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| LOUISA HEALTH & REHABILITATION CENTER | 210 ELM STREET LOUISA, VA 23093 |

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| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard survey was conducted on 11/4/19 through 11/5/19. Seven complaints were investigated during the survey. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this ninety certified bed facility was 79 at the time of the survey. The survey sample consisted of three current resident reviews (Residents #1, #8 and #9) and six closed record reviews (Residents #2 through #7). | F 000 | | |
| F 559 SS=D | Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6)<br><br>§483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.<br><br>§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.<br><br>§483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical record review, the facility staff failed to provide a written notice for a room change, seek the resident's input and allow the resident to see the new room for one of 9 in the survey sample, | F 559 | The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein.<br>To remain in compliance with all state and | 12/2/19 |

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

Electronically Signed | 11/20/2019

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| F 559 | Continued From page 1<br>Resident #1.<br><br>The findings include:<br><br>Resident #1 was originally admitted to the facility on 07/31/18 and readmitted on 09/19/19. Diagnoses included peripheral venous insufficiency, hypertension, asthma, edema, mild anxiety, and depression. The most recent minimum data set (MDS) dated 10/14/19, which was a quarterly assessment, assessed Resident #1 as moderately impaired for daily decision making with a score of 12 out of 15.<br><br>Resident #1's clinical record was reviewed on 11/04/19. Observed in the electronic clinical record was the following progress notes:<br><br>"1/9/2019. 10:15. Medical Note (MD, NP, PA). M. D. (Medical Director) follow-up patient at bedside today. Patient very unhappy with recent move. Patient's behaviors for sometime have been very concerning as with her prior roommate multiple behaviors alarming with roommate who is a very pleasant woman with dementia. Patient has been known to attempt to flat iron straighten roommate's hair, consistently kept door closed wherein one day M.D. recalls recently use of nail polish and nail polish removal by both residents with no ventilation in closed room, unsupervised room-and roommate with noted pulmonary fibrosis. An extremely toxic and high potential situation for harm for actually both roommate and patient. Reports of witnessed patient clipping finger nails of roommate, constantly physically dressing and undressing roommate, and becoming angry with staff - verbally abusive towards staff - if staff brought out an outfit that patient felt unbecoming for roommate. | F 559 | federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates indicated.<br><br>F-559<br><br>1. Resident #1 is currently comfortable in new room, and has no desire to change rooms at this time.<br>2. All residents are at risk.<br>3. The Staff Development Coordinator or designee will educate Discharge Planning Director on the requirements of room changes including:<br>a. Seeing the room prior to room change<br>b. Being provided with written notice of the room change.<br>4. DON or designee will audit 100% of all room changes in the center for 4 weeks, then review findings in following QA for compliance with:<br>a. Seeing the room prior to room change<br>b. Being provided with written notice of the room change; | |

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| F 559 | Continued From page 2 | F 559 | | |

Witnessed reports of roommate on toilet with patient in wheelchair blocking bathroom door. Other concerns - patient having coffee creamer which required refrigeration-kept in window seal and giving to roommate unrefrigerated. There was an occasion recently where patient had multiple over-the-counter medications hidden in a drawer-when discussion with M.D., unit manager nursing about findings patient lacked understanding of the concerns that such medications with potential to cause harm for other residents...MD has noted on frequent/multiple times where patient spoke on behalf of roommate noting that she desperately needed an inhaler at bedside. Roommate 100% of the time agreeing with patient revealed time after time some aspect of dependence versus control...MD recent discussion with UMN (unit manager nursing), DON (director of nursing), and Administration with strong concerns fortunately no harm has occurred to roommate-that in interest of roommate-patient needed to be relocated to another room-not on an announced schedule- as MD concerns for health and safety of roommate. Decision made medically, and in the best interests of roommate. Clearly the above information revealing for concerns for behaviors which mandated immediate action."

"1/2/2019. 13:07 (1:07 p.m.). Discharge Planning Note. DP (discharge planner) explained to resident that room change needed to accommodate clinical need and safety reasons. Resident was upset, speak to administrator. Administrator and DON (director of nursing) notified of conversation with resident and both will speak with resident."

"1/2/2019. 18:05 (6:05 p.m.). Discharge Planning

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| F 559 | Continued From page 3 | F 559 | | |

Note. Resident moved rooms from (room number) to (room number)."

On 11/05/19 at 8:00 a.m., the discharge planner (OS #1) was interviewed. OS #1 stated the because Resident #1 displayed unsafe behaviors and often interfered with her roommate's care, the facility administration made the decision to transfer Resident #1 to another room with more higher functioning residents. OS #1 was asked if Resident #1 had been given time to look at the new room and if there was a written explanation provided for the room change. OS #1 stated she could not remember and would check her records. OS #1 stated normally, she types up a room change notice of explanation to provide to the residents and/or the responsible party when a room change takes place.

On 11/05/19 at 9:00 a.m., the Administrator stated the facility did not provide a written notice to Resident #1 for the room change which took place on January 2, 2019. The Administrator stated due to the nature of the immediate move, a written notice was not provided to Resident #1, however the discharge planner did document a progress note of the explanation in the electronic clinical record.

On 11/05/19 at 9:15 a.m., Resident #1 was interviewed regarding the allegations of the complaint. Resident #1 stated she was not given an opportunity to look at the new room, nor was she given a written notice or explanation of why she had to change rooms. Resident #1 stated the discharge planner told her she needed to change to another room because of safety concerns for her roommate and to find a better roommate for her. Resident #1 was asked how

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| F 559 | Continued From page 4<br>soon after she was notified of the room change did she move to the new room. Resident #1 stated it was a matter of a few hours. Resident #1 stated "it didn't happen immediately because they had to move all my personal items, because I wasn't going to go without my stuff." Resident #1 stated she assisted her roommate with picking out her daily outfits, doing her hair, polish her nails and other things ladies enjoyed. Resident #1 stated "we were good friends and I looked out for her." Resident #1 stated "someone was always in here trying to tell us what we could and couldn't do." Resident #1 stated "the facility was just doing what her roommate's daughter wanted to be done, but that's just another story." Resident #1 was asked did she understand the safety concerns which had been discussed with her. Resident #1 stated "yes, but I wasn't doing anything wrong by helping my roommate and friend." Resident #1 was asked did she have concerns about privacy and she stated "no, I would just shut the door to keep out the noise from the hallway."<br><br>The above findings were shared with the director of nursing, corporate nurse consultant and administrator during a meeting on 11/5/19. No additional information was provided to the survey team prior to exit on 11/5/19 at 5:45 p.m.<br><br>This is a complaint deficiency. | F 559 | | |
| F 607 SS=D | Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3)<br><br>§483.12(b) The facility must develop and implement written policies and procedures that:<br><br>§483.12(b)(1) Prohibit and prevent abuse, | F 607 | | 12/2/19 |

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| F 607 | Continued From page 5<br>neglect, and exploitation of residents and misappropriation of resident property,<br><br>§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and<br><br>§483.12(b)(3) Include training as required at paragraph §483.95,<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to follow their abuse prevention policies for investigating and reporting an injury of unknown origin for one of nine residents in the survey sample. Facility staff failed to follow policies for investigating and reporting to the state agency Resident #2's forearm bruise of unknown cause.<br><br>The findings include:<br><br>Resident #2 was admitted to the facility on 12/29/17 and was discharged on 8/27/19. Diagnoses for Resident #2 included dementia with behavioral disturbance, macular degeneration, urinary tract infection, edema, history of vertebra compression fractures, high blood pressure, diabetes, seizures and dysphagia. The minimum data set (MDS) dated 6/29/19 assessed Resident #2 with short and long-term memory problems, severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility and transfers.<br><br>Resident #2's closed clinical record documented a nursing note dated 7/22/19 stating, "Large purple bruise noted to underside of right | F 607 | F-607<br><br>1. Resident #2 is no longer in the center.<br>2. All residents are at risk.<br>3. Regional Nursing Consultant or designee will educate administrator and DON on policies for investigation and reporting all injuries of unknown origin.<br>4. DON or designee will audit progress notes 7x per week for 2 weeks for notations with potential to be an injuries of unknown origin, then 5x per week for 2 weeks, then review findings in next QA meeting. | |

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| F 607 | Continued From page 6 | F 607 | | |

forearm..." There was no documentation indicating a source of the bruising. The clinical record made no further mention of the right forearm bruise.

Resident #2's plan of care (closed 8/28/19) listed the resident had impaired communication, severe dementia and was dependent upon staff for daily needs including transfers and bed mobility. The care plan listed the resident demonstrated behaviors that included spitting, transferring self, kicking, screaming, hitting at staff, removing clothing and refusing care.

There was no report to the state agency and no investigation regarding Resident #2's bruise of unknown origin.

On 11/5/19 at 8:15 a.m., the director of nursing (DON) was interviewed about any reporting and/or investigation of Resident #2's forearm bruise. On 11/5/19 at 9:45 a.m., the DON stated no incident report was entered regarding the forearm bruise assessed on 7/22/19. The DON stated the bruising was not investigated because an incident form was not completed and there was no report from nursing regarding the bruising. The DON stated the bruise of unknown origin should have been reported and investigated.

The facility's policy titled Abuse/Neglect/Misappropriation/Crime (effective 6/22/18) documented, "All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of patient property are to be reported immediately but...not later than 24 hours if the events that cause the allegation do

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| F 607 | Continued From page 7<br>not involve abuse and do not result in serious bodily injury...An incident report must be completed by a licensed nurse...The Administrator and/or his/her designee will immediately notify the [state agency]...Within five (5) working days of the initial reported incident the [state agency] is to receive a written follow-up letter from the Administrator or his/her designee summarizing in general the findings of the investigation..."<br><br>This finding was reviewed with the DON and corporate nursing consultant during a meeting on 11/5/19 at 5:00 p.m. | F 607 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. | F 609 | | 12/2/19 |

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| F 609 | Continued From page 8<br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to report an injury of unknown origin for one of nine residents in the survey sample, Resident #2.<br><br>The findings include:<br><br>Resident #2 was admitted to the facility on 12/29/17 and was discharged on 8/27/19. Diagnoses for Resident #2 included dementia with behavioral disturbance, macular degeneration, urinary tract infection, edema, history of vertebra compression fractures, high blood pressure, diabetes, seizures and dysphagia. The minimum data set (MDS) dated 6/29/19 assessed Resident #2 with short and long-term memory problems, severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility and transfers.<br><br>Resident #2's closed clinical record documented a nursing note dated 7/22/19 documenting, "Large purple bruise noted to underside of right forearm..." There was no documentation indicating a source of the bruising. The clinical record made no further mention of the right forearm bruise. | F 609 | F-609<br><br>1. Resident #2 is no longer in the center.<br>2. All residents are at risk.<br>3. SDC or designee to educate all facility staff on expectation and process of mandatory reporting of injuries of unknown origin.<br>4. DON or designee will audit:<br>a. Progress notes daily for 2 weeks for notations with potential to be an injuries of unknown origin, then 5x per week for 2 weeks, then review findings in next QA meeting.<br>b. 5 employees daily for 2 weeks on reporting expectation and process of mandatory reporting, then 5 employees 5x weekly for 2 weeks, then review the findings in next QA meeting. | |

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| F 609 | Continued From page 9<br>Resident #2's plan of care (closed 8/28/19) listed the resident had impaired communication, severe dementia and was dependent upon staff for daily needs including transfers and bed mobility. The plan of care listed the resident demonstrated behaviors that included spitting, transferring self, kicking, screaming, hitting at staff, removing clothing and refusing care.<br><br>There was no report to the state agency regarding Resident #2's bruise of unknown origin.<br><br>On 11/5/19 at 8:15 a.m., the director of nursing (DON) was interviewed about any reporting of Resident #2's forearm bruise. On 11/5/19 at 9:45 a.m., the DON stated no incident report was entered regarding the forearm bruise assessed on 7/22/19. The DON stated there was no report from nursing regarding the bruising. The DON stated the bruise of unknown origin should have been reported.<br><br>This finding was reviewed with the DON and corporate nursing consultant during a meeting on 11/5/19 at 5:00 p.m. | F 609 | | |
| F 610 SS=D | Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.<br><br>§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. | F 610 | | 12/2/19 |

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| F 610 | Continued From page 10<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to investigate an injury of unknown origin and report the results of the investigation to the State Agency, for one of nine residents in the survey sample, Resident #2.<br><br>The findings include:<br><br>Resident #2 was admitted to the facility on 12/29/17 and was discharged on 8/27/19. Diagnoses for Resident #2 included dementia with behavioral disturbance, macular degeneration, urinary tract infection, edema, history of vertebra compression fractures, high blood pressure, diabetes, seizures and dysphagia. The minimum data set (MDS) dated 6/29/19 assessed Resident #2 with short and long-term memory problems, severely impaired cognitive skills and as requiring the extensive assistance of two people for bed mobility and transfers.<br><br>Resident #2's closed clinical record documented a nursing note dated 7/22/19 documenting, "Large purple bruise noted to underside of right forearm..." There was no documentation indicating a source of the bruising. The clinical record made no further mention of the right | F 610 | F-610<br>1. Resident #2 is no longer in the center.<br>2. All residents are at risk.<br>3. SDC or designee to educate all facility staff on expectation and process of mandatory reporting of injuries of unknown origin.<br>4. DON or designee will audit:<br>c. Progress notes daily for 2 weeks for notations with potential to be an injuries of unknown origin, then 5x per week for 2 weeks, then review findings in next QA meeting.<br>d. 5 employees daily for 2 weeks on reporting expectation and process of mandatory reporting, then 5 employees 5x weekly for 2 weeks, then review the findings in next QA meeting. | |

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| F 610 | Continued From page 11<br>forearm bruise.<br><br>Resident #2's plan of care (closed 8/28/19) listed the resident had impaired communication, severe dementia and was dependent upon staff for daily needs including transfers and bed mobility. The plan of care listed the resident demonstrated behaviors that included spitting, transferring self, kicking, screaming, hitting at staff, removing clothing and refusing care.<br><br>There was no investigation and no reporting to the State Agency regarding Resident #2's bruise of unknown origin.<br><br>On 11/5/19 at 8:15 a.m., the director of nursing (DON) was interviewed about any reporting and/or investigation of Resident #2's forearm bruise. On 11/5/19 at 9:45 a.m., the DON stated no incident report was entered regarding the forearm bruise assessed on 7/22/19. The DON stated the bruising was not investigated because an incident form was not completed and there was no report from nursing regarding the bruising. The DON stated the bruise of unknown origin should have been reported and investigated.<br><br>This finding was reviewed with the DON and corporate nursing consultant during a meeting on 11/5/19 at 5:00 p.m. | F 610 | | |
| F 656 SS=D | Develop/Implement Comprehensive Care Plan<br>CFR(s): 483.21(b)(1)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the | F 656 | | 12/2/19 |

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| F 656 | Continued From page 12<br>resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.<br>(iv)In consultation with the resident and the resident's representative(s)-<br>(A) The resident's goals for admission and desired outcomes.<br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, | F 656 | F-656 | |

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| F 656 | Continued From page 13<br>and in the course of a complaint investigation, facility staff failed to develop a comprehensive care plan (CCP) for a PICC (peripherally inserted central catheter) line, IV (intravenous) antibiotics, and contact isolation, for one of nine residents in the survey sample, Resident #8.<br><br>Findings included:<br><br>Resident #8 was admitted to the facility on 06/10/2019 and readmitted on 10/08/2019 with diagnoses including, but not limited to: Neurogenic Bladder, Suprapubic Catheter, Urinary Tract Infection, MRSA (methicillin resistant staphylococcus aureus), and a PICC line.<br><br>The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 10/14/2019. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15.<br><br>Resident #8's record was reviewed on 11/04/2019 at 3:30 p.m. and again on 11/05/2019 at 10:30 a.m. Physician orders were noted for IV Vancomycin, PICC line, and contact isolation. Subsequent review of the CCP included no mention of IV Vancomycin, a PICC line, or contact isolation.<br><br>The DON (director of nursing) was interviewed on 11/05/2019 at 5:20 p.m. regarding care plans. The DON stated, "The care plan is a working tool. The nurses and all disciplines should update the care plan as the needs of the patient change."<br><br>No further information was received by the survey team prior to the exit conference on 11/06/2019. | F 656 | 1. Resident #8□s comprehensive care plan is now updated to include PICC line and Contact Precautions ordered for resident.<br>2. All residents receiving IV therapies and/or noted with infections are at risk.<br>3. SDC or designee to educate licensed nursing staff on maintaining a current and accurate care plan including PICC lines, IV antibiotics, and Transmission based precautions.<br>4. DON or designee will audit 100% of care plans in the center to ensure inclusion of all IV/PICC lines, IV antibiotics, and appropriate Transmission-based precautions, then 20% 5x weekly for 4 weeks, then review findings in following QA meeting. | |

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| F 656 | Continued From page 14<br><br>This is a complaint deficiency. | F 656 | | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities<br>CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting,<br><br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including | F 676 | | 12/2/19 |

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| F 676 | Continued From page 15<br>(i) Speech,<br>(ii) Language,<br>(iii) Other functional communication systems.<br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and staff interview, the facility failed to provide activities of daily living for one of nine residents in the survey sample, Resident # 6. Resident # 6 did not receive a bed bath or shower during the 12 day period he was a resident of the facility.<br><br>The findings were:<br><br>Resident # 6 was admitted to the facility on 7/23/19 with diagnoses that included encephalopathy, acute kidney failure, generalized muscle weakness, hematuria, dementia, major depressive disorder, hypertension, aphasia, rash and other non-specific skin eruption. According to the Admission Minimum Data Set, with an Assessment Reference Date of 7/30/19, the resident was assessed under Section C (Cognitive Patterns) as being cognitively intact, with a Summary Score of 15 out of 15.<br><br>Under Section G (Functional Status), Resident # 6 was assessed as needing supervision with set-up help only for locomotion on and off the nursing unit, and walking in the unit corridor; as needing supervision with one person physical assist for transfer, walking in his room, dressing, and personal hygiene. Under the bathing portion of Section G, the resident was assessed as not bathing.<br><br>Resident # 6 was discharged to his home on 8/3/19. | F 676 | F-676<br><br>1. Resident #6 is no longer in the center.<br>2. All residents requiring assistance with ADLs are at risk.<br>3. SDC or designee to educate all nursing staff on the importance of ensuring all resident□s receive assistance with ADLs including bed baths and showers.<br>4. DON or designee will audit 25% of residents weekly x4 weeks to validate receiving assistance with bed baths and/or showers, then review findings in following QA meeting. | |

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| F 676 | Continued From page 16 | F 676 | | |

Resident # 6's base line care plan, dated 7/26/19, included the following problem, "The resident has an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) activity intolerance." The goal for the problem was, "The resident will improve current level of function in (sic) through the review date." Interventions to the stated problem included, "Provide sponge bath when a full bath or shower cannot be tolerated; The resident is able to mobilize independently in bed; and, The resident is able to eat with set-up."

A thorough review of Resident # 6's Electronic Health Record failed to reveal any documentation related to his bathing, including when bathing occurred, and what type of bathing was provided.

The facility staff provided two ADL documents related to Resident # 6's bathing. Both documents noted the resident's bathing preference was for showers. The first ADL document noted the following:

7/27/2019 Task Completed? Not Applicable Name of staff member
7/31/2019 Task Completed? Resident Refused Name of staff member
8/3/2019 Task Completed? Not Applicable Name of staff member

The second ADL document included the same three dates as the first document, with the following question for each of the three dates, "BATHING: SUPPORT PROVIDED - How resident takes full body bath/shower, sponge bath, and transfers in/out of tub/shower (excludes washing of back and hair)."

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| F 676 | Continued From page 17<br>The response to the question for each of the three dates was, "ADL activity itself did not occur or family and/or non-facility staff provided care 100% of the time."<br><br>At approximately 10:50 a.m. on 11/5/19, the Director of Nursing (DON) was asked if she could determine who provided bathing, and what type of bathing, for Resident # 6 on 7/27/2019 and 8/3/2019.<br><br>At approximately 11:30 a.m. on 11/5/19, the DON returned and stated she was unable to find any documentation to indicate that bathing did, or did not, occur for Resident # 6 on the two dates in question. | F 676 | | |
| F 686 SS=G | COMPLAINT DEFICIENCY<br>Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, and clinical | F 686 | F-686 | 12/2/19 |

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| F 686 | Continued From page 18<br>record review, the facility staff failed to provide treatment and services for the prevention of, and subsequent development of pressure ulcers for two of nine residents, Resident #4 and Resident #9. This was identified as harm and is a complaint deficiency.<br><br>Findings were:<br><br>1. Resident # 4 was originally admitted to the facility on 06/03/2019. His diagnoses included but were not limited to: Guillain-Barre' Syndrome, Complete paraplegia, altered mental status, end stage renal disease with hemodialysis, diabetes mellitus, Tibula/fibula fracture, protein-calorie malnutrition, total blindness, benign intracranial hypertension, encephalopathy, and atherosclerotic heart disease.<br><br>The admission MDS (minimum data set) with an ARD (assessment reference date) 06/10/2019 assessed Resident #4 as moderately impaired in his cognitive status with a summary score of "12". He was coded as not having any pressure ulcers upon admission and was at risk for developing pressure ulcers.<br><br>The clinical record was reviewed on 11/04/2019 beginning at approximately 1:00 p.m. The admission documentation dated 06/04/2019 contained the following information "...has no major skin issues but has a healing laceration in his scalp..."<br><br>A nursing progress note dated 06/14/2019 documented: "Patient has wound to right heel that is open with loose tissue with a foul odor there is no indication of any infection in terms of color it is semi dry with small drainage of no | F 686 | 1. Resident #4 is no longer in the center, and Resident #9□s prevalon boots have been discontinued and now has heel floater in place.<br>2. All residents are at risk.<br>3. SDC or designee will educate licensed nursing staff on wound identification, skin/wound assessment, providing treatment, and/or nursing interventions to reduce the risk or prevent the development of pressure ulcers.<br>4. DON or designee will audit 100% of resident□s skin for any pressure ulcers, then audit 20% of skin assessments 5x weekly for 4 weeks for: wound identification, completed assessment, appropriate treatment being provided, and/or nursing intervention implementation for the reduction/prevention of pressure ulcers, then review findings in following QA meeting. | |

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significance will continue to monitor and reassess."

Another nursing progress note dated 06/18/2019 read: "The wound to the right heel was present at time of admission and was too large to capture in photo therefore it was omitted yet present with skin breakdown and macerated wound edges it was varied in color and depth minus any true redness foul smell was present with slight pinkish drainage it was cleaned and redressed, on the right lateral ankle there was a red blood blister still intact and was gently cleaned and skin prep applied."

The skin evaluation sheets were reviewed. There were no assessment sheets for either the heel wound or the blister on the ankle from the date of admission until 06/16/2019.

The assessment on 06/16/2019 described the right heel as a "Diabetic ulcer, present on admission, 3.8 cm X 6.6 cm; 50% of wound with granulation, 10% with slough and 40% eschar; light serosanguineous exudate, no odor." The physician was notified and orders were given for wet to dry dressing changes every day.

An additional Skin and Wound Evaluation dated 06/16/2019 for the right ankle blister was observed and contained the following: "Blister, in house acquired, 3.9 cm X 2.7 cm, intact serum filled blister." The physician ordered skin prep to the area every shift.

Additional Skin and Wound Evaluation Sheets documented the following:
Right Heel
07/04/2019: Diabetic, 5.1 cm X 3.4 cm, 10 %

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slough, 90% eschar, no exudate
07/31/2019: Diabetic, 4.3 cm X 4.3 cm, the wound bed was not described, light serosanguineous exudate
08/10/2019: Diabetic, 2.7 cm X 6.4 cm, 100 % eschar, no exudate
08/15/2019: Diabetic, 3.9 cm X 5.1 cm, 20% epithelial, 80 % eschar, no exudate
09/04/2019: Pressure, Unstageable: Obscured full thickness skin and tissue loss due to slough and/or eschar, 5.5 cm X 7.5 cm, eschar (no percentage documented), no exudate
09/12/2019: Pressure, Unstageable: Obscured full thickness skin and tissue loss due to slough and/or eschar, 3.4 cm X 6.8 cm, granulation/slough/eschar all checked as present without percentages documented, light serous exudate.
09/24/2019: Pressure, Unstageable: Obscured full thickness skin and tissue loss due to slough and/or eschar, 2.6 cm X 6.0 cm, granulation/slough/eschar all checked as present without percentages documented, exudate not documented.

The DON (director of nursing) was interviewed on 11/04/2019 at approximately 3:00 p.m. The areas described above were discussed. She was asked if the area originally documented as a diabetic ulcer and then a pressure ulcer were the same area. She stated, "Yes." She was asked what had been done with the area from the time of admission until 06/14/2019. She stated, "I don't know. There is no documentation about the heel or ankle until the note on June 14th...there is no assessment of them nor any mention of any skin issues in the admission physician's note... The nurse who documented that information is no longer working here." She was asked why the

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wound description changed from diabetic to pressure. She stated, "We identified that we had a problem with the wound assessments, I usually look at them on Mondays now, I didn't this week because of the survey." She was asked if the areas had been addressed by the admitting nurse and left for 10 days. She stated, "I don't know if those areas were really present on admission or not. I really don't know what happened."

The medical director was interviewed on 11/04/2019 at approximately 4:00 p.m. regarding Resident #4. He was asked about the area on Resident #4's heel that was identified in June. He stated, "I don't believe that was a diabetic ulcer. His Hgb A1C was 7.1 at the time...I believe that was from pressure. He spent so much time on his back...He had dialysis three days a week and was gone a total of 7 hours every time, plus he had multiple appointments outside of the facility. He and the family were resistant to changing to a dialysis center that is down the street which would have greatly reduced the time he was out of the facility."

On 11/05/2019 at approximately 10:30 a.m., the DON was interviewed. She stated, "I reviewed [name of Resident #4] hospital discharge report and his notes from here. There isn't anything documented about any pressure areas or wounds at the time of his discharge from the hospital or on any of the physician notes here. I don't believe he came here with the wound described on his heel. I don't know why the nurse documented that...We also identified that the area was not a diabetic ulcer but was initially found as an unstageable pressure ulcer...we've made some changes regarding wound assessments since I have been here." She was asked how a wound

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would be found at that advanced stage and why the nurse had documented that it was present on admission. She stated, "I don't know."

The above information was discussed during an end of the day meeting with the facility staff on 11/05/2019. Concerns were voiced that an area had been discovered on Resident#4's heel at the level of an unstageable pressure ulcer with no prior assessment.

No further information was obtained prior to the exit conference on 11/05/2019. This is a complaint deficiency.

2. Resident #9 was admitted to the facility on 06/13/2019 with the following diagnoses, including but not limited to: Dementia, cerebrovascular disease, and peripheral vascular disease.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 09/20/2019. He was assessed as being severely impaired with both long and short term memory as well as being severely impaired with daily decision making skills.

The clinical record was reviewed on 11/05/2019 beginning at approximately 9:30 a.m. The following progress notes were observed:

"10/21/2019 13:12 [1:12 p.m.] Area of DTI [deep tissue injury] to left heel observed this am. Deep purple in color blistering in center and non blanchable redness surrounding purple. 4.2 [cm] X 5.3 [cm] MD [name] made aware. New orders for received for skin prep q [every] shift. New prevalon boots obtained for resident. Heel floater

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| F 686 | Continued From page 23<br>to be used when prevalon boots removed..."<br><br>"10/21/2019 19:07 [7:07 p.m.] MD informed today of pressure ulcer present-Deep tissue injury to left heel-describes as deep purple with blister at surrounding area-nonblanchable. MD discussed with UM (unit manager). Apparently developed with removal of prevalon boots (to wash-then return)..."<br><br>On 11/05/2019 at approximately 10:00 a.m., the unit manager was interviewed regarding the DTI to Resident #9's heel. She stated, "It occurred over the weekend; they sent his prevalon boots to the laundry. Residents who have those have two pair so we can switch them out, if they aren't in the room there are two boxes of them in the therapy department. I don't know why no one got him another pair, maybe it was an agency nurse, I don't know."<br><br>At approximately 11:00 a.m., Resident #9's right heel was observed. His prevalon boots were removed by the unit manager and his leg lifted up. The heel was dark purple in color, the area was closed. She was asked if there was any eschar. She stated, "No."<br><br>The above information was discussed during an end of the day meeting with the facility staff on 11/05/2019.<br><br>No further information was obtained prior to the exit conference on 11/05/2019. This is as complaint deficiency. | F 686 | | |
| F 689 SS=D | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) | F 689 | | 12/2/19 |

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| F 689 | Continued From page 24<br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to implement interventions and provide supervision to prevent a fall for one of nine residents in the survey sample (Resident #3).<br><br>The findings include:<br><br>Resident #3 was admitted to the facility on 12/6/18 and was discharged home on 12/7/18. Diagnoses for Resident #3 included dementia, COPD (chronic obstructive pulmonary disease), pneumonia, diabetes, high blood pressure, cardiomegaly, obesity, depression and urinary tract infection. A post-fall incident report dated 12/7/19 documented the resident had poor safety awareness and was oriented to person and situation only.<br><br>Resident #3's clinical record documented the resident was admitted to the facility on 12/6/18 for palliative care. A nursing note dated 12/7/18 listed the resident had been in the facility less than 48 hours and experienced an unwitnessed fall. A post-fall assessment dated 12/7/18 documented the resident fell on 12/7/18 at 6:45 a.m. and had attempted to transfer and/or ambulate unsafely. Resident #3's incident report | F 689 | F-689<br><br>1. Resident #3 is no longer in the center.<br>2. All residents are at risk.<br>3. The SDC or designee will educate all licensed nursing staff on expectation of completing all admitting assessments including fall-risk assessment and implementation of fall interventions, for all admitting residents including respite stays.<br>4. DON or designee will audit 100% of admitting residents for completion of assessments and implementation of fall interventions daily for 2 weeks, then 100% of admitting patients 5x weekly for 2 weeks, then review findings in following QA meeting. | |

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dated 12/7/18 documented, "Resident observed on the floor by her bedside. CNA [certified nurses' aide] voiced 'resident was attempting to get OOB [out of bed] so she dressed her and went to obtain the lift for transfer to w/c [wheelchair] and when she returned she was in the floor'." This report documented the resident was unable to give an account of what happened, had a history of falls, required assistance for transfers, had memory loss and was new to the nursing home environment. The resident's injuries were listed as a hematoma to top of the scalp, swelling above the right eyebrow and a bloody left nostril.

Resident #3's clinical record documented no assessment of the resident since her admission on 8/6/18. There was no admission assessment and no assessment of the resident's fall risks. The record included no immediate plan or interventions for fall prevention.

On 11/4/19 at 3:00 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about Resident #3's fall and any prior assessments and/or interventions to prevent accidents. LPN #1 stated the floor nurses were responsible for conducting a comprehensive assessment at the time of admission and this included an assessment for fall/accident prevention. LPN #1 reviewed Resident #3's clinical record and stated she did not see any assessments completed at the time of admission. LPN #1 stated Resident #3 was admitted for "respite care" and she did not think all the routine assessments were completed for respite patients because they were only in the facility for several days. LPN #1 stated concerning the lack of assessments, "I would think it was because she

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was here for respite care."

On 11/4/19 at 3:35 p.m., the corporate nursing consultant (administration staff #3) was interviewed about any fall interventions or safety plan for Resident #3. The corporate nursing consultant stated the resident had no care plan in the system. The corporate nursing consultant stated the admission assessments, including fall risks, were supposed to be completed by nursing at the time of admission. The corporate nursing consultant stated the requirement for admission assessments, including identification of fall risks was the same for all residents, including those admitted for respite care. The corporate nursing consultant stated interventions were supposed to be in place for residents at the time of admission based on the assessment of the resident's condition and needs.

On 11/5/19 at 7:15 a.m., LPN #2 caring for Resident #3 at the time of the fall was interviewed. LPN #2 reviewed the record but stated he did not remember the resident or recall the events of that morning. LPN #2 stated he documented on the incident report that the resident was attempting to get out of bed and the CNA left the resident unattended while getting the mechanical lift. LPN #2 stated when the CNA returned to the room the resident was on the floor.

On 11/5/19 at 9:30 a.m., the director of nursing (DON) was interviewed about Resident #3's fall on 12/7/18. The DON stated nurses were supposed to complete a comprehensive assessment upon admission for all residents and this included identifying fall risks. The DON stated an initial plan of care was included as part

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| F 689 | Continued From page 27<br>of the admission assessment and should have included interventions for fall prevention. The DON stated she reviewed Resident #3's clinical record and no comprehensive assessment or initial care plan was completed at the time of admission. The DON stated the resident should have been supervised if attempting to get out of bed unsafely.<br><br>This finding was reviewed with the DON and corporate nursing consultant during a meeting on 11/5/19 at 5:00 p.m.<br><br>This was a complaint deficiency. | F 689 | | |
| F 757 SS=G | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this | F 757 | | 12/2/19 |

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| F 757 | Continued From page 28<br>section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure adequate monitoring of Vancomycin levels prior to administering the medication, for two of nine residents in the survey sample, Residents #5 and #8, resulting in harm of Resident #5.<br><br>Findings included:<br><br>1. Resident #5 was admitted on 06/08/2019 with diagnoses including, but not limited to: Sepsis, Cellulitis, and a PICC (peripherally inserted central catheter) line.<br><br>The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 06/15/2019. Resident #5 was assessed as cognitively intact with a total cognitive score of 15 out of 15.<br><br>Resident #5's clinical record was reviewed on 11/04/2019 at 1:30 p.m.<br><br>A discharge order sheet from the hospital's Infectious Disease Physician, dated 6/7/2019 included:<br>"Home IV (intravenous) Orders...<br>3. Antibiotic: ...vancomycin 1 gram q12 hours IV<br>4. Lab each Monday: ...Trough Vancomycin level<br>5. Lab each Thursday: ...Trough Vancomycin level...<br>6. Fax lab to Dr. (Name) @(at) (phone number)...<br>8. Duration of therapy: last day of therapy should be July 17, 2019<br>Please call Dr. (Name) @ (phone number) | F 757 | F-757<br><br>1. Resident #5 is no longer in the center. Resident #8 is no longer receiving Vancomycin. Resident #8□s Infectious Disease Doctor and the medical director have been made aware of the error in Vancomycin administration.<br>2. All residents receiving Vancomycin are at risk.<br>3. SDC or designee to educate all licensed nurses on the importance of:<br>a. Obtaining Vancomycin levels prior to the administration of medication as ordered<br>b. Timely notification of the results to Pharmacy and MD<br>c. Notification to physician for any reason medication or laboratory work could not be provided<br>4. DON or designee will audit 100% of residents receiving Vancomycin daily for 4 weeks, then review findings in following QA meeting:<br>a. Laboratory work being obtained<br>b. Notification of Laboratory results to MD and Pharmacy<br>c. Administration per order of Vancomycin | |

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before stopping therapy...
10. Pharmacy Consult for Vancomycin dosing. Maintain trough between 15-20..."

Included on the physician order sheet (POS) was the following: Order date: 06/08/2019 Start date: 06/09/2019 Stop date: 07/21/2019, "Vancomycin HCl Solution 1000MG/200ML (milligrams/milliliter) Use 1000 mg intravenously every 12 hours every 42 day(s) related to SEPSIS, UNSPECIFIED ORGANISM for 42 Days Take every 12 hours for 42 Days"

According to the hospital discharge orders, vancomycin trough should have been drawn on Monday 06/10/2019. Resident #5 continued to receive vancomycin IV as ordered without these labs being completed. Vancomycin lab was drawn on 06/12/2019 and was within normal limits at 18.4.

The next vancomycin trough should have been drawn on Thursday 06/13/2019 and Monday 06/17/2019. The vancomycin trough was not done until 06/18/2019. During this time, Resident #5 continued to receive IV vancomycin as ordered without lab work being completed.

The vancomycin lab result for 06/18/2019 was 46.0, which was annotated as "HH" meaning "critically high". A progress note dated 06/19/2019 at 15:45 (3:45 P.M.) included: "MD (Name-facility doctor) notified of vanc (vancomycin) trough level. Not a true trough as vanc was being administered at the time. Vanc trough reordered for 6*19*19. He is his own RP (responsible party) and aware."

The vancomycin lab result for 06/19/2019 was

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48.4, which was annotated as "H" meaning "high". Review of the MAR (medication administration sheet), dated June 2019 included documentation that Resident #5 received IV vancomycin as ordered on 06/19/2019, with the last dose being given at 7:55 p.m.

The vancomycin lab result for 06/20/2019 was >50.00 (greater than 50). A progress note dated 06/20/2019 at 13:09 (1:09 p.m.) included: "...Per pharm (pharmacy) Vancomycin on hold until further notice..." The doses scheduled for 6:00 p.m. on 06/20/2019 and 6:00 a.m. on 06/21/2019 were held.

A Medical Note dated 06/20/2019 at 14:35 (2:35 p.m.) included: "MD f/u (follow-up) patient-Labs noted with increased creatinine at 2.23 w/Vancomycin >50-On 6/10/2019 creatinine at 0.87. MD reviewing orders for labs-apparently somehow not followed..."

A skilled progress note dated 06/20/2019 at 20:50 (8:50 p.m.) included: "vanc trough results in, md (name-facility doctor) reviewed new order hold vanc, recheck trough 530am on sat 6/22/2019. pt own rp and is aware." (sic)

Progress notes for Resident #5 also included the following:

06/15/2019 at 08:22 a.m.: "noted rash like raised fluid blister located to shaft and head of penis. also noted to scrotum. pt c/o (complains of) burning itching. notify dr. (Name). pt won rp and is aware." (sic)

06/17/2019 at 03:53 a.m.: "Patient...did complain of cast to right hand upon assessment I found it

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to be tight with good capillary refill 3 seconds but the exposed fingers and palm was red with several fluid filled blisters his left hand was also red with a few blisters he also complained of his Penis and scrotum being irritated it too was red somewhat swollen and had several blisters which erupted and draining slightly pink fluid..." (sic)

06/17/2019 at 1:35 p.m.: "...Family in to visit and concerned about blisters on his hands and penile area in which family and pt states has gotten better. MD (Name) not treating at this time and will assess..."

06/17/2019 at 4:02 p.m.: "Pt with new 'rash' to left hand. Appears to be multiple small blisters over palm and pinky of left hand. Pt. states they do not itch or hurt. He states that they appeared the night before...Pt. also has a new rash to the penis..."

06/17/2019 at 5:33 p.m.: Medical Note: "...Right palm w (with)/small blistering sore-believe directly related to edge of hard casting material-abrasion. Left palm and fingers with central palm displaying an approximate 0.75 cm (centimeter) blister, and adjacent to this an annular target violaceous lesion-flat, measuring approximately 1 cm. Small fluid filled blisters on several sides of digits. No other rash/blister noted on body...A/P (assessment/plan) - Unusual left palm annular lesion with small blisters forming-Nursing suggesting possible varicella zoster. Area without pain/burning or stinging. MD concerned of drug reaction-though w/IV Vanc-systemic would suspect to see other signs over more of body surface..."

06/18/2019 at 11:16 a.m.: "Pt. left hand now red

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where blisters were yesterday. Appear to be reabsorbing. Still no complaints of pain or itching in the area. Spoke with pt wife who asked for us to call Dr. (Name) with Infectious Disease to make him aware of the situation. A call was placed...spoke with (Name). The situation was explained about the 'rash' and most recent Vanc trough results given..."

06/19/2019 at 1:46 p.m.: "...Unusual left palm annular lesion with small blisters forming-area without pain/burning or stinging. MD concerned of drug reaction-though w/IV Vanc-systemic would suspect to see other signs over more of body surface..."

06/20/2019 at 2:35 p.m.: "...Of acute concern-MD noting left palm with many more blisters and along side fingers. Additionally left toe now w/blister...Increasing blister/bullae-now showing signs of systemic spread-Urgent appointment to ID (infectious disease)-Nursing contacting office now..."

06/21/2019 at 4:19 p.m.: "Patient went out to a follow up appointment with ID Dr. (Name) at 1pm with family transport with concerns of medication interactions with multiple blisters to the left palm, right lower leg, toes, and back of bilateral thighs...He has been admitted to the hospital..."

Resident #5's hospital records included: "...Hospital course: 1. acute renal failure, cr 3.0 on admission, suspect a combination of pre-renal (from volume depletion/dehydration) along with vancomycin toxicity (his vanc trough was >50)...4. Blister on both hand...skin biopsy: spongiotic dermatitis consistent with drug reaction...Discharge diagnosis: Acute Kidney

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injury 2 to (secondary to) vancomycin toxicity...Allergic skin rash/spongiotic dermatitis..."

The facility Medical Director was interviewed on 11/04/2019 at 4:25 p.m. The Medical Director stated, "Yes, if specific instructions are sent by the hospital physician I write those orders. It has been problematic with agency nurses. We definitely dropped the ball on this one. We met with the family and (Name) DON (director of nursing) came up with a plan so this doesn't happen again."

The DON was interviewed on 11/04/2019 at 4:30 p.m. The DON stated regarding why the Infectious Disease Doctor's orders were not reviewed with the Medical Director and subsequent orders written, "It would appear it didn't make it into PCC (computer order system). I do know two nurses are no longer here because of this. We did a root cause analysis and brought the family in to help."

On 11/05/2019 at 9:25 a.m. the DON approached the conference room and stated, "I want to make sure I didn't misspeak earlier. The pharmacy gives us recommendations for labs. We call Dr. (Name) and he gives us an order. We write the order to obtain the labs." Regarding the Vancomycin level being drawn while medication was infusing, she stated "I believe that was the lab. I don't know why they were drawing it then. Of course you would get an abnormal high level. That is why the order for labs was given for the next day. Yes, that is when we noticed inconsistencies with the labs." Regarding pharmacy protocols for Vancomycin levels she stated, "We have been told it is patient specific. Some have altered renalstatus and may need

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labs more frequently. There is no cookie cutter orders, like to obtain levels every Wednesday."

Facility policy, "Blood Sampling for Peak and Trough Values" Revision Date: 05/01/16 documented the following: "...Considerations: 1. Many medications must remain within a certain therapeutic range in the blood stream in order to achieve desired effects. In some cases the level of medication in the blood may go beyond an acceptable limit and symptoms attributable to drug toxicity can develop...2. The pharmacy can provide guidance of accepted clinical practice standards to physicians for...Vancomycin therapy when provided accurate peak and trough serum levels from the facility...4. Proper dosing of Vancomycin is important to achieve sustained serum concentrations and to prevent resistance, progression of infection and mortality. Guidance:...2. The "trough" is a measurement of drug in the blood right before the next dose is due to be administered and when it's at its lowest level concentration in the blood...6. The ACTUAL TIME a specimen is obtained and the ACTUAL TIME the medication was hung is CRITICAL to accurately interpret drug levels for dosing considerations. 7. To ensure accurate monitoring and dosing, all lab values must be faxed to the infusion pharmacy upon receipt."

No further information was received prior to the exit conference on 11/06/2019.

2. Resident #8 was admitted to the facility on 06/10/2019 and readmitted on 10/08/2019 with diagnoses including, but not limited to: Neurogenic Bladder, Suprapubic Catheter, Urinary Tract Infection, MRSA (methicillin resistant staphylococcus aureus), and a PICC

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| F 757 | Continued From page 35 | F 757 | | |

line.

The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 10/14/2019. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

Resident #8's record was reviewed on 11/04/2019 at 3:30 p.m. and again on 11/05/2019 at 10:30 a.m. Physician orders were noted for IV (intravenous) vancomycin, but no lab orders.

A progress note dated 10/14/2019 at 1:03 p.m. included: "Patient receiving vancomycin for a 6 week course (10/2-11/13) with trough goal of 15-20. Vanc (vancomycin) trough drawn on 10/11 resulted 21.2, Pharmacy recommended to place on hold and redraw 10/12. Results from draw on 10/12 was 10.7. New recommendations to restart vanc 1.5G (grams) q24hr. (every 24 hours) and recheck vanc trough, BMP, and serum creat prior to administration of 4th dose. Reviewed with MD and new orders in system."

A progress note dated 10/19/2019 at 7:02 a.m. included: "Serum Creatinine, BUN, and Vanc trough to be drawn prior to the 4th dose of vancomycin after dose change. one time only for 1 Day Call for a STAT draw To be done on Monday and needs to be reschedule." (sic)

A progress note dated 10/21/2019 at 3:22 p.m. included: "...This nurse was not able to administer Vanc IV this morning as Vanc trough had not been drawn. This matter was reported to unit manager who has ordered STAT Vanc trough to be drawn today by lab..."

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| F 757 | Continued From page 36 | F 757 | | |

A progress note dated 10/21/2019 at 3:43 p.m. included: "Vanc trough ordered stat during at 0800, company contact. No draw was done during shift. Company contact again and stated that there was no pending orders for resident, order was reentered by customer service agent and stated that someone would be here to draw it as soon as possible. Pharmacy made aware."

A progress note dated 10/21/2019 at 6:04 p.m. included: "...lab in to draw vanc trough..."

Review of the MAR (medication administration sheet) dated October 2019 included: "Vancomycin 750mg intravenously every 12 hours...Order Date: 10/08/2019 2001, Hold Date: from 10/11/2019 1850 to 10/12/2019 0800, D/C Date 10/14/2019 2345." Resident #8's IV Vancomycin was held on 10/11/2019 at 9:00 p.m. and 10/12/2019 at 9:00 a.m. The medication was resumed 10/12/2019 at 9:00 p.m.

A new order for Vancomycin 1.5 Gms. in 150 ml of NS (normal saline) was written 10/14/2019 1245. Resident #8 received the first dose on 10/15/2019 at 9:00 a.m.

The DON (director of nursing) was interviewed on 11/04/2019 at 4:50 p.m. regarding lab orders. The DON stated, "We are at the mercy of the pharmacy for vanc level orders and dosing."

On 11/05/2019 at 9:25 a.m. the DON stated, "I want to make sure I didn't misspeak earlier. The pharmacy gives us recommendations for labs. We call Dr. (Name) and he gives us an order. We write the order to obtain the labs."

Other #4 (pharmacist) was interviewed via phone

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| F 757 | Continued From page 37 | F 757 | | |

on 11/05/2019 at 11:00 a.m. regarding vancomycin dosing and lab orders. Other #4 stated, "We always do the dosing at the pharmacy. We have a guideline, but it is clinical judgment. Usually every three days or so. Our IV pharmacist takes care of dosing and labs. We go by the manufacturing recommended guidelines and clinical judgment. Depending on renal function, other labs, what we are treating, length of treatment, etc."

Other #5 (IV pharmacist) was interviewed via phone on 11/05/2019 at 1:35 p.m. regarding vancomycin dosing and lab orders. Other #5 stated, "Yes, we do have a policy in place for vancomycin. When someone is first admitted to the facility we get baseline labs and go from there." Regarding Resident #8, Other #5 stated, "Originally she was getting vanc 750mg IV Q12H. Her vanc trough level on 10/11/19 was 21.2, so we held her dose and repeated the lab on 10/12/19. Generally, yes we hold vancomycin if the trough is greater than 20. The vanc was restarted on 10/12/19 the pm dose. On 10/14/2019 we recommended to change the vancomycin to 1.5 Gms. every 24 hours and to draw a vanc trough prior to the 4th dose administration. Resident #8 received the first dose of 1.5 Gms. on 10/15/2019. It is documented in our computer system to obtain labs before the fourth dose on the 18th."

The DON and Corporate Nurse were interviewed on 11/05/2019 at 2:05 p.m. regarding pharmacy medication recommendations. The DON stated, "We send the lab results to the pharmacy. They call us back with recommendations for dosing and labs. We call the physician with the recommendations and obtain an order. The

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| F 757 | Continued From page 38<br>order is written and the pharmacy sends out the medication."<br><br>On 11/05/2019 at 2:30 p.m. the DON and Staff Development Coordinator (RN #1-registered nurse) were interviewed. They stated they reviewed the pharmacy recommendations for Resident #8 and her labs were missed on 10/18/2019. RN #1 stated, "That is my fault. I miscalculated the date. They should have been drawn on the 18th." RN #1 stated, "Pharmacy recommendations are faxed from the pharmacy and then facility staff notify the physician and write the order."<br><br>No further information was received prior to the exit conference on 11/06/2019.<br><br>This is a complaint deficiency. | F 757 | | |
| F 760 SS=E | Residents are Free of Significant Med Errors<br>CFR(s): 483.45(f)(2)<br><br>The facility must ensure that its-<br>§483.45(f)(2) Residents are free of any significant medication errors.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure timeliness of IV (intravenous) Vancomycin administration for one of nine residents in the survey sample, Resident #5.<br><br>Findings included:<br><br>Resident #5 was admitted on 06/08/2019 with diagnoses including, but not limited to: Sepsis, | F 760 | F-760<br><br>1. Resident #5 is no longer in the center.<br>2. All residents receiving Vancomycin are at risk.<br>3. SDC or designee to educate licensed nursing staff on the importance of ensuring timely administration of Vancomycin.<br>4. DON or designee will audit 100% of the medication administration records of | 12/2/19 |

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| F 760 | Continued From page 39<br>Cellulitis, and a PICC (peripherally inserted central catheter) line.<br><br>The most recent MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 06/15/2019. Resident #5 was assessed as cognitively intact with a total cognitive score of 15 out of 15.<br><br>Resident #5's clinical record was reviewed on 11/04/2019 at 1:30 p.m. Included in the physician order sheet was, "...Vancomycin HCl Solution 1000MG/200ML [1000 milligrams in 200 milliliters] Use 1000 mg intravenously every 12 hours..." The IV Vancomycin was on a 6:00 a.m., 6:00 p.m. schedule.<br><br>Review of Resident #5's MAR (medication administration sheet) dated June 2019 included on the "Location of Administration Report" the following regarding Vancomycin:<br><br>Scheduled Time: 06/09/19 18:00 (6:00 p.m.)<br>Administration Time: 06/09/19 22:33 (10:33 p.m.)<br><br>Scheduled Time: 06/11/19 18:00<br>Administration Time: 06/11/19 20:23 (8:23 p.m.)<br><br>Scheduled Time: 06/12/19 06:00 (6:00 a.m.)<br>Administration Time: 06/12/19 07:26 (7:26 a.m.)<br><br>Scheduled Time: 06/13/19 18:00<br>Administration Time: 06/13/19 19:21 (7:21 p.m.)<br><br>Scheduled Time: 06/15/19 18:00<br>Administration Time: 06/16/19 00:56 (12:56 a.m.)<br><br>Scheduled Time: 06/16/19 18:00<br>Administration Time: 06/16/19 21:15 (9:15 p.m.) | F 760 | residents receiving Vancomycin for timeliness of medication administration daily for 4 weeks, then review findings in following QA meeting. | |

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| F 760 | Continued From page 40<br><br>Scheduled Time: 06/17/19 18:00<br>Administration Time: 06/17/19 22:52 (10:52 p.m.)<br><br>Scheduled Time: 06/19/19 18:00<br>Administration Time: 06/19/19 19:55 (7:55 p.m.)<br><br>A skilled progress note dated 06/17/2019 at 13:35 (1:35 p.m.) included: "...Vanc administered at 0915 [9:15 a.m.]. This nurse spoke with [Name] at [Name] pharmacy to determine how we could get vanc back to 0600 and 1800 time [Name] conferred with another pharmacist who stated vanc trough due at 0530 [5:30 a.m.] on 6*19*19 and that tonight's dose [6/17] to be given at 2100 [9:00 p.m.], tomorrow am [6/18] dose at 0800 [8:00 a.m.] and dose on 6*18*19 evening be given at 1800 [6:00 p.m.]..."<br><br>The DON (director of nursing) was interviewed on 11/05/2019 at approximately 4:30 p.m. regarding late Vancomycin dosage administration. The DON stated, "The one that was really late, six hours late, was given by an agency nurse and she no longer works here. I don't know why all the others were that late. I have educated the nursing staff on the importance of medication administration timing. My expectation is medications can be given one hour before to one hour after the scheduled administration time. That is standard practice."<br><br>No further information was received prior to the exit conference on 11/06/2019.<br><br>This is a complaint deficiency. | F 760 | | |
| F 770 SS=D | Laboratory Services<br>CFR(s): 483.50(a)(1)(i) | F 770 | | 12/2/19 |

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| F 770 | Continued From page 41<br><br>§483.50(a) Laboratory Services.<br>§483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.<br>(i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to provide immediate lab services for one of nine residents in the survey sample, Resident #8.<br><br>Findings included:<br><br>Resident #8 was admitted to the facility on 06/10/2019 and readmitted on 10/08/2019 with diagnoses including, but not limited to: Neurogenic Bladder, Suprapubic Catheter, Urinary Tract Infection, MRSA (methicillin resistant staphylococcus aureus), and a PICC line.<br><br>The most recent MDS (minimum data set) was a 5-day assessment with an ARD (assessment reference date) of 10/14/2019. Resident #8 was assessed as cognitively intact with a total cognitive score of 15 out of 15.<br><br>Resident #8's record was reviewed on 11/04/2019 at 3:30 p.m. and again on 11/05/2019 at 10:30 a.m. A progress note dated 10/19/2019 at 7:02 a.m. included: "Serum Creatinine, BUN, and Vanc trough to be drawn prior to the 4th dose of | F 770 | F-770<br><br>1. Resident #8□s MD is now aware of deficiency in obtaining STAT laboratory orders. Resident #8 is no longer receiving medication that required missed lab.<br>2. All residents receiving STAT labs are at risk.<br>3. SDC or designee to educate licensed nursing staff on importance of ensuring immediate lab services are obtained as ordered.<br>4. DON or Designee will audit 100% of STAT labs for collection and completion daily for 2 weeks, then 5x weekly for 2 weeks, then review findings in following QA meeting. | |

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| F 770 | Continued From page 42 | F 770 | | |

vancomycin after dose change. one time only for 1 Day Call for a STAT draw To be done on Monday and needs to be reschedule." (sic)

A progress note dated 10/21/2019 at 3:22 p.m. included: "...This nurse was not able to administer Vanc IV this morning as Vanc trough had not been drawn. This matter was reported to unit manager who has ordered STAT Vanc trough to be drawn today by lab..."

Progress note dated 10/21/2019 at 3:43 p.m. included: "Vanc trough ordered stat during at 0800, company contact. No draw was done during shift. Company contact again and stated that there was no pending orders for resident, order was reentered by customer service agent and stated that someone would be here to draw it as soon as possible. Pharmacy made aware."

Progress note dated 10/21/2019 at 6:04 p.m. included: "...lab in to draw vanc trough..."

Review of the MAR (medication administration sheet) dated October 2019 included: "Vancomycin 750mg intravenously every 12 hours...Order Date: 10/08/2019 2001, Hold Date: from 10/11/2019 1850 to 10/12/2019 0800, D/C Date 10/14/2019 2345."

Resident #8's IV Vancomycin was held on 10/11/2019 at 9:00 p.m. and 10/12/2019 at 9:00 a.m. The medication was resumed 10/12/2019 at 9:00 p.m.

A new order for Vancomycin 1.5 Gms. in 150 ml of NS (normal saline) was written 10/14/2019 1245. Resident #8 received the first dose on 10/15/2019 at 9:00 a.m.

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| F 770 | Continued From page 43 | F 770 | | |

Other #5 (IV pharmacist) was interviewed via phone on 11/05/2019 at 1:35 p.m. regarding Vancomycin dosing and lab orders. Other #5 stated, "Originally she was getting Vanc 750mg IV Q12H. Her Vanc trough level on 10/11/19 was 21.2, so we held her dose and repeated the lab on 10/12/19. Generally, yes we hold Vancomycin if the trough is greater than 20. The Vanc was restarted on 10/12/19 the pm dose. On 10/14/2019 we recommended to change the Vancomycin to 1.5 Gms. every 24 hours and to draw a Vanc trough prior to the 4th dose administration. Resident received the first dose of 1.5 Gms. on 10/15/2019. It is documented in our computer system to obtain labs before the fourth dose on the 18th."

On 11/05/2019 at 2:30 p.m. the DON and Staff Development Coordinator (RN #1-registered nurse) were interviewed. The stated they had reviewed the pharmacy recommendations for Resident #8. Her labs were missed on 10/18/2019. RN #1 stated, "That is my fault. I miscalculated the date. They should have been drawn on the 18th." RN #1 stated, "Her labs were not drawn on 10/19/19 because this was a Saturday. The lab called that morning and said they couldn't come and obtain the labs that day because they didn't have any staff. The lab is usually here in our facility around 3:30 or 4:00 a.m. Her lab needed to be drawn at 8:30 a.m., 30 minutes prior to her IV administration of Vanc. That is how the labs were rescheduled for Monday 10/21. The physician and pharmacy were notified."

No further information was received prior to the exit conference on 11/06/2019.

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| F 770 | Continued From page 44<br><br>This is a complaint deficiency. | F 770 | | |