And Number Or Rural Route, City Or Town, State, And Zip Code)
REHAB CENTER	12850 METCALF AVE, OVERLAND PARK, KANSAS, 66213

34a. Date Pronounced Dead	34b. Time Pronounced Dead	34c. Actual Or Presumed Time Of Death	34d. Name Of Person Pronouncing Death	34e. License No.
04/11/2018	0622	0622		

35a. Pronouncing and Certifying Physician	35b. License No.	35c. Date Certified	35d. Address And Zip Code Of Person Completing Cause Of Death
/e/ROBERT PROSSER - MD	0422505	05/17/2018	13851 W 63RD ST #345, SHAWNEE, KANSAS, 66216

IN THE 7TH JUDICIAL CIRCUIT COURT, CLAY COUNTY, MISSOURI

Judge or Division: PROBATE	**Case Number: 18CY-PR00883**
In the Estate of TRAVIS WILLIAM CLAUSSEN, Deceased.	(Date File Stamp)

Letters of Administration
(Independent Administration)

The State of Missouri to All Persons Interested in the Estate of TRAVIS W CLAUSSEN:

TRAVIS WILLIAM CLAUSSEN, who resided at 18125 BAXTER ROAD, LAWSON, CLAY COUNTY, MISSOURI, died intestate, and to the end that the property of the decedent may be collected and disposed of, we appoint DEBRA L CLAUSSEN personal representative, who may administer the estate independently without adjudication, order, or direction of the Probate Division of the Circuit Court, with full power and authority as provided by law.

Date of Death: 11-APR-2018

I, Clerk of the Probate Division of the Circuit Court of Clay County, Missouri, have signed my name and affixed the seal of the said Court on JANUARY 8, 2019

Joyce Gray
Clerk

Inventory Due: FEBRUARY 7, 2019
Statement of Account Due: ONE YEAR FROM DATE OF LETTERS
Earliest Date Statement of Account can be filed: 6 MONTHS and 10 DAYS FROM 1ST DATE OF PUBLICATION

COURT SEAL OF
CIRCUIT COURT OF MISSOURI
CLAY COUNTY

Certificate

I, Clerk of the Probate Division, certify that the foregoing Letters, now in full force and effect, is a true copy from the record as it appears in my office

Witness my hand and seal of court on _____ (date)

_____
Clerk

IN THE 7TH JUDICIAL CIRCUIT COURT, CLAY COUNTY, MISSOURI

Judge or Division: PROBATE	**Case Number: 18CY-PR00883**
In the Estate of TRAVIS WILLIAM CLAUSSEN, Deceased.	(Date File Stamp)

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(Independent Administration)

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Witness my hand and seal of court on _____ (date)

_____
Clerk

MEDICARE AUTHORIZATION FORM

****ALL SECTIONS REQUIRED****

SECTION A: BENEFICIARY INFORMATION

Enter beneficiary name as it appears on Medicare card.

First Name:	Middle Name:	Last Name:
Travis		Claussen

Date of Birth *(mm/dd/yyyy)*	Medicare Identification Number:
[redacted]	[redacted]

Address: Deceased

City:	State:	Zip code:

SECTION B: RECORD DETAILS DEFINITION

Medicare will only disclose the claim information identified below for the individual in Section A.

Select **one** option:
- [X] Release **all** records to date
- [ ] Release records in timeframe from start date _____ to end date: _____

NY residents only:
- [ ] Include all records
- [ ] Exclude information about alcohol and drug abuse, mental health treatment, and HIV

Indicate whether authorization release is for a one-time disclosure, or identify a future date or event when the authorization will expire.

Select **one** option:
- [X] One-time disclosure
- [ ] Expiration upon specified date _____
- [ ] Expiration upon specified event _____

SECTION C: RELEASE INFORMATION TO

Identify the name, address and contact information of the person and/or organization to whom you want Medicare to disclose the claim records. Medicare will only release claim records to those listed.

Release claim records to beneficiary at mailing address above.

Organization/Individual 1 Name	Recipient 1 Email Address
Dempsey & Kingsland, PC	kris@dandklaw.com

Recipient 1 Mailing Address:

1100 Main St., Ste. 1860, Kansas City, MO 64105

SECTION D: PURPOSE FOR REQUEST

This section helps Medicare understand the reason or intent for use for this record request.

At the request of the individual	Litigation

SECTION E: AUTHORIZATION AGREEMENT

I authorize Medicare to disclose claim records to the person(s) or organization(s) documented in Section C. I understand that these claim records may be re-disclosed by the recipient and may no longer be protected by law.

I understand I have the right to revoke this authorization at any time, in writing, except to the extent that Medicare has already acted based on my permission.

I understand that signing this authorization is voluntary. Treatment, payment, enrollment in a health plan or eligibility for benefits will not be conditioned on my authorization of this disclosure.

Signature of Beneficiary or Representative Authorized by Law:	Date Signed:
Travis Claussen	4.15.20

Legal Role of Representative (Requires Additional Documentation):

PRINTED: 05/10/2018
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	170201	A. BUILDING _____ B. WING _____	R 04/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE VALLEY HOSPITAL, INC	12850 METCALF AVENUE OVERLAND PARK, KS 66213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{A 000}	INITIAL COMMENTS On behalf of the Centers for Medicare and Medicaid Services (CMS), the State Agency conducted an onsite revisit survey from 04/22/18 to 04/25/18 to determine whether the hospital was "primarily" engaged in providing inpatient services. Review of the facility's admission data from April 1, 2017 thru March 31, 2018 provided to the surveyor showed that the facility reported an average daily census (ADC) of less than two patients with an average length of stay (ALOS) of less than two days. After consideration of the facility's data and other factors such as volume of outpatient surgical procedures compared to inpatient surgical procedures it was determined that the facility was not "primarily engaged" in providing inpatient services. The survey resulted in non-compliance with two Conditions of Participation: A-0008, 42 CFR 482.1, requirements for Basis and Scope, A-0043 and 42 CFR 482.12, requirements for Governing Body.	{A 000}		
A 008	Basis and Scope CFR(s): 482.1 §482.1 Basis and scope. (a) Statutory basis. (1) Section 1861(e) of the [Social Security] Act provides that- (i) Hospitals participating in Medicare must meet certain specified requirements; and	A 008		

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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A 008	Continued From page 1	A 008		

(ii) The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.
. . .

(b) Scope. Except as provided in subpart A of part 488 of this chapter, the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.
This CONDITION is not met as evidenced by:
Based on admission data review, staff interviews, and document review the facility failed to be in compliance with the regulations at 42 CFR 482.1 (a)(1) because it is not "primarily engaged in providing, by or under supervision of physicians, to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons. The facility operates like a surgical center that primarily provides services to outpatients.

Findings include:

1. Review of Blue Valley Hospital's (BVH) utilization review data and meeting minutes dated August 23, 2017 from 3:43 PM till 3:48 PM showed that "outpatients are increasing, and inpatients are remaining about the same." The meeting minutes also showed that BVH reported "an average of 312 procedure room cases performed each month with a total of 1,874 cases performed for 1Q-2Q 2017." "Operating room procedures average 335 cases a month, with a total of 2,012 for 1Q-2Q 2017."

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A 008	Continued From page 2	A 008		

2. Review of BVH's utilization review data and meeting minutes dated 01/24/18 from 4:00 PM till 4:10 PM showed that BVH had "an average of 808 procedure room cases performed each quarter with a total of 3,233 cases performed for 2017." "Operating room procedures average 868 cases a quarter, with a total of 3,473 for 2017."

3. Review of the Provider Statistical and Reimbursement System data dated 04/19/18 (PS&R - a summary of all claims submitted by the provider and paid by Medicare through April 19, 2018) provided by the Medicare Administrative Contractor (MAC) Wisconsin Physicians Service Insurance Corporation (WPS) showed BVH's average daily census (ADC) (inpatients) was 0.09 in 2014, 0.21 in 2015, 0.25 in 2016, 0.22 in 2017 and dropped to 0.18 for the first quarter 2018 (01/01/18 through 03/31/18). WPS data showed BVH's average length of stay (ALOS) in 2014 was 1.5 days, in 2015 1.04 days, in 2016 1.08 days, in 2017 1.1 days and for first quarter 2018 was 2 days.

A. PS&R data also showed that BVH had a Net Reimbursement of $845,237 for Inpatients in 2017 and Net Reimbursement for the same timeframe for Outpatients of $1,723,629 (more than double the amount for inpatients).

B. PS&R data also showed that BVH had a Net Reimbursement of $67,377 for Inpatients for the first quarter of 2018 and Net Reimbursement for the same timeframe for Outpatients of $494, 586 (more than 7 times the amount for inpatients).

4. Review of the "Medicare Hospital Database Worksheet" completed by the surveyor in collaboration with Staff A, Quality Manager, on

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A 008	Continued From page 3 04/23/18 showed that the facility had two operating rooms and reported it had ADC of 1.29 inpatients from 04/01/17 to 03/31/18. This data was inconsistent with the data reported by WPS in 2017/2018. 5. Review of the data provided by BVH specifying its ALOS by month from 04/01/17 through 03/31/18 showed that BVH reported an ALOS of 1.7 days. 6. During an interview on 04/25/18 at 2:45 PM, Staff A, Director of Quality stated that we have a poor electronic medical record system. In order to provide the requested monthly inpatient and outpatient lists with the average length of stay (ALOS) and average daily census (ADC) calculations, we had to go into the medical record and manually identify which patients were an inpatient or an outpatient. Staff B indicated there could be some errors. 7. Review of BVH's policy number "ADM-013" titled, "Inpatient and Outpatient Guidelines," with an effective date of January 2018, showed BVH defined which patients were included in the hospital's definition of "inpatient and outpatient admissions." "Inpatient: Can be Outpatient Observations (>24 hrs.) or Inpatient Status." "Any patient admission with an admit and discharge date that are different (24 hours or more), who was admitted either Observation or Inpatient status to the Medical-Surgical Unit and received inpatient level care." The policy is inconsistent with the Centers for Medicare and Medicaid Services (CMS) guidance: Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at	A 008		

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A 008	Continued From page 4	A 008		

least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.

8. Evidence of inaccurate reporting of BVH's ALOS included review of the monthly patient census sheets and medical records for Patient #6, Patient #14, Patient #13 (BVH employee), Patient #10, and Patient #35.

A. Review of the January 2018 monthly patient census sheet showed Patient #13 and Patient #10 were counted "Inpatients." Review of Patient #13's 01/02/18 medical record showed "Physician Orders" dated 01/02/18 at 12:00 PM specified Patient #13 was admitted to "outpatient observation" for monitoring. Further review showed that nursing staff inaccurately documented throughout the medical record that Patient #13 was an "inpatient." Documentation showed that Patient #13 left the hospital on 01/03/18 at 3:00 PM.

B. During an interview on 05/03/18 at 8:52 AM, Staff A, Director of Quality, confirmed Patient #13's medical record showed the patient was an outpatient admission even though the census documents provided during the survey on 04/22/18 thru 04/25/18 showed they were an inpatient.

C. Review of Patient #10's 01/25/18 medical record showed she was admitted for intolerance to the band (a silicone device placed around the upper section of the stomach, creating a small pouch above the band and thereby restricting the amount of food that can be comfortably eaten), chronic pain, nausea can't seem to keep anything

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BLUE VALLEY HOSPITAL, INC	12850 METCALF AVENUE OVERLAND PARK, KS 66213

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A 008	Continued From page 5	A 008		

down, now just wants the band out. Review of Patient #10's record showed a handwritten order on 01/25/18 at 1:00 PM, that read, "Admit to Observation (outpatient), admit for severe nausea, vomiting and dehydration." Staff Y, Registered Nurse (RN) noted the order on 01/25/18 at 1:10 PM. Staff Z, Physician, signed the ordered 02/06/18 at 10:00 AM. The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and who wrote the order. However, throughout the medical record, nursing staff referred to Patient #10 as an "inpatient." Review of another handwritten order on 01/26/18 at 1:30 PM read, "Admit to inpatient, Staff Y, RN noted the order on 1/26/18 at 1:40 PM. Staff Z, Physician signed the order on 02/12/18 at 3:00 PM. The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and who wrote the order. Patient #10 discharged to home on 01/26/18 at 4:20 PM. The medical record did not contain any notes by Physician Staff Z regarding the medical necessity to change her admission status from Observation to Inpatient Admission.

D. Review of the March 2018 monthly patient census sheet showed Patient #6 and Patient #14 were counted as "Inpatients." Review of Patient #6's 03/04/18 medical record showed that Physician Staff H signed an order to admit to "Observation Status" (outpatient) on 03/04/18 at 10:00 PM for treatment of a migraine headache with intravenous (IV) Fentanyl (opioid narcotic). At 10:45 PM nursing staff inaccurately documented Patient #6 was an "inpatient." On 03/05/18 at 7:13 AM Staff Q, Advanced Practice Registered Nurse (APRN) placed an order in the electronic medical record "Admit to INPATIENT." The medical record

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A 008	Continued From page 6 did not contain any notes by Physician Staff H or APRN Staff Q regarding the medical necessity to change the patient from observation to inpatient. E. Review of Patient #14's 03/08/18 medical record showed that she was admitted for back and leg pain, a Posterior/Transforaminal Lumbar Interbody Fusion of L4-L5 (spinal fusion procedure that joins together the front and back section of the spine). The medical record showed Physician Staff M approved an order to admit to outpatient on 03/08/18. However, throughout the medical record, nursing staff referred to Patient #14 as an "inpatient." Patient #14 discharged on 03/10/18. Further review of the record showed a handwritten order dated 03/14/18 read, "Amendment to outpatient admission order documented on 03/08/14 2104 (9:04 PM) by Staff M, amend to inpatient admission order." Staff M then signed the order on 03/14/18. The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and who wrote the amendment order. The medical record did not contain any notes by Physician Staff M regarding the medical necessity to change Patient #14's Admission from Outpatient to Inpatient Admission. F. Review of the April 2018 monthly patient census sheet showed Patient #6 and Patient #35 were counted as "Inpatients." Review of Patient #6's medical record showed he arrived at BVH on 4/19/18 for treatment of a migraine headache. The medical record did not contain documentation specifying the patient's time of arrival, however at 3:18 PM the initial nurse's note showed "this RN assumed care from 1:50 PM to 3:15 PM." Staff Q, APRN gave a verbal order to admit Patient #6 to "Observation Status" on	A 008		

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A 008	Continued From page 7 04/19/18 at 12:54 PM for severe headache. However, throughout the medical record, nursing staff referred to Patient #6 as an "inpatient." Review of the "Patient Discharge Planning Needs Assessment" form dated 04/20/18 at 12:15 PM under "Admission Status" showed the Registered Nurse (RN) documented that "No order Found" - "clarifying admission status with hospitalist group." Staff Q, APRN gave a verbal order to admit Patient #6 to "INPATIENT" on 04/20/18 at 1:29 PM for severe headache. The medical record did not contain any notes by Staff H, Physician or Staff Q, APRN regarding the medical necessity to change Patient #6 from "observation status" to inpatient admission. The medical record showed Patient #6 discharged on 04/24/18 at 10:45 AM. G. Review of Patient #35's medical record showed that APRN Staff Q signed an order dated 04/11/18 specifying Patient #35 was an "outpatient admission." Further review showed that nursing staff inaccurately documented throughout the medical record that Patient #35 was an "inpatient." H. During an interview on 05/03/18 at 8:52 AM Staff A, Director of Quality, confirmed Patient #35's medical record showed the patient was an outpatient even though the census documents provided during the survey on 04/22/18 thru 04/25/18 showed they were an inpatient. Staff A stated we realize we are not always capturing the correct status in our tracking spreadsheets and are now going back to the previous weeks to verify what we have listed and that an order for inpatient or outpatient admission is present in the medical record.	A 008		

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A 008	Continued From page 8 9. In response to the deficiencies cited at BVH during the survey which concluded on 11/14/17, BVH outlined in its 02/12/18 plan of correction, plans to grow service lines that were focused on inpatient care to increase the ADC as well as the ALOS. A. During an interview on 04/23/18 at 10:00 AM, Staff L, Chairman of the Board, stated he has a contractor already hired and plans were sent to the state agency for review so that the facility could add an additional 12 beds upstairs. Staff L stated they are planning to use the beds as an inpatient detox unit. B. Tour of the second floor of the facility showed empty office spaces without construction activity in progress. C. BVH staff failed to provide documentation supporting concrete plans and activities necessary to develop an inpatient detox unit. D. During an interview on 04/25/18 at 1:00 PM, the State Agency Director confirmed they lacked any communications from BVH requesting review and approval of construction plans. 10. During an interview on 04/2318 at 10:00 AM, Staff L, Chairman of the Board, discussing the current status of the hospital stated that, When Medicare guidance came out (regarding "primarily engaged"), we didn't pick up on it right away...We understood with the new guidance we weren't keeping our patients long enough...Our AO (accrediting organization) granted us accreditation based on what we were planning to do in the future not the past. They did acknowledge our average length of stay was not	A 008		

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A 008	Continued From page 9 enough...They (the State Agency surveyors) said we didn't have the average length of stay numbers and a high enough census. We agreed with them and said we would do what we need to do to meet the current regulations. We did a lot of extra surgeries to get the numbers we needed. I knew that alone wouldn't get us there. So, I offered a new benefit to all employees and their families. I told them for those that medically qualify for a gastric sleeve, we would pay what insurance didn't. Our staff has requested it for years because the insurance we have won't cover the costs for the surgery here. Unfortunately, I have a lot of obese employees and they wanted this surgery. So it was something that could help us both. We have done about 50 -60 employee/family surgeries to date with about 70 more that want it...My QA (Quality Assurance) director, Staff A came to us about a year ago and we went back and update and reviewed our policies so we would be in compliance with CMS. We spent so much time on that, we were sure we would pass a survey. 11. Staff indicated that physician staff (Staff M) and facility administration (unidentified) attempted to have the Registered Nurse (RN) Staff document symptoms or complications in the medical record that would make it look like it was medically necessary for continued hospitalization and for a patient to stay another night (thus increasing their inpatient days and average length of stay). A. Review of BVH's policy number "ADM-013" titled, "Inpatient and Outpatient Guidelines," with an effective date of January 2018 directed, Acceptable Indications for Inpatient Hospitalization: Gastrointestinal System:	A 008		

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A 008	Continued From page 10 Nausea/Vomiting. B. During an interview on 04/25/18 at 10:07 AM Staff G, RN, stated that she quit working there in December 2017 because administrative staff including a doctor (Staff M, Physician) told her and the other nurses that they must enter false documentation of symptoms. This false documentation was for all patients that had a gastric sleeve (a surgical procedure used to reduce the size of the stomach to help patients with weight loss). Staff G, RN stated the nurses were expected to document that patients had complications like nausea and vomiting so that it would be appropriate to keep them for two nights. C. During an interview on 04/25/18 at 1:15 PM, Staff C, RN, stated that administrative staff told the nurses to document all gastric sleeve patients had complications like nausea and vomiting, but stated, "None of us would do it, we rebelled and said No!"	A 008		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on record review and staff interview, it was determined that the governing body did not ensure that patients are admitted to the hospital as an inpatient based on medical necessity for	A 043		

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A 043	Continued From page 11 three of 27 records reviewed (Patient #6, Patient #10 and Patient #14). The cumulative effect of this deficient practice has the potential for inpatient admissions that are not medically necessary. Findings include: - Review of the January 2018 monthly patient census sheet showed Patients #10 was counted as "Inpatient." Review of Patient #10's 01/25/18 medical record showed she was admitted for intolerance to the band (a silicone device placed around the upper section of the stomach, creating a small pouch above the band and thereby restricting the amount of food that can be comfortably eaten), chronic pain, nausea can't seem to keep anything down, now just wants the band out. Review of Patient #10's record showed a handwritten order on 01/25/18 at 1:00 PM, that read, "Admit to Observation (outpatient), admit for severe nausea, vomiting and dehydration." Staff Y, RN noted the order on 01/25/18 at 1:10 PM. Staff Z, Physician, signed the ordered on 02/06/18 at 10:00 AM (11 days later). The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and what licensed practitioner wrote the order. Additionally, throughout the medical record, nursing staff referred to Patient #10 as an "inpatient." Review of another handwritten order on 01/26/18 at 1:30 PM read, "Admit to inpatient, Staff Y, RN noted the order on 01/26/18 at 1:40 PM. Staff Z, Physician signed the order on 02/12/18 at 3:00 PM (17 days later). The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and	A 043		

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A 043	Continued From page 12	A 043		

what licensed practitioner wrote the order. Patient #10 discharged to home on 01/26/18 at 4:20 PM. The medical record did not contain any notes by Physician Staff Z regarding the medical necessity to change her admission status from Observation to Inpatient Admission.

- Review of the March 2018 monthly patient census sheet showed Patient #14 was counted as "Inpatient." Review of Patient #14's 03/08/18 medical record showed that she was admitted for back and leg pain, a Posterior/Transforaminal Lumbar Interbody Fusion of L4-L5 (spinal fusion procedure that joins together the front and back section of the spine). The medical record showed Physician Staff M approved an order to admit to outpatient on 03/08/18. However, throughout the medical record, nursing staff referred to Patient #14 as an "inpatient." Patient #14 discharged on 03/10/18. Further review of the record showed a handwritten order dated 03/14/18 read, "Amendment to outpatient admission order documented on 03/08/14 2104 (9:04 PM) by Staff M, amend to inpatient admission order." Staff M then signed the order on 03/14/18 (four days after Patient #14's discharge). The medical record lacked documentation of the type of order (how it was obtained, for example: telephone or verbal) and what licensed practitioner wrote the amendment order. The medical record did not contain any notes by Physician Staff M regarding the medical necessity to change Patient #14's Admission from Outpatient to Inpatient Admission.

- Review of the April 2018 monthly patient census sheet showed Patient #6 was counted as an "Inpatient." Review of Patient #6's medical record showed he arrived at BVH on 04/19/18 for

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A 043	Continued From page 13	A 043		

treatment of a migraine headache. The medical record did not contain documentation specifying the patient's time of arrival, however at 3:18 PM the initial nurse's note showed "this RN assumed care from 1:50 PM to 3:15 PM" Staff Q, APRN gave a verbal order to admit Patient #6 to "Observation Status" on 04/19/18 at 12:54 PM for severe headache. However, throughout the medical record, nursing staff referred to Patient # 6 as an "inpatient." Review of the "Patient Discharge Planning Needs Assessment" form dated 04/20/18 at 12:15 PM under "Admission Status" showed the Registered Nurse (RN) documented that "No order Found" - "clarifying admission status with hospitalist group." Staff Q, APRN gave a verbal order to admit Patient #6 to "INPATIENT" on 04/20/18 at 1:29 PM for severe headache. The medical record did not contain any notes by Staff H, Physician or Staff Q, APRN regarding the medical necessity to change Patient #6 from "observation status" to inpatient admission. The medical record showed Patient #6 discharged on 04/24/18 at 10:45 AM.

1. During an interview on 04/24/18 at 10:00 AM Patient #6, stated that I am a fall risk when I have migraines because sometimes it causes me to pass out. I get "ice pick" headaches with cold sweats, weakness, and dry heaves. When I am admitted here they give me pain medications every four hours until the migraine goes away.

2. During an interview on 04/25/18 at 10:07 AM Staff G, Registered Nurse (RN), stated that Patient #6 thought he could just walk in and say he had a headache and get admitted as an inpatient. Once he looked at the board (patient tracker dry erase board mounted on the wall near the nurse's station) and said, "We don't have

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A 043	Continued From page 14 enough patients. I need to be admitted." Another time he walked in to the facility in his pajamas and said he had a headache and wanted to be admitted. Staff G stated these things happened after surveyors were there in November 2017. Staff G said that she could not remember the dates that this occurred, but that he did end up getting admitted. 3. During an interview on 04/25/18 at 1:15 PM, Staff C, RN, stated that Patient #6 had come into the hospital in his pajamas and walked down the hallway and said he had a headache and needed to be admitted. Staff C confirmed that Patient #6 had also came on to the unit one day and looked at the patient board and commented that the census was too low, and then he said he had a headache and needed to be admitted. Staff C does not recall the exact dates this happened but remembered that he ended up being admitted.	A 043		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations.	A 405		

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A 405	Continued From page 15 (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on record review and staff interview, the nursing staff failed to use safe practices for medication administration by not documenting medication administration on the Medication Administration Record, by not following physician or practitioner's orders for medication administration, and by not documenting a verbal order for a medication for three records of 27 records reviewed (three admissions of Patient #6). Failure to follow safe practices for medication administration has the potential for medication errors, drug overdose, adverse drug reactions, and ineffective medication management. Findings include: 1. Review of Patient #6's 02/22/18 through 02/26/18 medical record showed the following: Admit to Inpatient for pain management and management of urinary retention. Medication Reconciliation (Med Rec) documents showed, Home Meds Reviewed: Staff R, Registered Nurse (RN) on 02/22/18 at 12:00 AM. The patient brought home medications to the facility. Home medications are not verified for administration. Patient #6's inpatient medication orders approved by Staff Q, Advanced Practice Registered Nurse (APRN) on 02/22/18 at 10:38 AM read, Patient may continue home meds as documented on the Med Rec form. Review of medication	A 405		

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administration record showed, [Hold] Indomethacin (nonsteroidal anti-inflammatory drug (NSAID) used to treat pain, swelling, and joint stiffness caused by arthritis, gout, and bursitis) 25 mg capsule, Medication unavailable on 02/23/18 at 12:11 PM; [Hold] Crestor (helps lower cholesterol) 20 mg, Medication unavailable on 02/23/18 at 12:10, 02/24/18 at 8:55 AM and 02/25/18 at 9:17 AM; [Hold] Tizanidine (helps treat muscle spasms) 4 mg tablet, Medication unavailable on 02/23/18, 02/24/18, and 02/25/18. Nursing staff failed to document a reason for holding the medication and the medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the unavailability of the medication.

2. Review of Patient #6's 03/04/18 through 03/07/18 medical record showed the following. Admission diagnosis auditory neuropathy, acute sinusitis (infection in the sinus), pain management.

A. Staff T's, Registered Nurse (RN) Nurses Notes dated 03/04/18 at 11:15 AM, showed pain medication given at 11:15 PM after IV (intravenous) started. Nursing staff failed to document the administration of pain medication on the medication administration record.

B. Staff T's, RN Nurses Notes dated 03/05/18 at 5:42 AM, showed, did vs (vital signs), gave pain medication. Nursing staff failed to document the administration of pain medication on the medication administration record.

C. Staff U's, RN Nurses Notes dated 03/05/18 at

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2:07 PM, showed, Assumed care at 6:00 AM. PT (patient) resting in bed on RA (room air). Oriented x4, assessment done, WNL (within normal limits). Denies nausea. C/O (complains of) pain, PRN (as needed) pain med (medication) given. Nursing staff failed to document the administration of pain medication on the medication administration record.

D. Staff R's, RN Nurses Notes dated 03/06/18 at 5:00 AM, showed, Pain to ears, up 8/10 and treated with Fentanyl and Benadryl (treats itching). This am pt (patient) reported better. Pain still 8/10 but more tolerable as he reported. Nursing staff failed to document the administration of the pain medication and the Benadryl on the medication administration record.

E. Staff U's, RN Nurses Notes dated 03/06/18 at 2:47 PM, showed, C/O head pain, multiple PRN meds given. Nursing staff failed to document the kind of PRN medications and what time the PRN medications were given on the medication administration record.

F. Staff R's, RN Nurses Notes dated 03/07/18 at 4:50 AM, showed, Pain treated with Fentanyl IV and Benadryl. Nursing staff failed to document the administration of the pain medication and the Benadryl on the medication administration record.

G. Staff U's, RN Nurses Notes dated 03/07/18 at 10:33 AM, showed, feels better and pain level is at a 5. Asked for Valium (treats anxiety) to keep pain at bay. Nursing staff failed to document the administration of the anti-anxiety medication on the medication administration record.

H. Review of Patient #6's Medication

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A 405	Continued From page 18 Reconciliation showed, Home Meds Reviewed: Staff T, on 03/05/18 at 1:28 AM. The patient brought home medications to the facility. Home medications are not verified for administration. I. Review of Patient #6's inpatient admission orders approved by Staff Q, APRN, on 03/05/18 at 7:13 AM showed, Patient may continue home meds as documented on the Med Rec form. J. The Medication Administration Record failed to include these home medications. The Medical Record showed no evidence nursing staff administered Patient #6's home medications as documented on the Med Rec form including, oxycodone (a narcotic medication given for pain) 10 milligrams (mg) every six hours as needed (PRN) for pain; Fluticasone nasal (a medication uses to prevent seasonal allergies) twice a day, tizanidine 4mg twice daily, Crestor 20 mg once daily, and Isoniazid (an antibiotic uses to treat tuberculosis) 300 mg once daily. The medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the medication discrepancy. 3. Review of Patient #6's 03/16/18 through 03/20/18 medical record showed the following. A. Staff S's, Registered Nurse (RN) Nurses Notes dated 03/17/2018 08:10 AM, read, Pain meds administered. Nursing staff failed to document the administration of pain medication on the medication administration record. It is unknown what kind and how much pain medication the patient received.	A 405		

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A 405	Continued From page 19	A 405		

B. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/17/2018 11:15 PM, read, Pt given Percocet 7.5/325 (schedule II narcotic pain medication) two tablets po (by mouth) prior to shower. Nursing staff failed to document the administration of pain medication on the medication administration record.

C. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 00:30 AM, read, Pt had had 3 large diarrhea after dinner...Zofran (treats nausea) 4 mg (milligrams) IV (through the vein) and Toradol (non-steroidal anti-inflammatory pain medication) 30 mg IV offered for relief. Nursing staff failed to document the administration of anti-nausea medication and the pain medication on the medication administration record.

D. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 01:40 AM, read, Physician Staff H notified about episode of diarrhea pt has had. Immodium (anti-diarrheal) ordered, pt had family bring in Immodium for him. The nurse documented in her notes that the physician ordered Immodium, however, the medical record did not contain a verbal or written order for Immodium and the medication administration record lacked documentation of administration of the medication. Additionally, the medical record lacked approval by the Physician or the Pharmacist for use as a home medication .

E. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 02:40 AM, read, Pt reports relief with use of Immodium 2 caplets. The medical record did not contain a verbal or written order for Immodium and the medication administration record lacked documentation of

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A 405	Continued From page 20	A 405		

administration of the medication. Additionally, the medical record lacked approval by the Physician or the Pharmacist for use as a home medication.

F. Staff S's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 11:31 AM, read, Assessed pain level and administered pain meds as well as AM meds. Nursing staff failed to document the administration of pain medication on the medication administration record. Nursing staff failed to document the administration of two "AM" medications : Eliquis (used to prevent blood clots) 5 mg twice a day and Neurontin (treats nerve pain) 100 mg twice a day on the medication administration record.

G. Agency Nurse 5's, RN Nurses Notes dated 03/19/18 04:01 AM read, he had diarrhea again and administered himself Immodium he brought from home...Continues to complain of "ice pick" headache and states the toradol does nothing to help the pain. After 2 percocet, pt (patient) is sleeping soundly and drowsy when awake. The medical record did not contain a verbal or written order for Immodium and the medication administration record lacked documentation of administration of the medication. Additionally, the medical record lacked approval by the Physician or the Pharmacist for use as a home medication. Nursing staff failed to document administration of Toradol and/or Percocet on the Medication Administration Record.

H. Staff J's, Registered Nurse (RN) Nurses Notes 03/19/18 7:56 AM read, pt walks to nurses station, states he's ready for pain meds, percocet given to pt.states headache pain 7/10...pt recently had a valium and wanting to rest. Nursing staff failed to document the administration of the

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percocet or the valium on the Medication Administration Record.

I. Staff J's, Registered Nurse (RN) Nurses Notes 03/19/18 2:43 PM read, pt been laying in bed most of day...Pain meds given as needed. Nursing staff failed to document the administration of any pains meds on the Medication Administration record.

J. Staff J's, Registered Nurse (RN) Nurses Notes 03/19/18 5:52 PM read, pt continues to rest in bed. toradol given for pain. Nursing staff failed to document the administration of the pains medication on the Medication Administration record.

K. Staff R's, RN Nurses Notes dated 03/20/2018 05:28 AM, read, c/o (complaint of) pain to Left ear, Pain treated with Percocet. This am pain down to a 4/10 (scale of 0-10 with 0 being no pain to 10 being excruciating). Nursing staff failed to document the administration of pain medication on the medication administration record.

4. Review of Patient #6's 04/19/18 through 04/24/18 medical record showed the following:

A. Staff D's, RN Nurses Notes dated 04/22/18 at 11:40 PM, showed Pt. (Patient) complaining of HA (headache) after his shower, will medicate and continue to monitor. The medication administration record lacked documentation pain medication was given. Nursing staff failed to document the administration of pain medication on the medication administration record.

B. Staff D's, RN Nurses Notes dated 04/23/18 at

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A 405	Continued From page 22 2:38 AM, showed Medicated for HA (headache) at this time, will continue to monitor. Nursing staff failed to document the administration of pain medication on the medication administration record. C. Staff R's, RN Nurses Notes dated 04/24/18 at 5:24 AM, showed Pt alert and oriented x4, reporting c/o headache at 8/10 feeling like an ice pick to his ears. Pain treated with Fentanyl PRN, nausea reported x1 Phenergan (a medication given to prevent vomiting) given PRN. Nursing staff failed to document the administration of the Fentanyl or Phenergan on the Medication Administration Record on 04/24/18. D. Medication Reconciliation showed, Home Meds Reviewed: Staff V, Pharmacist on 04/19/18 at 12:08 PM. The patient brought home medications to the facility. Home medications are not verified for administration. E. Review of Patient #6's medication administration record showed, [Hold] Crestor 20 mg, Medication not brought in from home, med not available on 04/21/18 at 1:10 PM, 04/22/18 at 12:12 PM and [Hold] Tizanidine 4 mg tablet, Medication not brought in from home, med not available on 04/19/18 at 8:59 PM, 04/21/18 at 1:10 PM and 8:46 PM, 04/22/18 at 12:12 PM and 9:09 PM. The medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the unavailability of the medication.	A 405		
A 467	CONTENT OF RECORD: ORDERS,NOTES,REPORTS CFR(s): 482.24(c)(4)(vi)	A 467		

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A 467	Continued From page 23 [All records must document the following, as appropriate:] All practitioner's orders, nursing notes, reports of treatment, medication records, radiology and laboratory reports, and vital signs and other information necessary to monitor the patient's condition. This STANDARD is not met as evidenced by: Based on record review and staff interview, the medical record failed to include nursing documentation of medication administration on the medication administration record for four records of 27 records reviewed (four admissions for Patient #6), the medical record failed to include practitioner's orders following standards of practice for one of 27 records reviewed (Patient #9), and the medical record included an operative report for one of one record reviewed of patients having their surgery cancelled (Patient #9). Failure to document medication administration has the potential for medication errors including overdose, and ineffective medication management. Failure to write orders and verify orders in a manner consistent with accepted guidelines has the potential for medical errors and omissions. Failure to have an accurate medical record that reflects the treatments, procedure and care a patient receives has the potential for a patient to have an inaccurate medical history and follow up care. Findings include: 1. Review of Patient #6's 02/22/18 through 02/26/18 medical record showed the following: Admit to Inpatient for pain management and	A 467		

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management of urinary retention. Medication Reconciliation (Med Rec) documents showed, Home Meds Reviewed: Staff R, Registered Nurse (RN) on 02/22/18 at 12:00 AM. The patient brought home medications to the facility. Home medications are not verified for administration.

Patient #6's inpatient medication orders approved by Staff Q, Advanced Practice Registered Nurse (APRN) on 02/22/18 at 10:38 AM read, Patient may continue home meds as documented on the Med Rec form. Review of medication administration record showed, [Hold] Indomethacin (nonsteroidal anti-inflammatory drug (NSAID) used to treat pain, swelling, and joint stiffness caused by arthritis, gout, and bursitis) 25 mg capsule, Medication unavailable on 02/23/18 at 12:11 PM; [Hold] Crestor (helps lower cholesterol) 20 mg, Medication unavailable on 02/23/18 at 12:10, 02/24/18 at 8:55 AM and 02/25/18 at 9:17 AM; [Hold] Tizanidine (helps treat muscle spasms) 4 mg tablet, Medication unavailable on 02/23/18, 02/24/18, and 02/25/18. Nursing staff failed to document a reason for holding the medication and the medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the unavailability of the medication.

2. Review of Patient #6's 03/04/18 through 03/07/18 medical record showed the following. Admission diagnosis auditory neuropathy, acute sinusitis (infection in the sinus), pain management.

A. Staff T's, Registered Nurse (RN) Nurses Notes dated 03/04/18 at 11:15 AM, showed pain

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medication given at 11:15 PM after IV (intravenous) started. Nursing staff failed to document the administration of pain medication on the medication administration record.

B. Staff T's, RN Nurses Notes dated 03/05/18 at 5:42 AM, showed, did vs (vital signs), gave pain medication. Nursing staff failed to document the administration of pain medication on the medication administration record.

C. Staff U's, RN Nurses Notes dated 03/05/18 at 2:07 PM, showed, Assumed care at 6:00 AM. PT (patient) resting in bed on RA (room air). Oriented x4, assessment done, WNL (within normal limits). Denies nausea. C/O (complains of) pain, PRN (as needed) pain med (medication) given. Nursing staff failed to document the administration of pain medication on the medication administration record.

D. Staff R's, RN Nurses Notes dated 03/06/18 at 5:00 AM, showed, Pain to ears, up 8/10 and treated with Fentanyl and Benadryl (treats itching). This am pt (patient) reported better. Pain still 8/10 but more tolerable as he reported. Nursing staff failed to document the administration of the pain medication and the Benadryl on the medication administration record.

E. Staff U's, RN Nurses Notes dated 03/06/18 at 2:47 PM, showed, C/O head pain, multiple PRN meds given. Nursing staff failed to document the kind of PRN medications and what time the PRN medications were given on the medication administration record.

F. Staff R's, RN Nurses Notes dated 03/07/18 at 4:50 AM, showed, Pain treated with Fentanyl IV

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and Benadryl. Nursing staff failed to document the administration of the pain medication and the Benadryl on the medication administration record.

G. Staff U's, RN Nurses Notes dated 03/07/18 at 10:33 AM, showed, feels better and pain level is at a 5. Asked for Valium (treats anxiety) to keep pain at bay. Nursing staff failed to document the administration of pain medication on the medication administration record.

H. Review of Patient #6's Medication Reconciliation showed, Home Meds Reviewed: Staff T, on 03/05/18 at 1:28 AM. The patient brought home medications to the facility. Home medications are not verified for administration.

I. Review of Patient #6's inpatient admission orders approved by Staff Q, APRN, on 03/05/18 at 7:13 AM showed, Patient may continue home meds as documented on the Med Rec form.

J. The Medication Administration Record failed to include these home medications. The Medical Record showed no evidence nursing staff administered Patient #6's home medications as documented on the Med Rec form including, oxycodone (a narcotic medication given for pain) 10 milligrams (mg) every six hours as needed (PRN) for pain; Fluticasone nasal (a medication uses to prevent seasonal allergies) twice a day, tizanidine 4mg twice daily, Crestor 20 mg once daily, and Isoniazid (an antibiotic uses to treat tuberculosis) 300 mg once daily. The medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the medication discrepancy.

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A 467	Continued From page 27 3. Review of Patient #6's 03/16/18 through 03/20/18 medical record showed the following. A. Staff S's, Registered Nurse (RN) Nurses Notes dated 03/17/2018 08:10 AM, read, Pain meds administered. Nursing staff failed to document the administration of pain medication on the medication administration record. It is unknown what kind and how much pain medication the patient received. B. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/17/2018 11:15 PM, read, Pt given Percocet 7.5/325 (schedule II narcotic pain medication) two tablets po (by mouth) prior to shower. Nursing staff failed to document the administration of pain medication on the medication administration record. C. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 00:30 AM, read, Pt had had 3 large diarrhea after dinner...Zofran (treats nausea) 4 mg (milligrams) IV (through the vein) and Toradol (non-steroidal anti-inflammatory pain medication) 30 mg IV offered for relief. Nursing staff failed to document the administration of anti-nausea medication and the pain medication on the medication administration record. D. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 01:40 AM, read, Physician Staff H notified about episode of diarrhea pt has had. Immodium (anti-diarrheal) ordered, pt had family bring in Immodium for him. The nurse documented in her notes that the physician ordered Immodium, however, the medical record did not contain a verbal or written	A 467		

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order for Immodium and the medication administration record lacked documentation of administration of the medication. Additionally, the medical record lacked approval by the Physician or the Pharmacist for use as a home medication .

E. Agency Nurse 5's, Registered Nurse (RN) Nurses Notes dated 03/18/2018 02:40 AM, read, Pt reports relief with use of Immodium 2 caplets. The medical record did not contain a verbal or written order for Immodium and the medication administration record lacked documentation of administration of the medication. Additionally, the medical record lacked approval by the Physician or the Pharmacist for use as a home medication.

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G. Agency Nurse 5's, RN Nurses Notes dated 03/19/18 04:01 AM read, he had diarrhea again and administered himself Immodium he brought from home...Continues to complain of "ice pick" headache and states the toradol does nothing to help the pain. After 2 percocet, pt (patient) is sleeping soundly and drowsy when awake. The medical record did not contain a verbal or written order for Immodium and the medication administration record lacked documentation of administration of the medication. Additionally, the

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medical record lacked approval by the Physician or the Pharmacist for use as a home medication. Nursing staff failed to document administration of Toradol and/or Percocet on the Medication Administration Record.

H. Staff J's, Registered Nurse (RN) Nurses Notes 03/19/18 7:56 AM read, pt walks to nurses station, states he's ready for pain meds, percocet given to pt.states headache pain 7/10...pt recently had a valium and wanting to rest. Nursing staff failed to document the administration of the percocet or the valium on the Medication Administration Record.

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K. Staff R's, RN Nurses Notes dated 03/20/2018 05:28 AM, read, c/o (complaint of) pain to Left ear, Pain treated with Percocet. This am pain down to a 4/10 (scale of 0-10 with 0 being no pain to 10 being excruciating). Nursing staff failed to document the administration of pain medication on the medication administration record.

4. Review of Patient #6's 04/19/18 through

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A 467	Continued From page 30 04/24/18 medical record showed the following: A. Staff D's, RN Nurses Notes dated 04/22/18 at 11:40 PM, showed Pt. (Patient) complaining of HA (headache) after his shower, will medicate and continue to monitor. The medication administration record lacked documentation pain medication was given. Nursing staff failed to document the administration of pain medication on the medication administration record. B. Staff D's, RN Nurses Notes dated 04/23/18 at 2:38 AM, showed Medicated for HA (headache) at this time, will continue to monitor. Nursing staff failed to document the administration of pain medication on the medication administration record. C. Staff R's, RN Nurses Notes dated 04/24/18 at 5:24 AM, showed Pt alert and oriented x4, reporting c/o headache at 8/10 feeling like an ice pick to his ears. Pain treated with Fentanyl PRN, nausea reported x1 Phenergan (a medication given to prevent vomiting) given PRN. Nursing staff failed to document the administration of the Fentanyl or Phenergan on the Medication Administration Record on 04/24/18. D. Medication Reconciliation showed, Home Meds Reviewed: Staff V, Pharmacist on 04/19/18 at 12:08 PM. The patient brought home medications to the facility. Home medications are not verified for administration. E. Review of Patient #6's medication administration record showed, [Hold] Crestor 20 mg, Medication not brought in from home, med not available on 04/21/18 at 1:10 PM, 04/22/18 at 12:12 PM and [Hold] Tizanidine 4 mg tablet,	A 467		

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Medication not brought in from home, med not available on 04/19/18 at 8:59 PM, 04/21/18 at 1:10 PM and 8:46 PM, 04/22/18 at 12:12 PM and 9:09 PM. The medical record lacked documentation that nursing staff attempted to contact the physician, APRN, and/or the pharmacist regarding the unavailability of the medication.

5. Review of Patient #9's 02/15/18 through 02/18/18 medical record showed the following.

A. Staff W, RN's nurse's note dated 02/15/18 at 12:54 PM read, 02/16/18 at 10:35 AM this RN spoke with Physician Staff H and received orders to admit pt. (patient) for acute renal injury.

B. An order written on 02/15/15 at 10:35 showed, Admit to obs. (observation) status secondary to prerenal/azotemia (abnormally high levels of nitrogen-containing compounds (such as urea, creatinine, various body waste compounds, and other nitrogen-rich compounds in the blood) with likely dehydration. The order does not indicate what practitioner gave the order and what type of order it was (verbal or telephone). A late entry signature by Physician Staff H on 02/27/17 at 1335 (1:35 PM)(9 days after the patient discharged).

C. An admit to INPATIENT order was approved 02/15/18 at 16:03 by Staff Q, APRN, with diagnosis of Acute Renal Injury.

D. Further review of the record showed a nurse note written by Staff AA, RN on 02/15/18 at 12:00 PM, read Patient lab work indicates a creatinine level trending upward. iSTAT (An advanced,

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easy-to-use blood analyzer that provides healthcare professionals with access to lab-quality results in minutes) drawn per orders, Creatinine (Cr) level is 2.7 (normal 0.6 to 1.2). Surgery cancelled per MD and pt. admitted for IV hydration and monitoring of creatinine level.

E. Even though there is documentation in the record indicating that Patient #9's surgery was canceled, the medical record contains a Physician Operative Report that read:

Operative Report: Sleeve w/o hernia
PREOPERATIVE DIAGNOSIS:
1. Morbid Obesity, diabetes, hypertension
Morbid obesity with a BMI: 64.4
POSTOPERATIVE DIAGNOSIS:
1. Morbid Obesity
PROCEDURE: Laparoscopic sleeve gastrectomy and EGD
SURGEON: Physician Staff BB
FIRST ASSISTANT: None.
BLOOD LOSS: 20 cc ' s
COMPLICATIONS: None.
DESCRIPTION OF PROCEDURE: The patient was taken to the operating room. After adequate general endotracheal anesthesia, the abdomen was scrubbed, prepped, and draped in the usual sterile
fashion. Then, 0.25% Marcaine was injected at all intended port sites and against countertraction, a 5 Visiport was placed several centimeters above the umbilicus. The abdomen was insufflated to 15 mm Hg with CO2 gas. One 5mm trocar was placed in the left midclavicular line and then another 5
in the left anterior axillary line. A right midclavicular 15 mm trocar was placed under direct vision.

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A small trocar incision placed in the epigastrium for a Nathanson Retractor to lift the left lateral lobe
of the liver anteriorly. We used the Covidien LigaSure device to then start taking down the greater
curvature. Once we got up passed the short gastrics, the left crus was identified, we had anesthesia
placed the calibration tubing and had no evidence of hiatal hernia. Anesthesia placed a 40 bougie oral down through the gastroesophageal junction to make sure it was not too tight. With this, we took down the vessels greater curvature all the way to 4-5 cm from the pylorus. Using the black stapling load the linear staple cutter was used to divide the stomache longitudinally along the bougie
to the GE junction. We made sure to not be too close to the GE junction and left a bit of an "Elves ear" shape there. Once that portion of the stomach was excised, it was removed thru the 15 mm
trocar site. That was then closed with a transfascial o vicryl suture. The patient was placed in
Trendelenburg position and the stomach was insufflated with air from the gastroscope. The upper
abdomen had been filled up with water. There were no air bubbles. There was good passage of the
scope down into esophagus. No hiatal hernia was seen during endoscopy. It was then advanced to the area of antrum/incisura down towards the pylorus and duodenum. There was no internal bleeding from the staple line, and no air leaks with this. We took pictures of all this and then the air

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A 467	Continued From page 34 was aspirated. I scrubbed back in. We sucked out the majority of the fluid, the Nathan Retractor was removed, all the other trocar sites were closed with 3-0 Vicryl, Steri-Strips and dermabond. Sponge and needle counts were correct. There were no complications. G. The medical record showed an order that read: Operation cancelled due to ARF (Acute Renal Failure) with Cr 2.7. Physician Staff BB signed the order with a late entry on 02/22/18 at 0700 (4 days after the patient discharged). The late entry failed to indicate the date and time the operation was canceled. H. Review of document titled, "Blue Valley Hospital Medical Staff Rules and Regulations," revised by the Medical Staff 09/28/2016 read, All orders for treatment and medication shall be in writing with date and time. Verbal orders may be substituted for a written order if dictated by the responsible practitioner to authorized personnel, these must be date and time by the authorized personnel and signed by the responsible practitioner. Authorized personnel accepting verbal orders shall enter the order on the physician order sheet: the date, time, sign their name and the dictating practitioner. Orders which are illegible or improperly written shall not be carried our until they are written or properly understood by the person responsible for carrying out the order...All medical record entries shall be entered in a timely, legible, authenticated and permanent manner.	A 467		
A 619	ORGANIZATION CFR(s): 482.28(a)	A 619		

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A 619	Continued From page 35 Organization This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility failed to have organized dietary services that provides food and food menus that meets the nutritional needs of their patients and failed to ensure the food they deliver is at a safe temperature. The facility failed to show evidence of a contracted service that can provide therapeutic dietary services consistent with those provided to inpatients at a hospital. This deficient practice has the potential to cause patients to receive inappropriate diet options and potentially contaminated foods that could lead to foodborne illness. Findings include: 1. During an interview on 4/25/18 at 5:50 PM, Staff A, Quality Director, stated that we use Hy-Vee foods to supply meals for all our patients. Our Dietician is in contact with them and makes sure we can get what we need including specialty diets like diabetic diets and cardiac diets. We have thermometers and after we reheat the food, we take the temperature and document it on a log. 2. During an interview on 04/30/18 at 1:55 PM Staff N, food catering services manager, stated that they have not been in contact with the dietician from Blue Valley Hospital and have not provided the facility their recipes nor do they have carbohydrate counts, low sodium options, or pureed items listed on their catering guide. Staff N confirmed they did not provide a patient menu but stated the items listed on the "Hy-Vee Kitchen Menu Selections" document are consistent with	A 619		

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A 619	Continued From page 36 items from their catering catalog. 3. Review of the document titled "Hy-Vee Kitchen Menu Selections" on 04/25/18 showed a sample of the Hy-Vee menu options from their catering guide. The menu provided to patient's lists breakfast, lunch, dinner, and side dish options. Some heart healthy selections are marked with a heart symbol and a notation on the bottom indicating, "Diabetic Diet will consist of sugar-free options, if applicable" the facility provides a patient menu to their patients without knowledge of the nutritional value of its offerings. 4. Review of contract for Hy-Vee services failed to identify the type of services they agreed to provide. The contractual agreement was for setting up the facilities charge account. 5. Review of two documents titled "Diet Service Quality on 04/25/18 at 9:03 AM revealed staff documented only 7 temperatures on 1/22/16, 12/07/16, 04/04/17, 05/03/17, 05/22/17, 01/06/18, and 03/03/18 for microwaved foods in a period of more than two years.	A 619		

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A 000	INITIAL COMMENTS On behalf of the Centers for Medicare and Medicaid Services (CMS), an onsite, unannounced complaint survey (ASPEN #2UP911; KS00130029) conducted on 06/04/18 to 06/14/18 resulted in an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more Condition of participation requirements resulted in potential harm, injury, or even death) with requirements for the hospital Nursing Services Condition of Participation (CoP) requirements at 42 CFR 482.23, that was not removed prior to the survey exit.	A 000		
A 385	NURSING SERVICES CFR(s): 482.23 The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on staff interview, record review, and policy and procedure review, the hospital failed to ensure nursing staff: 1. Addressed the ongoing needs of one of 10 patient medical records reviewed (Patient 3); 2. Ensured contracted nurses who are working in the hospital adhere to the hospital's policies and procedures; 3. Administered medications according to acceptable standards of practice including: giving the medication at the right time according to a prescribed frequency and time for six of 29 patient with medication administration record (MAR) review(Patients 2, 3, 5, 6, 7 and 10), documenting the disposal of a controlled substance used to treat pain for one of 10 patients' medical records reviewed (Patient 10),	A 385		

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

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following administration limits of Acetaminophen (Tylenol) for one of 29 patients (Patient 29) with MAR review; and 4. Limit the number of verbal orders and failed to ensure provider staff authenticated the verbal orders within 48 hours for six out of 10 patient medical records reviewed (Patients 1, 3, 4, 5, 7, and 8).

The hospital's systemic failure to ensure compliance with the Condition of Participation for Nursing Services places all patients at risk for potential harm or even death during any admissions and resulted in notification to the hospital during the exit conference on 06/14/18 that an Immediate Jeopardy (IJ - a situation in which the facility's non-compliance with one or more Condition of participation requirements resulted in potential harm, injury, or even death) exists.

Findings Include:

1. The hospital failed to ensure Registered Nurse Staff addressed the ongoing patient needs of one of 10 patient medical records reviewed (Patient 3) by failing to notify a supervisor or other practitioner when a physician ordered the discharge of a surgical patient with a current fever and pain management requiring frequent dosing (Refer to A-0395 for further details).

2. The hospital failed to ensure contracted Registered Nurse (RN), Staff S adhered to the hospital's Advanced Cardiac Life Support and Code Blue protocols for one of one patient (Patient 10) that required resuscitation, failed to ensure contracted Registered Nurse (Staff S) completed hospital required code and transfer

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A 385	Continued From page 2 documentation, and failed to ensure contracted Registered Nurse (Staff S) was appropriately experienced to provide independent care and recognize a potential opioid overdose in a patient receiving copious amounts of narcotics (Refer to A-0398 for further details). 3. The hospital failed to ensure nursing staff administered medications at the right time according to a prescribed frequency and time for six of 29 patients (Patients 2, 3, 5, 6, 7 and 10) with medication administration record (MAR)review, failed to ensure staff documented the disposal of a controlled substance for one of 10 patients (Patient 10), failed to ensure nursing staff followed standard of practice guidelines for administration limits of Acetaminophen (Tylenol) for one of 29 patients (Patient 29) with MAR review (Refer to A-0405 for further details). 4. The hospital failed to limit the number of verbal orders and failed to ensure the provider authenticated the verbal orders within 48 hours for six out of 10 patient medical records reviewed (Patients 1, 3, 4, 5, 7, and 8) (Refer to A-0407 for further details).	A 385		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on record review and staff interview, the hospital failed to ensure Registered Nurse Staff addressed the ongoing patient needs of one of 13 records reviewed (Patient 3) by failing to notify a supervisor or other practitioner when a physician	A 395		

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ordered the discharge of a surgical patient with fever and pain requiring frequent dosing.

The hospital's failure to ensure nurses continually evaluate and address the needs of the patient has the potential to result in untreated pain, re-hospitalization, or even death.

Findings include:

Patient 3 was discovered unresponsive in bed at his home on 12/27/17, the morning after discharge from this hospital. Emergency medical services were notified and transported the patient to Hospital YY, where he was pronounced dead at 4:43 AM on 12/27/17.

Patient #3's autopsy report dated 12/28/17 showed that based on the circumstances surrounding death, the patient died as a result of acute bronchopneumonia (infection that inflames air sacs in one or both lungs which may fill with fluid), oxycodone intoxication, hypertensive (high blood pressure), atherosclerotic cardiovascular disease (damage or disease in the heart's major blood vessels), and recent lumbar fusion surgery for spondylolisthesis. Quantification studies performed on femoral blood revealed an oxycodone level of 190 mg/ml. The concentration of oxycodone is above the expected therapeutic range and within the potentially fatal range. Oxycodone causes respiratory depression, or a decreased drive to breath. This cause is increased risk of sudden death, which would exacerbate the risk of death with underlying pneumonia. Additionally, the respiratory depression can cause edema (fluid retention), which increases the risk of developing pneumonia. However, according to medical

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records, prior to Patient 3's release from the hospital following his surgery, chest radiographs and lab studies indicate a pneumonia was developing prior to discharge. Surgery is another risk factor for the development of pneumonia.

Review of Patient 3's medical record on 06/04/18 showed he was admitted on 12/22/17 with a diagnosis of Spondylolisthesis L5-S1 (a spinal disorder in which a bone (vertebra (bones that form the backbone) slips forward onto the bone below it) for this patient the bone slip occurred between the 5th lumbar vertebra and the 1st sacrum vertebra (the lower back). The patient has a history of Chronic Obstructive Pulmonary Disease (COPD) (a lung disease that blocks airflow and makes it difficult to breath), Hypertension (high blood pressure), Kidney Disease, Liver disease, Charcot-Marie-Tooth syndrome (a disease characterized by progressive loss of muscle tissue and touch sensation across various parts of the body), and his inability to walk has been precipitated by a "heat stroke" incident which left him with a prolonged hospitalization for recovery and now weakness in his lower extremities. The patient had complained of back pain for the last 15 years and received chiropractic care as well as three epidural injections (a steroid medication (to reduce inflammation) injected into the epidural space (the space around the spinal cord) to decrease pain). The patient's history and physical was completed on 12/22/17 by the surgeon, Physician Staff ?, who performed a Transforaminal Instrumented Fusion Minimally Invasive (the joining or fusing of two or more vertebrae together) on 12/22/17. The operative report showed the patient went to the recovery room in good condition where normal motor and

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sensory examination of the lower extremities was confirmed to be present.
The physician ordered a Respiratory consult on 12/22/17 that failed to be performed throughout the patient's hospitalization.

Patient 3 received the following pain medications on 12/22/17: Toradol (pain medication) 15 milligrams (mg) intravenous (IV) at 8:45 PM, Percocet (pain medication) 7.5/325 mg, 2 tablets at 8:46 PM, and Fentanyl 100mcg IV at 9:00 PM.

On 12/23/17, the patient's labs showed his white blood cell count (WBC) (indication of inflammation or infection in the blood) were 13.4 high (normal range is 3.4-10.8) with neutrophils (part of the white blood cells) at 10.5 (normal range 1.4-7.0).

Patient 3 received the following pain medications on 12/23/17: Toradol (pain medication) 15 milligrams (mg) intravenous (IV) at 00:15 AM, 8:01 AM and 2:26 PM, Oxycodone (pain medication) 10mg tablets (2 tablets) at 8:02 AM, 12:10 PM, 4:08 PM, and 8:04 PM, Fentanyl (pain medication) 50 micrograms (mcg) IV injectable at 4:40 AM, and Morphine (pain medication) 2mg/ml, 2mg IV at 9:21 PM.

On 12/24/17, the WBC count at 5:00 AM was 15.5 high and neutrophil count 10.1 high and on 12/24/17 at 12:00 PM was 11.2 high and the neutrophil count was 6.7.

Normal temperature is 98.6. The patient had temperatures on 12/24/17 with readings throughout the day of 100.7, 99.5, 99, 99.1, and 99.1.

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A 395	Continued From page 6 Patient 3 received the following pain medications on 12/24/17: Oxycodone (pain medication) 10mg tablets (2 tablets) at 00:20 AM, and 4:34 AM, 4:27 AM, 8:20 AM, and 11:51 AM, Hydromorphone (pain medication) 2mg tablets (2 tablets) at 6:16 AM and 10:08 AM, Fentanyl (pain medication) 50 micrograms (mcg) IV injectable at 2:28 AM, 7:20 PM and 10:32 PM, and Fentanyl 100mcg IV at 1:59 PM and 4:50 PM. On 12/24/17, Physician, Staff N documented in his progress note that Patient 3 was "somewhat lethargic" and was complaining of pain in his back and legs. The nurse documented in the nursing notes "Decision made to hold discharge today." The patient's record showed a chest x-ray was performed on 12/24/17 with results of reticulonodular opacities (the overlapping of reticular (connective tissues and fibers) shadowing and pulmonary nodules (a small mass in the lungs that is usually benign (lacks the ability to invade nearby tissues)) are seen in the left lower lobe of the lung suggestive of developing infiltrates (to cause something such as a liquid to permeate something by penetrating its pores, cells, or surrounding tissue), follow up recommended. The medical record lacked documentation of a follow up X-ray. On 12/25/17, Patient 3's temperature continued to be elevated with readings of 100.7, 102, 100.1 99.4, and 100.4. Physician Staff N documented that the patient had a significantly low oxygen saturation of 87% on room air but improved to 90% with deep breathing. Patient 3 received the following pain medications on 12/25/17: Dilaudid (pain medication) 1mg/ml, 1	A 395		

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mg IV at 00:30 AM and 3:31 AM, Oxycodone (pain medication) 10mg tablets (2 tablets) at 9:30 AM, 1:25 PM, 5:21 PM and 9:25 PM.

On 12/26/17 (day of discharge), Patient 3 had elevated temperatures of 101.5, 103 and 101 (at discharge).

Patient 3 received the following pain medications on 12/26/17 prior to discharge: Oxycodone (pain medication) 10mg tablets (2 tablets) at 4:27 AM, 8:20 AM, and 11:51 AM.

The patient's pain score ranged from 4/10 to 10/10 (10 being the worst pain) throughout his hospitalization.

The patient's pain upon discharge was a 5/10 and his goal was a 4/10. He was to follow up with the Surgeon, Staff DD in one week, have a walker delivered to his home, and he was given a prescription for Oxycodone with taper instructions and Flexeril (muscle relaxant). Prior to the surgery the documented home pain medications were Lyrica (nerve, muscle pain and fibromyalgia) 200mg one tablet three times a day and Norco (pain medication) 10mg tablet every 6 hours as needed.

On 12/26/17 at 8:10 AM registered nurse (RN), Staff L documented that the patient had an elevated temperature of 103 degrees Fahrenheit. At 9:16 AM, Physician, Staff N documented that he switched the patient to a form of oxycodone that did not contain Tylenol and discharged the patient despite the patient's significantly elevated temperature.

Review of the discharge instructions given to the

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patient and his significant other stated to notify your provider if any of the following occur - temperature over 101 (despite the fact that the patient's temperature was 101 at discharge and had been over 101 each time his temperature was taken that day).

The physician wrote the patient a prescription for a pharmacist to dispense 90 tablets of Oxycodone 10 mg with directions for the patient to take 1 or 2 tablets every 4 hours as needed, taper to 1 tablet every four hours in 3 days.

On the "Physician Orders" page of the medical record, RN, Staff K documented on 12/26/17 at 10:30 AM, "Ok to D/C home." The nurse did not indicate whether the order for discharge came from a practitioner with admitting privileges or whether the order was provided verbally or by telephone. Two weeks after the patient was discharged, a physician signed the order written by the nurse on the record.

On 12/29/17 at 12:17 PM, after Patient 3 expired, RN, Staff L entered the following in nursing notes: Late Entry: For care provided on 12/26/17. Patient still having intermittent high temperatures. Recheck prior to D/C patient at 101.0. Physician Staff N in to round on patient, discussed patient status, after seeing patient. OK to d/c/home.... Patient often asking for pain medication frequently or sooner than ordered.

The medical record lacked documentation that Staff L took her concerns about the patient's temperature or frequent need for pain medication prior to time for additional doses to any supervisor or other Practitioner prior to Patient 3's discharge.

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A 395	Continued From page 9 Interview on 06/05/18 at 2:58 PM, Staff L, RN stated that it is not normal practice to discharge a patient with a temperature of 101.0. Staff L further stated that she did collaborate with Staff N, (b)(6) & (b)(7)(c) the day of discharge concerning the fevers, but she did not have the final say on the patient's disposition. Interview on 06/05/18 at 4:00 PM, Staff N, (b)(6) & (b)(7)(c) stated that he was consulted to provided care for Patient 3 after he had surgery. He stated that he stayed at the hospital an additional day over Christmas to keep his pain controlled until he could have the prescription filled. Patient 3's elevated temperature and intermittent temperatures are very common with surgery. He stated that even though Patient 3 had a temp up to 103, and the WBC was elevated initially, there were no bands to indicate an acute infection. At discharge, "I looked at the labs to make sure he did not have an active infection." The autopsy showed Patient 3 had pneumonia. "I did not hear crackles (lung sounds which may indicate extra fluid in the lungs), he did not desaturate (have a lower oxygen level), and I did not think he had pneumonia. I have an ongoing conversation with the County Coroner and do not agree with the autopsy report. I don't know if I would have done anything different. I saw him the day of dismissal. He was totally non-symptomatic." Interview on 06/05/18 at 9:58 AM, Staff M, (b)(6) & (b)(7)(c) remembered "they" talked about Patient 3 in an administrative staff meeting. It was discussed that Patient 3 died of bronchopneumonia and oxycodone overdose and the hospital was negligent in their care. Staff M	A 395		

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A 395	Continued From page 10 further stated that the hospital was fighting to have the reason for the cause of death changed. She stated that the patient had passed away in his home the morning following the discharge. Staff M stated that there is a lot of the blame game going on between Staff N, (b)(6) & (b)(7)(c) and Staff L, the (b)(6) & (b)(7)(c), who cared for the patient prior to discharge home, and that (b)(6) & (b)(7)(c) Staff M tried to change the documentation. The RN (Staff L) said that she reported to the doctor that Patient 3 had a fever, but the (b)(6) & (b)(7)(c) (Staff N) said he didn't know about it. They were arguing back and forth. Staff M stated that the patient had a fever off and on since his surgery and that Staff N (b)(6) & (b)(7)(c) failed to put in an order for a repeat chest x-ray.	A 395		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) Non-employee licensed nurses who are working in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of the clinical activities of non-employee nursing personnel which occur within the responsibility of the nursing services. This STANDARD is not met as evidenced by: Based on staff interview, record review, and policy and procedure review the hospital failed to ensure contracted Registered Nurse (RN) staff, Staff S adhered to the hospital's Advanced Cardiac Life Support and Code Blue protocols for one of one patient (Patient 10) that required resuscitation, failed to ensure contracted Registered Nurse staff (Staff S) completed hospital required code and transfer documentation, and failed to ensure contracted	A 398		

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Registered Nursing staff (Staff S) was appropriately experienced to provide independent care and recognize a potential opioid overdose in a patient receiving copious amounts of narcotics.

These deficient practices have the potential to cause ineffective resuscitation efforts and a failure to recognize a narcotic overdose which could lead to patient harm or death.

Findings include:

Patient 10 had right hip replacement surgery on 02/06/18 and within a short time developed a surgical site infection. Patient 10 returned to the hospital on 02/19/18 and was treated with pain medications, intravenous antibiotics, and a wound vacuum (therapeutic technique using a vacuum dressing to promote healing in acute or chronic wounds). He was discharged on 02/26/18. Patient 10 was then re-admitted on 03/01/18 for the removal of the wound vacuum, irrigation and debridement of the wound, and application of new wound vacuum device. Patient 10 received pain medications and IV antibiotics during this hospitalization as well. Patient 10 was readmitted on 03/28/18 for a wash out (removal of unhealthy tissue from a wound to promote healing) of the right hip and received pain medications and IV antibiotics. On 03/30/18, an incision and drainage of the right hip with wound vacuum was performed. On 04/09/18, the surgeon performed and removed the right total hip implants and applied a wound vacuum to the right hip and during the procedure the right femur fractured.

Interview on 06/05/18 at 1:15 PM, Staff T, (b)(6) & (b)(7)(C) stated that Patient 10 needed to have additional surgery at a hospital that provided a

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higher level of care. He further stated that he did not feel comfortable performing the surgery at this hospital and that Patient 10 needed to be transferred form this hospital to another facility.

The medical record further showed the 24 hours before the patient's death, nursing staff administered large quantities of narcotic pain medications to the patient including: a fentanyl (narcotic pain medication used to treat severe pain) patch (absorbed through the skin), fentanyl IV (through the vein), PO (by mouth) Oxycodone (narcotic pain medication used to treat severe pain), PO and IV Dilaudid (narcotic pain medication used to treat moderate to severe pain), and sedatives including PO Valium and PO Ativan.

Review of Patient 10's medical record on 06/07/18 showed that he received the following narcotic and sedative medications:

04/07/18: Fentanyl 100 mcg (micrograms)/hr (hour) transdermal (narcotic medication used to treat severe pain; released through the skin) film, extended release 100 mcg Transdermal
04/10/18: 12:10 AM - Fentanyl 100 mcg IV (through the vein)
04/10/18: 4:00 AM- Oxycodone Hydrochloride (narcotic used to treat moderate to severe pain) 10 mg oral tablet 2 PO (by mouth) tablet
04/10/18: 5:01 AM - Fentanyl 100 mcg IV
04/10/18: 7:30 AM - Fentanyl 100 mcg IV
04/10/18: 8:37 AM- Hydromorphone Hydrochloride (narcotic used to treat moderate to severe pain; 2 mg oral tablet) 2 PO tablets
04/10/18: 8:44 AM - Valium (diazepam - a sedative) 10 mg PO
04/10/18: 10:48 AM - Fentanyl 100 mcg IV

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04/10/18: 10:52 AM - Ativan (lorazepam-a sedative) 1 mg PO
04/10/18: 11:40 AM - Dilaudid (hydromorphone - narcotic used to treat moderate to severe pain) 1 mg IV
04/10/18: 2:24 PM - Hydromorphone Hydrochloride 4 mg PO
04/10/18: 2:56 PM - Fentanyl 100 mcg/hr Transdermal patch
04/10/18: 4:17 PM- Dilaudid 1 mg IV
04/10/18: 6:38 PM - Fentanyl 100 mcg IV
04/10/18: 9:56 PM - Valium 10 mg PO tablet
04/10/18: 9:57 PM - Oxycodone Hydrochloride 20 mg PO
04/10/18: 11:00 PM - Ativan 1 mg PO

Mixing sedatives with narcotics can be risky as both classes of drugs can heighten the risk of respiratory depression, extreme sedation, and death.

On 04/11/18 at 12:00 AM, Staff S documented that Patient 10 had an oxygen saturation rate of 93% and was placed on two liters per minute of oxygen.

Review of the medical record showed Patient 10 had not routinely required oxygen therapy and had not required oxygen prior to his admission to the hospital.

On 04/11/18 at 3:52 AM Staff S documented the following information:

The patient was found unresponsive at about 3:50 AM. He was warm to the touch with a normal color. The patient's blood pressure 148/59 (average 120/80) , pulse was 110 beats per minute (normal = regular and 60 - 100), but was

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intermittent. The patient was taking deep intermittent breaths at that time approximately 10 seconds apart or 6 breaths per minute (normal 12-20). The patient was on oxygen and the oxygen saturation was at 89% (normal 90 - 100 on room air) on 2 Liters (L) of oxygen per minute. Oxygen was increased to 5 liters per minute. A sternal rub was performed three times with no response. CPR (cardio-pulmonary resuscitation) was started, and a colleague summoned EMS (Emergency Medical Services). The crash cart was availed, Ambu bag (a manual airway device used to deliver forced oxygen into the lungs) with oxygen was applied, while Staff S and colleague continued compressions. AED shock pads were attached on to the patient and the AED analyze the Rhythm. No shock was advised two times. We kept performing chest compressions until EMS arrived. EMS took over and continued compressions, secured the airway, suctioned the patient. Compressions were continued for 23 minutes. Pulse was regained at about 4:33 AM. Blood pressure was 84/49 and the pulse was 111. The patient was transferred to gurney by EMS and taken to Hospital ZZ at about 4:40 AM.

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Review of hospital policy titled, "Code Blue Management," dated July 2017, showed Staff S failed to administer ACLS appropriate drugs as directed by the guidelines of the American Heart Association...and...At the end of the CODE BLUE the documentation will be reviewed, signed by the documenter, and the Physician directing the code. A code summary will be run form the monitor on the crash cart, mounted on a progress sheet and attached to the code blue summary sheet.

Review of the American Heart Association's Adult

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A 398	Continued From page 15 Cardiac Arrest Algorithm updated in 2015 and located on the crash cart showed the following: Step 1- Start CPR, give oxygen, attach monitor/defibrillator. If the rhythm is not shockable and the rhythm is Asystole/PEA the next step is to give CPR for two minutes and establish an IV/IO access, deliver Epinephrine every three to five minutes, and consider an advanced airway, capnography (carbon dioxide monitoring). The record lacked any documentation that showed that Staff S recognized Patient 10's respiratory depression as a potential sign of opioid overdose or that the medication Naloxone, which is designed to rapidly reverse an opioid overdose was given. The record further showed that the Staff S did not follow Advanced Cardiac Life Support (ACLS) guidelines for a heart rhythm that is not shockable, in that they failed to administer the medication Epinephrine (adrenalin - a vasopressor used to treat pulseless electrical activity) every three to five minutes, during the approximate 50 minutes after Patient 10 was found unresponsive and he was taken to the other hospital. Staff S failed to deliver any ACLS medications during the code as directed by the algorithm and failed to recognize the potential for respiratory depression related to the large amount of narcotic medications and sedatives Patient 10 had received during the previous 24-hours. These deficient practices have the potential to diminish resuscitation attempts and could lead to death. During an interview on 06/06/18 at 12:22 PM Staff B, (b)(6) & (b)(7)(c) , stated she was unable to locate any code sheet documentation for Patient 10. Staff B also confirmed the hospital requires a	A 398		

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transfer form to be completed with all transfers, but stated a transfer form was not located for Patient 10.

During an interview on 06/07/18 at 8:30 AM Staff M, (b)(6) & (b)(7)(c) stated, I can tell you that after the code for Patient 10 I reviewed the crash cart to make sure I didn't need to replace any medications. The only thing that was used was a saline flush. No Narcan was used. No epinephrine was used. As a matter-of-fact no emergency drugs were taken from the crash cart. I would have expected at least one dose of Narcan or one dose of epinephrine would have been used. We gave Patient 10 a lot of narcotics and I believe anyone with experience would have recognized a potential for narcotic overdose and would have tried at least one dose of Narcan. I agree the ACLS algorithm shows that epinephrine should have been delivered while CPR was in progress.

During an interview on 06/05/18 at 12:00 PM Staff H, (b)(6) & (b)(7)(c) stated Patient 10's symptoms screamed of overdose to me. Patient 10 should have gotten Narcan. We do stock Narcan here, so it was available.

Review of the Autopsy report for Patient #10 on 06/07/18 showed the cause of death documented as coronary artery disease (a blockage in the coronary arteries) with Fentanyl intoxication as a contributing factor.

During an interview on 06/07/18 at 9:39 AM Staff FF, (b)(6) & (b)(7)(c) , stated that coronary artery disease was the actual cause of death, but Fentanyl intoxication was a contributory cause. Staff FF indicated a therapeutic level for a

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A 398	Continued From page 17 Fentanyl patch is 1.9 to 3.8 and Patient 10's laboratory studies at autopsy showed his level was 18. Staff FF indicated this was six times the therapeutic level for a patient with a Fentanyl patch.	A 398		
A 405	ADMINISTRATION OF DRUGS CFR(s): 482.23(c)(1), (c)(1)(i) & (c)(2) (1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under §482.12(c), and accepted standards of practice. (i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under §482.12(c) only if such practitioners are acting in accordance with State law, including scope of practice laws, hospital policies, and medical staff bylaws, rules, and regulations. (2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures. This STANDARD is not met as evidenced by: Based on staff interview, record review, document review, and policy review the hospital failed to ensure nursing staff administered medications at the right time according to a prescribed frequency and time for six of 29 patients (Patients 2, 3, 5, 6, 7 and 10) with medication administration record (MAR) review,	A 405		

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A 405	Continued From page 18 failed to ensure staff documented the disposal of a controlled substance for one of 10 patients (Patient 10), failed to ensure nursing staff followed standard of practice guidelines for administration limits of Acetaminophen (Tylenol) for one of 29 patients (Patient 29) with MAR review. These deficient practices have the potential to cause ineffective medication (antibiotic or pain) management, drug overdose, adverse drug reactions, and medication errors that could lead to harm or death. Findings include: - Document review of the hospital's Medication Administration Policies showed the hospital failed to provide a policy identifying time-critical and non-time critical medications and for the administration of time-critical and non-time critical medications. According to the Institute for Safe Medication Practices (ISMP): Time-critical scheduled medications are those for which an early or late administration of greater than thirty minutes might cause harm or have significant, negative impact on the intended therapeutic or pharmacological effect. Accordingly, scheduled medications identified under the hospital's policies and procedures as time-critical must be administered within thirty minutes before or after their scheduled dosing time, for a total window of 1 hour. It is possible for a given medication to be time- critical for some patients, due to diagnosis, clinical situation, various risk factors, or therapeutic intent, but not time-critical for other patients. Therefore, hospital policies and procedures must address the process for determining whether specific scheduled	A 405		

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medications are always time-critical, or only under certain circumstances, and how staff involved in medication administration will know when a scheduled medication is time-critical. Examples of time-critical scheduled medications/medication types may include, but are not limited to: Antibiotics; Anticoagulants; Insulin; Anticonvulsants; Immunosuppressive agents; Pain medication (non-IV); Medications prescribed for administration within a specified period of time of the medication order; Medications that must be administered apart from other medications for optimal therapeutic effect; or Medications prescribed more frequently than every 4 hours.

Non-time critical scheduled medications are those for which a longer or shorter interval of time since the prior dose does not significantly change the medication's therapeutic effect or otherwise cause harm. For such medications greater flexibility in the timing of their administration is permissible. Specifically: Medications prescribed for daily, weekly or monthly administration may be within 2 hours before or after the scheduled dosing time, for a total window that does not exceed 4 hours; Medications prescribed more frequently than daily but no more frequently than every 4 hours may be administered within 1 hour before or after the scheduled dosing time, for a total window that does not exceed 2 hours.

Review of Patient 10's medical record on 06/05/18 showed the following:

Patient 10 had a hip replacement surgery at the hospital on 02/06/18.

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A 405	Continued From page 20 During the 02/06/2017 date of service medication orders are as follows; Fentanyl (a narcotic medication used to treat pain) - order for 100 micrograms (mcg) Intravenously (IV, into the vein) every two hours for four days: Scheduled for administration on 02/06/18 at 4:56 PM and administered at 10:36 PM (five hours and 40 minutes late). Scheduled for administration on 02/06/18 at 6:56 PM and administered on 02/07/18 at 4:45 AM (33 hours and 41 minutes late). Scheduled for administration on 02/06/18 at 8:56 PM and administered on 02/07/18 at 9:38 AM (25 hours and 38 minutes late) Scheduled for administration on 02/06/18 at 10:56 PM and administered on 02/07/18 at 9:38 AM (22 hours and 42 minutes late). Patient 10's medical record showed no other documented doses of every two hour scheduled doses of Fentanyl 100 mcg's on the printed MAR provided by the facility on 06/05/2018 for the dates of 02/06/18, 02/07/18, 02/08/18 and 02/09/18. Depakote 250 milligrams (mg) (unit of measure) by mouth (PO) administered twice daily for four days (medication used for mood stabilization, to treat seizure disorders, certain psychiatric conditions and to prevent migraine headaches. Medication directions include taking at the same time each day to maintain constant amounts of	A 405		

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the medication in the blood stream.)

Scheduled for administration on 02/06/18 at 9:00 PM; however, Staff C, Registered Nurse, did not administer the medication and documentation showed, "Patient does not have medication with him. Uses it for sleep".

Scheduled for administration on 02/07/18 at 9:00 AM; however, Staff D, Registered Nurse, did not administer the medication and documentation showed, "Patient no longer taking. Did not bring medication from home.

Scheduled for administration on 02/07/18 at 9:00 PM; however, Staff E, Registered Nurse, did not administer the medication and documentation showed, "Patient is no longer taking".

Scheduled for administration on 02/08/18 at 9:00 AM; however, Staff F, Registered Nurse, did not administer the medication and documentation showed, "Patient refused".

History and Physical Progress Note signed by Staff G, Advanced Practice Registered Nurse, on 02/06/18 at 3:19 PM showed Patient 10 was currently taking Depakote for mood stabilization.

During an interview on 06/05/18 at 12:00 PM with Staff I, (b)(6) & (b)(7)(c) , stated, "Patients are instructed to bring their home medications in with them and then we take them to the pharmacy, but if a patient forgot to bring it and it is something we don't carry we are supposed to get it from a local pharmacy usually by that afternoon".

During an interview on 06/06/18 at 4:45 PM, Staff M (b)(6) & (b)(7)(c) stated that if there is a medication

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on the patient's home medication list that they did not bring with them and we don't stock it, the nurses are supposed to let the pharmacy know so we can order it in for them. We can get most medications relatively quick.

Patient 10's medical record lacked communication from the nursing staff to the physician regarding the absence of the patient's home medication (Depakote). The record failed to show the nursing staff notified the pharmacy that the patient did not have this home medication with him.

After he was discharged from the facility, he developed a surgical site infection. Patient 10 went to a local emergency department where he received intravenous antibiotics (IV) and was advised to follow up with his surgeon. Patient 10 followed up at the clinic and was directed to go to the hospital on 02/19/18. Patient 10 was treated with an increasing amount of pain medications, and intravenous antibiotics, a wound vacuum (a device used to promote wound healing). He was discharged on 02/26/18.

During the 02/19/2018 through 02/25/18 dates of service medication orders are as follows;

Fentanyl (narcotic pain medication) order for 50 micrograms (mcg) (unit of measure Intravenously (IV) every two hours for four days.

Scheduled for administration on 02/20/18 at 1:55 AM and administered on 02/20/18 at 3:15 AM (1 hour and 20 minutes late).

Scheduled for administration on 02/20/18 at 3:55 AM administered on 02/20/18 at 7:36 PM (10

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A 405	Continued From page 23 hours and 5 minutes late). Scheduled for administration on 02/20/18 at 5:55 AM and administered on 02/20/18 at 11:19 PM (16 hours and 24 minutes late). Scheduled for administration on 02/20/18 at 7:55 AM and administered on 02/21/18 at 6:12 AM (22 hours and 17 minutes late). Scheduled for administration on 02/20/18 at 9:55 AM and administered on 02/21/18 at 11:15 AM (23 hours and 20 minutes late). Scheduled for administration on 02/20/18 at 11:55 AM and administered on 02/21/18 at 4:25 PM (28 hours and 30 minutes late). Scheduled for administration on 02/20/18 at 1:55 PM and administered on 02/21/18 at 6:57 PM (29 hours and 5 minutes late). Scheduled for administration on 02/20/18 at 3:55 PM and administered on 02/21/18 at 9:40 PM (29 hours and 45 minutes late). Scheduled for administration on 02/20/18 at 5:55 PM and administered on 02/21/18 at 2:40 AM (33 hours and 45 minutes late). Scheduled for administration on 02/20/18 at 7:55 PM and administered on 02/21/18 at 4:44 AM (33 hours and 49 minutes late). Scheduled for administration on 02/20/18 at 9:55 PM and administered 02/21/18 at 7:04 AM (9 hours and 9 minutes late). Is this correct-it doesn't fit in line with the others.	A 405		

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A 405	Continued From page 24 Scheduled for administration on 02/20/18 at 11:55 PM and administered on 02/22/18 at 2:15 PM (38 hours and 20 minutes late). Scheduled for administration on 02/21/18 at 1:55 AM and administered on 02/22/18 at 5:09 PM (39 hours and 14 minutes late). Scheduled for administration on 02/21/18 at 3:55 AM and administered on 02/22/18 at 9:32 PM (41 hours and 37 minutes late). Scheduled for administration on 02/21/18 at 5:55 AM and administered on 02/23/18 at 8:08 am (51 hours and 23 minutes late). Scheduled for administration on 02/21/18 at 7:55 AM and administered on 02/23/18 at 12:42 PM (52 hours and 47 minutes late). Scheduled for administration on 02/21/18 at 9:55 AM and administered on 02/23/ 18 at 8:29 PM (58 hours and 33 minutes late). Scheduled for administration 02/21/18 at 11:55 AM and administered on 02/24/18 at 3:27 AM (63 hours and 32 minutes late). Scheduled for administration on 02/21/18 at 1:55 PM and administered on 02/24/18 at 6:29 AM (104 hours and 34 minutes late). During an interview on 06/05/18 at 10:10 AM with Staff I, stated "a fentanyl order should be written as needed (PRN), but if it is not, it will show up on the medical administration record (MAR) as a medication to be given on a schedule based on the frequency of administration in the order."	A 405		

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Vancomycin 1 gram (gm) (unit of measure) IV every eight hours for two days (antibiotic that leaves the body through the kidneys and has a half-life of four to six hours. Accumulation of the medication in the blood stream can result in permanent ototoxicity (damage to hearing) and nephrotoxicity (damage to the kidneys). The medication requires administration at predetermined times and monitoring blood stream residual levels between doses by obtaining trough levels) to avoid permanent damage.)

Scheduled for administration on 02/19/18 at 7:30 PM and administered on 02/19/18 at 8:46 PM (1 hour and 16 minutes late.)

Scheduled for administration on 02/20/18 at 11:30 AM and administered on 02/20/19 at 4:28 PM (4 hours late.)

During an interview on 06/05/18 at 10:10 AM with Staff I, stated scheduled medications are to be given within an hour of the scheduled time, but she was unsure if that meant a half hour either side of the scheduled time of administration or an hour either side of the scheduled time of administration. She also stated there was no policy she was aware of for reporting medications given outside of the scheduled time.

Interview on 06/07/18 (b)(6) & (b)(7)(c) Staff M stated that we don't have time dependant policies for medication administration (like Vancomycin). But I would expect it to be given within 30 minutes of the scheduled time because it's time-sensitive. I am available to answer questions all the time so if they had a question about the medication, if I wasn't here they could have called.

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Depakote 250 milligrams (mg) (unit of measure) by mouth (PO) administered twice daily for eight days.

Scheduled for administration on 02/20/18 at 9:00 PM and administered 02/21/18 at 3:15 AM with documentation by Staff AA, Registered Nurse (RN) stating "held, not available."

Scheduled for administration on 02/21/18 at 9:00 AM and administered on 02/21/18 at 9:35 AM with documentation by Staff BB, RN, stating "the medication is not available."

Xanax 0.5 mg PO at bedtime for eight days (tranquilizer medication given for panic and anxiety disorders).

Scheduled for administration 02/20/18 at 9:00 PM and administered 02/21/18 at 3:19 AM with documentation by Staff AA, RN, stating "held, not available."

Scheduled for administration 02/21/18 at 9:00 PM and administered 02/21/18 at 9:36 PM with documentation by Staff BB, RN, stating "held, medication not available."

During an interview on 06/04/18 at 12:00 PM in the (b)(6) & (b)(7)(c), Staff U stated that the process for checking and providing continuation of essential home medications for patients includes instructing for them to bring the actual medications to the hospital with them at admission. Those medications are sent to the (b)(6) & (b)(7)(c) for review of accuracy by the (b)(6) & (b)(7)(c) They are then placed in a baggy with

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A 405	Continued From page 27 the patient information label placed on the baggy and are placed into the Omnicell by the (b)(6) & (b)(7)(c) Staff U. (b)(6) & (b)(7)(c) further stated that if a patient does not bring home medications to the hospital and they are ordered to be continued, then they are ordered from a local Pharmacy and made available to the patient normally within the same day. He further stated medications are reviewed daily by Pharmacy for new orders, that at no time are patients allowed to self-administer medications. Staff U stated medication errors included omissions and the RN making the error is responsible for completing the incident report which then goes to Pharmacy, Quality, and the Director of Nursing (DON) for review. During an interview on 06/05/18 at 10:10 AM, Staff I (b)(6) & (b)(7)(c) stated that patients are instructed to bring home medications with them at the pre-operative phone call and if they do not bring them, the hospital will make arrangements to obtain them from a local pharmacy and provide them to the patient, usually by the afternoon of the same day. Staff I further stated, "we realize the psychiatric medications are an example of the medications frequently required for the patients that need to be continued during their hospital stay." During an interview on 06/06/18 at 3:30 PM, Staff M (b)(6) & (b)(7)(c) stated that home medications that are non-formulary and not brought to the hospital by the patient are made available to the patient if ordered by obtaining them from a local Pharmacy, usually the same day. Patient 10's medical record lacked communication from the nursing staff to the	A 405		

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physician regarding the absence of the patient's home medications (Depakote and Xanax). The record failed to show the nursing staff notified the pharmacy that the patient did not have these home medications with him.

Gentamicin 100 mg IV Piggy Back (IVPB) administered twice daily for three days (antibiotic that leaves the body unchanged and has a half - life of two to three hours. Accumulation of the medication in the blood stream can result in in ototoxicity (toxic to the ear; can cause hearing loss and imbalance.) The medication requires administration at predetermined times and monitoring of blood stream levels before and after administration to avoid permanent damage.)

Scheduled for administration 02/21/18 at 3:30 AM and administered 02/21/18 at 4:29 AM (1 hour and 29 minutes late).

Scheduled for administration 02/21/18 at 3:30 PM and administered 02/21/18 at 6:03 PM (2 hours and 27 minutes late).

Scheduled for administration 02/22/18 at 3:30 AM and administered 02/22/18 at 4:34 AM (1 hour and 4 minutes late).

Vancomycin 1250 mg IV administered every eight hours for two days.

Scheduled for administration 02/22/18 at 11:30 AM and administered 02/22/18 at 3:22 PM (3 hours and 48 minutes late)

Vancomycin 1500 mg IV administered every eight

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A 405	Continued From page 29 hours for four days. Scheduled for administration 02/23/18 at 7:30 PM and administered on 02/23/18 at 8:20 PM (50 minutes late). Scheduled for administration on 02/25/18 at 11:00 PM and administered on 02/25/18 at 11:52 PM (52 minutes late). Patient 10 was then re-admitted on 03/01/18 for the removal of the Prevena Plus Device (the wound vacuum device applied during the 02/19/18 admission), irrigation and debridement of the wound, and application of new wound vacuum device after it was discovered the Prevena device was not working appropriately. During the 03/01/2017 date of service medication orders are as follows: Fentanyl - order for 50 mcg IV every two hours for four days. Scheduled for administration on 03/01/18 at 2:36 PM and administered on 03/02 at 7:35 AM (16 hours and 59 minutes late). Scheduled for administration on 03/01/18 at 4:36 PM administered on 03/02/18 at 7:57 PM (15 hours and 21 minutes late). Scheduled for administration on 03/01/18 at 6:36 PM and administered on 03/03/18 at 5:19 AM (10 hours and 43 minutes late). Fentanyl ordered 100 mcg IV every two hours for	A 405		

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four days.

Scheduled for administration on 03/01/18 at 2:35 PM and administered at 6:47 PM (4 hours and 12 minutes late).

Scheduled for administration on 03/01/18 at 4:35 PM and administered on 03/03/18 at 2:00 PM (45 hours and 25 minutes late)

Scheduled for administration on 03/01/18 at 6:35 PM and administered on 03/04/18 at 3:41 PM (68 hours and 6 minutes late).

During an interview on 06/05/18 at 3:50 PM Staff A, (b)(6) & (b)(7)(c) , stated that there are several different reports showing the Medication Administration Record does not show that Fentanyl was scheduled every two hours as seen in the printed medical record. Staff A stated the computer system cut off the "as needed" verbiage in the printed medical record supplied for review. Staff A stated we do not schedule narcotic doses.

Review of alternate Medication Administration Record reports provided and printed on 06/05/18 showed "as needed" added to the end and "every two hours for four days" removed from the Fentanyl orders documented above.

Review of the Medication Error Report on 06/05/18 showed that on 12/29/17 a medication error was reported by Staff C, Registered Nurse involving Staff W, Registered Nurse with the following documentation, "Most of our Fentanyl orders are IV for every two hours. I obtained the order from (Staff V, Physician) who ordered fentanyl 50 mcg IV every four hours. I as in a constant rush and gave the medication at 2.5

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hours after the last dose forgetting it was every four hours medication. The patient is still in pain and needing other medication. (Staff V, Physician) was contacted immediately, no new orders were obtained at this time".

During an interview on 06/06/18 at 4:45 PM Staff M (b)(6) & (b)(7)(c) stated that from the original printed view it does appear that there is not an area "cut off" and the order looks improperly written from the view displayed. Staff M stated that providers usually write an order for Fentanyl 100 mcg IV as an as needed (PRN) order. Staff M agreed that other medication orders on the example provided and like the Fentanyl order but were written with the "as needed" included had the "PRN" typed out and was not cut off so there would be not reason to believe that this particular order had "PRN" wording cut off.

Vancomycin order 1500 mg Intravenous piggyback (IVPB, an IV antibiotic given concurrently with another IV medication) administered every eight hours for four days.

Scheduled for administration on 03/02/18 at 6:30 AM and administered at 7:35 AM (one hour and five minutes late).

Scheduled for administration on 03/03/18 at 10:30 PM and administered at 11:23 PM (57 minutes late).

Scheduled for administration on 03/04/18 at 10:30 PM and administered on 03/05/18 at 12:21 AM (one hour and 51 minutes late).

Scheduled for administration on 03/05/18 at 6:30

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AM and administered at 7:50 AM (one hour and 20 minutes late).

Xanax ordered 0.5 mg tablet at bedtime for four days.

Scheduled for administration on 03/01/18 at 9:00 PM; however, Staff E, Registered Nurse, did not administer the medication and documentation showed, "the patient did not have with him".

Scheduled for administration on 03/02/18 at 9:00 PM; however, Staff E, Registered Nurse, did not administer the medication and documentation showed, "the patient did bring".

Scheduled for administration on 03/03/18 at 9:00 PM; however, Staff C, Registered Nurse, did not administer the medication and documentation showed, "declined".

Scheduled for administration on 03/04/18 at 9:00 PM; however, Staff C, Registered Nurse, did not administer the medication and documentation showed, "the patient took valium instead".

Wellbutrin (medication used to treat major depressive disorder) XL ordered 300 mg tablet once daily for four days.
Scheduled for administration on 03/03/18 at 9:00 AM; however, Staff J, Registered Nurse, did not administer the medication and documentation showed, "not available".

Mobic (non-steroidal anti-inflammatory pain medication) ordered 15mg tablet once daily for four days.
Scheduled for administration on 03/03/18 at 9:00

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AM; however, Staff J, Registered Nurse, did not administer the medication and documentation showed, "wound vac? Return to OR."

Cymbalta (It can treat depression, anxiety, diabetic peripheral neuropathy, fibromyalgia, and chronic muscle or bone pain) ordered 60 mg capsule once daily for four days.

Scheduled for administration on 03/02/18 at 9:00 AM; however, Staff J, Registered Nurse, did not administer the medication and documentation on 03/03/18 at 10:55 AM (25 hours and 55 minutes after the missed dose) showed, "medication not available".

Scheduled for administration on 03/03/18 at 9:00 AM; however, Staff J, Registered Nurse, did not administer the medication and documentation showed, "not available".

Ferrous Sulfate (iron supplement) ordered 325 mg capsule every 12 hours for six days.

Scheduled for administration on 03/03/18 at 9:00 AM and administered at 10:52 AM (one hour and 52 minutes late),

Scheduled for administration on 03/03/18 at 9:00 PM and administered at 10:12 PM (one hour and 12 minutes late).

Colace (a stool softener) ordered 100mg capsule twice daily for six days.

Scheduled for administration on 03/04/18 scheduled for 9:00 PM and Staff C, Registered Nurse, reported the medication was not given on

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03/05/18 at 12:47 AM (three hours and 47 minutes after its scheduled administration time). The documentation showed, "declined."

During an interview on 06/06/2018 at 9:30 AM Staff B, (b)(6) & (b)(7)(c) stated that they do not have a current policy directing nursing staff what medications are critical for timing and which ones are non-critical. We will be developing a policy.

Patient 10 was again admitted on 03/28/18 for a wash out of the right hip. On 03/30/18 an incision and drainage of the right hip with wound vacuum was performed. On 04/09/18 Staff T, Physician, performed a removal of primary right total hip implants and applied a wound vacuum to the right hip. During the procedure the right femur fractured.

- During the 03/30/2018 through 04/10/18 dates of service medication orders are as follows;

Ancef 2 gm IVPB every eight hours for four days (antibiotic with a half - life of 1.8 hours and no laboratory monitoring for administration complications are required. Because of the short half-life, the medication is ordered to be administered at regularly scheduled intervals.)

Scheduled for 03/30/18 at 5:45 PM and administered 03/30/18 at 7:15 PM (1 hour and 30 minutes late).

Scheduled for 03/31/18 at 9:45 AM and administered on 03/31/18 at 10:31 AM (45 minutes late).

Scheduled for 04/01/18 at 9:45 AM and administered on 04/01/18 at 10:29 AM (45

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minutes late).

Scheduled for 04/01/18 at 5:45 PM and administered on 04/01/18 at 5:30 PM (45 minutes late).

Scheduled for 04/02/18 at 9:45 AM and administered on 04/02/18 at 11:30 AM (1 hour and 45 minutes late).

Ceftriaxone 2 gm IVPB every 24 hours for four days (antibiotic with a half-life of 5.5 to 8.7 hours and laboratory monitoring for administration complications are required.)

Scheduled for 04/03/18 at 7:30 PM and administered on 04/03/18 at 8:10 PM (40 minutes late).

Scheduled on 04/07/18 at 7:30 PM and administered on 04/07/08 at 9:33 PM (2 hours late).

Vancomycin 1.5 gm IV every eight hours for four days.

Scheduled for 04/03/18 at 8:30 PM and administered 04/03/18 at 9:49 PM (1 hour and 19 minutes late).

Scheduled for 04/07/18 at 8:30 PM and administered on 04/07/18 at 9:34 PM (1 hour and four minutes late).

Scheduled for 04/10/18 at 12:30 PM and administered 04/10/18 at 1:10 PM (40 minutes late).

Scheduled for 04/10/18 at 8:30 PM and

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administered on 04/10/18 at 9:51 PM (1 hour and 19 minutes late).

Document review of the hospital's policy titled, "Controlled Substance Waste," dated 06/2017, showed, "All controlled substance waste in schedules II-V (CII-CV) will be wasted and documented appropriately ... and ... The waste must be witnessed by two licensed professionals (nurse, pharmacist, or nurse anesthetist), according to policy Medications 933.

Review of the Medication Administration Report (MAR) on 06/06/18 showed Fentanyl 100 mcg/hour transdermal (through the skin) film, extended release 100 mcg Transdermal Administered as needed. Staff J, RN documented administration of the patch on 04/07/18 at 9:17 AM and Staff D, RN documented application of the second patch on 04/10/18.

Review of Patient #10's medical record on 06/06/18 showed nursing staff failed to document removal and disposal of the 100 mcg Fentanyl patch applied on 04/07/18 when the new patch was applied on 04/10/18.

Throughout Patient 10's multiple admissions he was treated with antibiotics that were not delivered according to acceptable standards of practice to include timing of critical medication administration. This failure to deliver scheduled antibiotic medications as ordered has the potential to cause them to be ineffective in killing the infectious organism because there are sub-therapeutic levels of the antibiotic in the patient's system.

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Review of Patient 2's medical record on 06/05/18 showed the following medication administration information:

- During the 12/12/17 date of service medication orders are as follows:

Ancef (cefazolin, an antibiotic) 2 grams Intravenous Piggy Back (IVPB, a secondary infusion) administered every 8 hours for 4 days

Scheduled for administration on 12/12/17 at 10:10 PM and administered 12/12/17 at 11:07 PM (57 minutes late).

Scheduled for administration on 12/13/17 at 6:10 AM and administered 12/13/17 at 6:59 AM (49 minutes late).

Cipro (ciprofloxacin, an antibiotic) 400 milligrams Intravenous Piggy Back (IVPB, a secondary infusion) administered every 12 hours for 4 days

Scheduled for administration 12/14/17 at 9:00 AM and administered 12/14/17 at 10:14 AM (1 hour and 14 minutes late).

The hospital staff failed to administer two different time-critical antibiotics for Patient 2 within 30 minutes of their scheduled dosing times.

Review of Patient 3's medical record on 06/05/18 showed the following medication administration schedule:
During the 12/22/17 through 12/26/17 dates of service medication orders are as follows:

Ancef (antibiotic) order for 1 gram (g) Intravenous

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A 405	Continued From page 38 Piggy Back (IVPB) (an IV solution hung in conjunction with another IV solution) administer every eight hours for two days. Scheduled for administration on 12/22/17 at 9:30 PM and administered on 12/22/17 at 8:44 PM (46 minutes early). Toradol (pain medication) 15 mg IV Injectable Solution administer every six hours for four times Scheduled for administration on 12/22/17 at 6:00 PM and administered on 12/22/17 at 8:45 PM (2 hours and 45 minutes late). Scheduled for administration on 12/23/17 at 6:00 AM and administered on 12/23/17 at 8:01 AM (2 hours and 1 minute late). Scheduled for administration on 12/23/17 at 12:00 PM and administered on 12/23/17 at 2:26 PM (2 hour and 26 minutes late). The hospital staff failed to administer two different time-critical medications (an antibiotic and scheduled pain medication) for Patient 3 within 30 minutes of their scheduled dosing times. Review of Patient 5's medical record on 06/05/18 showed the following medication administration information: During the 11/29/17 date of service medication orders are as follows; Ancef (cefazolin) 1gm Intravenous Piggy Back (IVPB, a secondary infusion) administered every 8 hours for 2 times.	A 405		

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A 405	Continued From page 39 Scheduled for administration on 11/30/17 at 1:40 AM and administered 11/30/17 at 8:06 AM (6 hours and 26 minutes late). The hospital staff failed to administer a time-critical antibiotic for Patient 5 within 30 minutes of its scheduled dosing time. Review of Patient 6's medical record on 06/05/18 showed the following medication administration schedule: Lovenox (medication for prevention of deep vein blood clots) (enoxaparin 40 mg/0.4 ml) subcutaneous solution administer 40 mg subcutaneously, pre-operative, ordered 03/15/18 at 9:12 AM by Staff V, Physician. Review of the medication administration record showed no documentation of Lovenox administration in the pre-operative area. Document "Omnicell Report", date range of 03/15/18, 12:00 AM through 03/05/18, 11:59 PM showed the medication was dispensed from the Omnicell to Staff X, RN on 03/15/18 at 5:55 AM. Document "Comprehensive Surgical Checklist" for Patient 6 date of service 03/15/18, showed a check mark located in the box under the preprinted notation "Include in pre-procedure check in per institutional custom: Venous thromboembolism prophylaxis ordered." Patient 6's medical record lacked documentation that a critical medication (anticoagulant) was given as ordered prior to their surgical procedure	A 405		

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A 405	Continued From page 40 or any other time during their hospitalization. Review of Patient 7's medical record on 06/05/18 showed the following medication administration schedule: Lovenox (enoxaparin 40 mg/0.4 ml) subcutaneous solution administer 40 mg subcutaneously pre-operatively, ordered 02/20/18 at 2 AM by Staff Y, Physician. Review of the medication administration record showed no documentation of Lovenox administration in the pre-operative area. Document "Omnicell Report" date range 02/20/18 12:00 AM through 02/20/18 11:59 PM showed the medication was dispensed from the Omnicell to Staff X, RN on 02/20/18 at 5:55 AM. Document "Comprehensive Surgical Checklist" for Patient 7, date of service 02/20/18, showed a check mark in the box under the preprinted notation "Include in pre-procedure check in per institutional custom: Venous thromboembolism prophylaxis ordered." Patient 7's medical record lacked documentation that a critical medication (anticoagulant) was given as ordered prior to their surgical procedure or any other time during their hospitalization. During an interview on 06/05/18 at 10:50 AM, Staff B, (b)(6) & (b)(7)(c) stated that the "only way Pharmacy knows medications are not given is to review the records every day. The computer system does not alert Pharmacy or	A 405		

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the nurse of missed or late medications." She also stated the Hospital has no policy related to missed medications or late administration.

During an interview on 06/06/18 at 12:45 PM, Staff B, (b)(6) & (b)(7)(c), stated that she was confident the medication was given because of the Omnicell report of the drug removal and the check mark documentation on the surgical checklist, but Staff X, RN definitely did not document the medication was administered on the medication administration record (MAR) for either Patient 6 or Patient 7.

- Review of Patient 29's Medication Administration report on 06/07/18 showed that on 02/15/18 at 1:51 PM the patient received one Acetaminophen (APAP) 10mg/1 ml as a 100 ml injection (this is equal to 1000 mg of Acetaminophen), on 02/15/18 at 6:38 PM the patient received two tablets of Oxycodone/APAP 7.5/325 mg each (this equals 650 mg of Acetaminophen), on 02/15/18 at 11:01 PM the patient received two tablets of Oxycodone/APAP 7.5/325 mg each (this equals 650 mg of Acetaminophen), on 02/16/18 at 3:28 AM the patient received two tablets of Oxycodone/APAP 7.5/325 mg each (this equals 650 mg of Acetaminophen), on 02/16/18 at 8:37 AM the patient received two tablets of Oxycodone/APAP 7.5/325 mg each (this equals 650 mg of Acetaminophen), on 02/16/18 at 12:07 PM the patient received two tablets of Oxycodone/APAP 7.5/325 mg each (this equals 650 mg of Acetaminophen), on 02/16/18 at 12:27 PM the patient received one Acetaminophen (APAP) 10 mg/1 ml as a 100 ml injection (this is equal to 1000 mg of Acetaminophen). The total amount of

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A 405	Continued From page 42 Acetaminophen Patient #29 received in a 24-hour timeframe was 5,250 mg. During an interview on 6/07/18 with Staff M, (b)(6) & (b)(7)(G) she stated that she had reported her concerns about the amount of Acetaminophen Patient 29 received to the director of nursing but did not believe any counseling occurred with the nursing staff that gave the medications during the 24-hours timeframe. Staff M indicated that orders for Acetaminophen contain a warning not to exceed 4,000 mg in 24-hours and failure to follow the safe dosing guidelines and exceeding 4,000 mg of Acetaminophen could cause liver damage.	A 405		
A 407	VERBAL ORDERS FOR DRUGS CFR(s): 482.23(c)(3)(i) If verbal orders are used, they are to be used infrequently. This STANDARD is not met as evidenced by: Based on observation, interviews, and document review the hospital failed to limit the number of verbal orders and failed to ensure verbal orders were authenticated by the provider within 48 hours for six out of 13 patient medical records reviewed (Patients 1, 3, 4, 5, 7, and 8). The hospital's failure to ensure the authentication of verbal orders within 48 hours and to limit the use of verbal orders has the potential for an increased risk of miscommunication that could contribute to a medication or other error, resulting in an adverse patient event. Findings include: Document review of the hospital policy titled, "Verbal and Telephone Orders," dated September	A 407		

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2017, showed the prescribing practitioner, or another practitioner responsible for the patient's care, must sign the written record of the verbal/telephone order within 48 hours of giving the order.

Review of Patient 1's medical record on 06/04/18 showed it failed to have the following verbal orders signed within 48 hours:

Flexeril (a muscle relaxant, can treat pain and stiffness caused by muscle spasms) 10 milligrams (a unit of measurement), by mouth three times a day; verbal order given 12/06/17 at 8:00 PM. The order was approved and signed 12/18/17 3:04 PM (12 days later).

Gaboarone (gabapentin, used to treat seizures and pain caused by neuropathy) 300 milligram (a unit of measurement), by mouth three times a day; verbal order given 12/06/17 at 8:00 PM. The order was approved and signed 12/18/17 3:04 PM (12 days later).

Sertraline (an antidepressant) 25 milligram (a unit of measurement), one daily verbal order given 12/06/17 at 8:00 PM. The order was approved and signed 12/18/17 3:04 PM (12 days later).

Review of Patient 3's medical record on 06/04/18 showed it failed to have the following verbal orders signed within 48 hours:

Remove the Foley catheter (a tube that drains urine from the bladder into a collection bag); verbal order given 12/23/17 at 2:55 AM. The order was approved and signed on 01/17/18 at

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A 407	Continued From page 44 10:30 AM (25 days later). Sodium Chloride Injectable (a saline and water solution) 125 milliliters (ml, a unit of measurement) via Intravenous (IV, a small tube placed into a vein to administer the fluids) every eight hours for four 4 doses; verbal order given on 12/24/17 at 10:30 AM. The order was approved and signed on 01/17/18 at 10:30 AM (24 days later). Ok to leave IV out at 5:30 PM verbal order given on 12/25/17 at 5:30 PM. The order was approved and signed on 01/17/18 at 10:30 AM (23 days later). Straight catheter (a straight tube placed into the bladder to drain urine into a basin and remove) every six hours as needed if greater than 300 ml after urination (the discharge of urine from the body); verbal order given on 12/25/17 at 5:30 PM. The order was approved and signed on 01/17/18 at 10:30 AM (23 days later). Discontinue IV fluids and discontinue Foley catheter; verbal order given on 12/25/17 at 5:30 PM. The orders were approved and signed on 01/17/18 at 10:30 AM (23 days later). Miralax (a laxative) administer one -17 gram (a unit of measurement) packet by mouth twice daily for three doses for constipation; verbal order given on 12/25/17 at 5:30 PM. The order was approved and signed on 01/17/18 at 10:30 AM (23 days later). Cyclobenzaprine (a muscle relaxant) administer 10 milligrams (a unit of measurement), tablet by mouth every six hours as needed for muscle	A 407		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BLUE VALLEY HOSPITAL, INC	12850 METCALF AVENUE OVERLAND PARK, KS 66213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 407	Continued From page 45	A 407		

spasms; verbal order given on 12/25/17 at 5:30 PM. The order was approved and signed on 01/17/18 at 10:30 AM (23 days later).

During an interview on 06/04/18 at 3:53 PM, Staff K, (b)(6) & (b)(7)(c) stated that the medical record for Patient #3 showed that the seven verbal orders for the hospitalization from 12/22/17 to 12/26/17 failed to be authenticated within 48 hours after the verbal order was received.

Review of Patient 4's medical record on 06/05/18 showed it failed to have the following verbal orders signed within 48 hours:

Toradol (a nonsteroidal anti-inflammatory, can treat pain) 30 milligrams (a unit of measurement) intravenous (IV) every six hours for four doses as needed for pain; verbal order given on 11/22/17 at 11:41 AM. The order was approved and signed on 11/29/17 at 3:30 PM (7 days later).

Ofirmev (acetaminophen, an analgesic can treat minor aches and pains, reduces fever) 1000 milligrams (a unit of measurement) every six hours as needed for four doses as needed for fever or pain; verbal order given on 11/23/17 at 9:00 PM. The order was approved and signed on 11/29/17 at 3:30 PM (6 days later).

Review of Patient 5's medical record on 06/05/18 showed it failed to have the following verbal orders signed within 48 hours:

Lopressor (metoprolol, can treat high blood pressure, chest pain and heart failure) 5 milligram

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A 407	Continued From page 46	A 407		

(a unit of measurement), Intravenous (IV) once give for systolic blood pressure greater than 180 millimeters of mercury (a unit of measurement); verbal order given on 11/29/17 at 2:04 PM. The order was approved and signed 12/05/17 at 10:09 AM (6 days later).

Hydralazine (can treat high blood pressure and heart failure) 10 milligrams (a unit of measurement) Intravenous (IV) every four hours for systolic blood pressure greater than 160 millimeters of mercury (a unit of measurement); verbal order 11/29/17 at 2:19 PM. The order was approved and signed 12/05/17 at 10:09 AM (6 days later).

Toradol (ketorolac, a nonsteroidal inti-inflammatory, can treat pain) 30 milligram (a unit of measurement), Intravenous (IV) every six hours for two days; verbal order 11/30/17 at 4:04 PM. The order was approved and signed 12/05/17 at 10:09 AM (5 days later).

Compazine (prochlorperazine, antipsychotic, can treat nausea and vomiting) 25 milligrams (a unit of measurement) suppository administer per rectum every eight hours as needed; verbal order given on 11/30/17 at 4:00 PM. The order was approved and signed 12/05/17 at 10:09 AM (5 days later).

Benadryl (diphenhydrAMINE, an antihistamine can treat pain and itching or severe allergic reactions) 25 milligrams (a unit of measurement) Intravenous (IV) every eight hours verbal order given on 11/30/17 at 11:45 AM. The order was approved and signed 12/05/17 at 10:09 AM (5 days later).

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A 407	Continued From page 47 Review of Patient 7's medical record on 06/05/18 showed it failed to have the following verbal orders signed within 48 hours: Toradol (ketorolac, a non-steroidal anti-inflammatory) 30 milligrams (a unit of measurement) intravenous (IV) every six hours as needed (PRN) for pain; verbal order given on 02/20/18 at 12:00 PM. The order was approved and signed on 02/27/18 at 1:31 PM (7 days later). Dilaudid (hydromorphone, a narcotic pain medication) 4 milligrams (a unit of measurement) tablet by mouth every six hours PRN for four doses; verbal order given on 02/21/18 at 5:13 PM. The order was approved and signed on 02/27/18 at 1:31 PM (6 days later). Review of Patient 8's medical record on 06/05/18 showed it failed to have the following verbal order signed within 48 hours: Cefazolin (antibiotic) 1 gram (a unit of measurement), IV every eight hours for two doses; verbal order given on 01/25/18 at 2:40 PM. The order was approved and signed 02/22/18 at 9:30 AM (28 days later). During an interview on 06/05/18 at 4:25 PM, Staff Z, (b)(6) & (b)(7)(c) , stated that its my fault verbal orders are not approved and signed within in 48 hours. "Amkia, our electronic medical record system does not flag or identify in any way verbal orders which need a signature." She also stated that it was a process improvement issue.	A 407		

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A 407	Continued From page 48 During an interview on 06/05/18 at 4:00PM, Staff N (b)(6) & (b)(7)(c) stated that this electronic medical record system does not identify verbal orders for me to sign. He stated that other systems, which he had worked with, have a way of prompting me to sign verbal orders or it doesn't let me sign in to the patient's chart. "I am getting pretty good at opening the medical administration record, checking the verbal orders and signing them."	A 407		