STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495189	A. BUILDING _____ B. WING _____	C 10/01/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENCY HEALTH AND REHABILITATION CENTER	112 N CONSTITUTION DR GRAFTON, VA 23692

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 09/30/20 through 10/01/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 60 certified bed facility was 48 at the time of the survey. The survey sample consisted of 3 resident reviews.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to ensure 1 resident (#1) was free from neglect in a survey sample of 3 residents. The findings included:	F 600	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of	11/3/20

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

Electronically Signed | 10/16/2020

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

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F 600	Continued From page 1 For Resident #1 the facility neglected to obtain a "STAT" appointment (as ordered). Resident #1, a 64-year-old woman was admitted to the facility on 8/21/20, with diagnosis of but not limited to peripheral vascular disease diabetes type two cellulitis lower limb, sepsis morbid obesity, surgical removal of fourth toe on left foot, anemia, hypertension, stage renal disease, and was a dialysis patient. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as " Z- none of the above" indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. On 10/30/20 clinical record review was revealed Resident #1 was admitted to the facility after having amputation of the fourth toe on the left foot, She was ordered to receive IV as well as oral antibiotics, physical therapy and wound care while at the facility. She was admitted with a Groshong catheter (implanted central line port to administer antibiotics). A record review reveled the following: "8/25/20 at 12:00 AM : Since patient has been	F 600	correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F600 1-Residents # 1 was discharged from the facility on 9/3/20. 2- Residents admitting into the facility have the potential to be affected. An audit will be completed by the DON or designee of current residents with orders for appointments, to include STAT appointment to ensure that the appointments are scheduled timely. 3- The Staff Development Coordinator will provide education to licensed nurses and the Medical Records Coordinator on scheduling appointments as ordered and provisions to follow when not able to obtain an appointment for residents timely or immediately as ordered. 4-The Unit Manager or designee will complete audits of ordered appointments for residents 3x week x 4weeks, weekly x2, and then monthly x1 to ensure that the appointments are scheduled appropriately. Results of the monitoring will be presented to the Quality Assurance Committee for review and recommendation.	

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F 600	Continued From page 2 admitted she has not received a dose of Cefepime. Initially she was started on the wrong antibiotic, Cefazolin, and received at least three doses of that. Her right Groshong catheter lost its lumen and a peripheral IV was placed last evening. Now this is currently not functioning or flushable." "Skin:"Where the fourth toe was previously located, ulcer with white base, no drainage, non tender, no erythema, no odor." "Plan:"STAT vascular surgeon consult [doctors name redacted] to fix Groshong Cath so she can receive antibiotics." Note: STAT refers to immediate "8/26/20 at 4:01 PM [Doctors name redacted] Office called concerning having residence Groshong catheter replaced due to it being removed. Left a voicemail with [name redacted] surgical scheduler at the [doctors name redacted]. Office waiting awaiting a return phone call. PA [physician assistant] notified [LPN name redacted]." "8/27/20 at 12:08 PM call placed to [Doctors name redacted] office to schedule central line (Groshong Cath) 8/21/20 insertion message left for [Name redacted] surgical coordinator resident made aware. [LPN name redacted]." On 10/1/20 2:12 PM an interview was conducted with the DON who was asked about the order on 8/25/20 for STAT appointment with surgeon to place the central line she stated "we could not get in touch so we called the PICC team and they put in a PICC LINE in her upper right arm on the night of 8/27/20 and she got her first dose of Cefepime on the morning of 8/28/20."	F 600	5-Completion date 11/03/20	

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F 600	Continued From page 3 Excerpt from the facility Abuse/Neglect Policy read: "Policy #703 page 93" "Neglect means a repeated or willful failure to provide timely and consistent services treatment or care to a patient which are necessary to obtain or maintain the patient's health safety or comfort" On 10/1/20 during the end of day meeting the Administrator was made aware of these concerns and no further information was provided.	F 600		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the	F 656		11/3/20

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F 656	Continued From page 4 findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to develop and implement a comprehensive care plan that includes measurable objectives and is Resident centered for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1 the facility failed to include care areas for wound care, pain, fluid restriction, non weight bearing status and updated the care plan after the Resident was discharged to the hospital. Resident #1, a 64-year-old woman was admitted to the facility on 8/21/20, with diagnosis of but not limited to peripheral vascular disease, diabetes type two, cellulitis lower limb, sepsis, morbid obesity, surgical removal of fourth toe on left foot, end stage renal disease, anemia, hypertension,	F 656	F656 1-Resident #1 was discharged from the facility on 9/3/20. 2- Residents admitting into the facility have the potential to be affected. The DON, the MDS Coordinator or designee will complete an audit of current residents care plans to ensure that the care plans accurately reflect all aspects of care, include measurable objectives, are Resident centered based on the physician orders and the Care Area Assessments (CAA□s). The DON or designee will review residents discharged in the last 30 days to ensure that the care plans were not updated after discharge outside the required timeframe. 3-The Staff Development Coordinator will	

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F 656	Continued From page 5 and was a dialysis patient. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as " Z- none of the above" indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. On 10/1/20 a review of the clinical record revealed the facility failed to address all aspects of care on her care plan. Care area focus of "Pain" was not addressed in the care plan until it was entered on 9/8/20 (5 days after discharge), in spite of her increasing pain requiring her to go from a PRN every 4 hours to a routine every 4 hours dose of Dilaudid 2 mg (Opioid pain medicine). Care area focus "Resident has potential for dehydration or potential fluid deficit due to infection" was entered on 9/8/20 (5 days after discharge). Care area focus "The Resident has bladder incontinence r/t impaired mobility" was entered on 9/8/20 (5 days after discharge). However, the resident is anuric (does not urinate) related to end stage renal disease and dialysis per hospital	F 656	educate licensed Nurses on appropriate completion and revisions of care plans to reflect the resident care needs. The MDS Consultant will educate the MDS Coordinator on accurately completing the care plan based on the resident Care Area Assessments and appropriately updating a care plan for discharged residents. 4-The DON or designee will complete audits of new resident admissions, new resident orders, changes in resident condition and resident Care Area Assessments 3x week x 4 weeks, weekly x2, and then monthly x1 to ensure that the care plans are completed and updated appropriately and are Resident Centered. Results of the audits will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 11/03/20.	

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F 656	Continued From page 6	F 656		

discharge and facility admission assessment.

Under the focus"Resident has limited physical mobility related to weakness" created 8/21/20 the goal states "Resident will demonstrate appropriate use of adaptive devices to increase mobility throughout the review date" dated 9/8/20 Revision 9/8/20 target date 11/19/20 Intervention "locomotion the resident is able with limited assistance" [left incomplete] created 9/8/20 revision 9/8/20 [note this resident is coded as not using a wheelchair, crutches, cane or walker per MDS]

On 10/1/20 at 3:00 PM, the DON was asked to provide notes about the focus area "Resident is resistant to care R/T refuses therapy and medications. Noncompliant with fluid restriction created on 9/2/20 revision 9/3/20."
No notes related to refusal of, or resistance to care, medications or treatments were provided. However, the DON provided notes as follows;

"9/3/20 at 11:41 PM patient noted to be noncompliant with diabetic diet and fluid restriction"

"8/31/20 at 4:05 AM patient is requesting chips and other snacks from nurse and CNA this shift. She has been educated that her blood sugar was above 400 before bed and she is allowed to have sugar free pudding if she would like a snack. Patient declined sugar-free snacks and asked what did chips have to do with my blood sugar being high?. More education provided to patient regarding healthy snack choices"

On 0/1/20 at approximately 11:00 AM, during an interview, LPN B stated, "All nurses have access

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F 656	Continued From page 7 to the care plan we can all update it." On 10/1/20 approximately 3:00 PM the Administrator was asked about the care plans being updated after the Resident had been discharged he stated that the "MDS person was off and the care plan got updated when she returned the Tuesday after labor day." On 10/1/20 during end of day meeting the Administrator was made aware of the concerns and no further information was provided.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed to provide services as directed by the care plan that meet with professional standards of care for 1 Resident (#1) in a survey sample of 3 Residents. The findings included: For Resident #1 the facility failed to: A) properly care and maintain the Groshong Central Line Catheter and B) failed to correctly document progression of wound. Resident #1, a 64-year-old woman was admitted to the facility on 8/21/20, with diagnosis of but not	F 658	F658 1-Resident #1 was discharged from the facility on 9/3/20. 2-Residents admitting into the facility have the potential to be affected. Current residents with wounds will be reviewed by the DON or designee to ensure that the wounds are accurately documented in the medical record. The DON or designee will review residents with Central line catheters to ensure that proper care and maintenance is being provided. 3-The Staff Development Coordinator will	11/3/20

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F 658	Continued From page 8 limited to peripheral vascular disease. diabetes type two. cellulitis lower limb, sepsis. morbid obesity. surgical removal of fourth toe on left foot. end stage renal disease, anemia, hypertension, and was a dialysis patient. Resident #1's most recent MDS parentheses (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psych treatments. The Resident's weight-bearing status is non weight bearing on the left leg. The MDS codes the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as " Z- none of the above" indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis. A) On 9/30/20 a review of the clinical record revealed that Resident #1 had orders that read: "Central line flush-10 ml NS [normal saline] flush and follow with 5 ml 10 units/ml Heparin one time per day for maintenance start date 8/23/20" Note: The resident was admitted to the facility on 8/21/20 but the orders were not put in for flush until 8/23/20. "8/24/20 8:02 PM - Resident right chest Cath is inaccessible. No lumen present. No S/S of infection at the site. Order received have Cath changed. Mobile services state they cannot replace a tunneled chest cath. Resident sent non-emergent to [hospital name redacted] for chest Catheter placement. Message left for LTC	F 658	educate licensed Nurses on proper documentation of wounds, and care and maintenance of Central line Catheters. 4-The DON or designee will complete audits of skin evaluation documentation of wounds and check central line catheters 3x week x 4 weeks, weekly x2, and monthly x1 to ensure that wounds are accurately documented and that appropriate care and management is provided for central line catheters. Results of the audits will be presented to the Quality Assurance Committee for review and recommendation. 5-Completion date 11/03/20.	

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F 658	Continued From page 9	F 658		

on-call. Resident informed older sister of her condition. [LPN #1 name redacted]. "

"8/24/20 at 8:23 PM orders administration note Cefepime HCl solution 1 g/50 ml administration PICC line inaccessible resident sent to ER for PICC line replacement family and MD are aware [LPN #1 one name redacted]."

"8/24/20 at 10:05 PM resident left facility via non-emergent medical transport by stretcher due to right chest Cath PICC line replacement, 2100 meds given prior to discharge, call placed to [hospital name redacted] transfer center spoke to [name redacted] awaiting residents arrival, skin assessment shows no new conditions prior to discharge family and MD aware of departure [LPN name redacted] "

Excerpts from ER record:
" Pt. arrived via [transport company name redacted] from [facility name redacted] for PICC line replacement. Pt. has no other complaints. Upon examination, the PICC line looks cut where the hubs should be.

On 10/1/20 at 1:20 PM and interview was conducted with RN A who stated that the dressing was intact when she went in there was no leaking. "I didn't have scissors with me or nothing." "I flushed as like I was supposed to. I hung the antibiotic, then I took it apart I flushed with normal saline and heparin and put the cap back. It was intact when I left the room...The next day they told me the port was cut." When asked if she had been received training on the Groshong catheter she stated that she had training in school and at other jobs.

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The Bard Nursing Procedure Manual for Groshong Central Venous Catheter
Page 34 read:
"Catheter Damage -When catheter damage or connector separation occurs, the catheter should be immediately clamped or kinked closed to prevent any possibility of air embolism or loss of blood."

"Possible Causes"
"Repeated clamping."
"Contact with a sharp object."
"Rupture from attempt to irrigate an occluded catheter with a small syringe."
"Small syringes can generate very high internal pressures with very little force. The back pressure from an occlusion may not be felt when using a small syringe until damage to the catheter has occurred."

B1) Review of clinical records reveals that wound notes up until 8/28/20 do not mention condition or site of wound.

On 10/1/20 at 2:13 PM an interview was conducted with the DON and when asked about the documentation of the wound she stated that the nurses should be documenting on the "color and appearance of the wound." She added it was hard to tell because the Resident had a "dark complexion and was getting betadine to her foot as a treatment so it was hard to see how it was doing." She was asked what is incumbent upon the nurse to do during a dressing change. She stated that the nurse should clean the wound before applying the medication so she can visualize the area. "She should be documenting any abnormal findings like heat swelling, drainage

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F 658	Continued From page 11 odor increase in pain and temp." B2) A review of the weekly skin assessments revealed that on 8/21/20 the initial skin assessment was done page 1 of 3 refers to the "Surgical incision on 4th digit L foot." Page 2 of 3 section B. 1. 4th digit Left foot, 2. Present on admission, 3. Wound Healed? NO 4. Visible observation of tissue (boxes checked f & g) f. dry and g. blood filled blister. 5. Drainage present NO." The subsequent assessments done on 8/29, 9/1/20 and 9/3/20 all are filled out identically with the same descriptions for 4. Visible Observations of tissue. On 10/1/20 at 2:13 PM an interview was conducted with the DON who was asked why all of the skin assessment sheets are identical when the progress notes on 9/1/20 and 9/3/20 reflect a deterioration in the condition of Resident's foot. She responded that she did not know. The administrator was made aware of the concerns at the end of day meeting on 10/1/20 and no further information was provided.	F 658		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, clinical record review and facility documentation, and in the course of a complaint investigation, the facility staff failed	F 760	Past noncompliance: no plan of correction required.	10/14/20

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provide medications as ordered by physician for 1 Resident (#1) in a survey sample of 3 Residents.

The findings included:

For Resident #1 the facility failed to provide the correct medications (IV Antibiotics) to treat a post-operative patient resulting in the Resident missing 6 doses of IV antibiotics.

Resident #1, a 64-year-old woman was admitted to the facility on 8/21/20, with diagnosis of but not limited to peripheral vascular disease diabetes type two cellulitis lower limb, sepsis morbid obesity surgical removal of fourth toe on left foot and stage renal disease, anemia, hypertension, and was a dialysis patient

Resident #1's most recent MDS (minimum data set) coded the resident as having a BIMS (brief interview of mental status) score of 15, indicating no cognitive impairment. The MDS also indicated no behaviors and no psychiatric treatments. The Resident's weight-bearing status was non weight bearing on the left leg. The MDS coded the Resident's functional status resident required limited - extensive assist with all ADLs except for eating. Eating required supervision and oversight only. The MDS Section G-0600 mobility devices coded the Resident as " Z- none of the above" indicating the Resident did not use cane, crutches, walker, wheelchair, or limb prosthesis.

A review of the clinical record reveals the discharge instructions from hospital (printed 8/21/20 entered into the facility EHR on 8/21/20) included the following:

Medications:

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"Cefepime (an antibiotic) give IV daily through 9/16/20,
Fluconazole 200 mg one tablet daily times two doses."

A review of the Physician orders revealed that the DON entered an order for Cefazolin 1 Gm (gram) intravenously every 24 hr. for infection related to Sepsis, on 8/21/20. Note: The discharge summary from hospital orders were for Cefepime not Cefazolin 1 gm every 24 hours.

Excerpts from the progress notes are as follows:
"8/23/20 at 4:41 PM pharmacy was contacted concerning patient's IV Cefazolin they have stated that the order has to be web signed and faxed the order was signed and faxed pharmacy verbalized order we received and medication will be sent out [nurse name redacted]."

"8/24/20 3:19 PM - skilled note- Patient's Central line to right upper chest, clean dry and intact. Central line flushes well. Received first dose of Cefazolin 1 g 12:00 PM. No adverse reactions noted From Medication."

"8/24/20 8:02 PM - Resident right chest Cath is inaccessible. No lumen present. No S/S of infection at the site. Order received have Cath changed. Mobile services state they cannot replace a tunneled chest cath. Resident sent non-emergent to [hospital name redacted] for chest Catheter placement. Message left for LTC on-call. Resident informed [family member] of her condition. [LPN #1 name redacted]. "

"8/24/20 at 8:23 PM orders administration note Cefepime HCl solution 1 g/50 ml administration PICC line inaccessible resident sent to ER for

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PICC line replacement family and MD are aware [LPN #1 name redacted]."

Excerpts from ER record:
"Pt. arrived via [transport company name redacted] from [facility name redacted] for PICC line replacement. Pt. has no other complaints. Upon examination, the PICC line looks cut where the hubs should be. "
"Pt. will get IV placed, her first round of antibiotics, observed for possible reaction, and sent back to facility. Informed nurses [2 nurses names redacted] at [facility name redacted] to send patient back to the ED during the daytime when the PICC team is here. [Dr. Name redacted] advised leaving the IV in place for access until the new PICC line is placed. "

Excerpts from facility progress notes are as follows:
" 8/25/20 at 7:26 AM skilled note patient returned from ER with IV site in right AC, vitals obtain skin intact no complaints of pain PO Dilaudid given call bell and reach patient picked up for dialysis at 5:15 via wheelchair "

"8/25/20 at 8:54 PM orders administration note Cefepime 1 g/50 ml use 1 g intravenously every 24 hours for infection related to cellulitis of the lower left limb. Administration unable to administer medications due to clogged IV [doctor's name redacted] made aware will follow up with vascular surgeon [LPN name redacted] "

Excerpts from Physician's note dated 8/25/20 at 12:00 AM read:
"Since patient has been admitted she has not received a dose of Cefepime. Initially she was started on the wrong antibiotic, Cefazolin, and

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received at least three doses of that. Her right Groshong catheter lost its lumen and a peripheral IV was placed last evening. Now this is currently not functioning or flushable."
[Note: Review of MAR revealed she only received 2 doses of the "wrong antibiotic" Cefazolin]

"8/28/20 5:30 AM infection note x-ray confirmed correct placement of PICC line in right upper extremity Cefepime 1 g IV given at this time. [Nurse's name redacted]."

A Review of the MAR revealed that Resident #1 did not get antibiotics on 8/22/22, and 8/23/20 due to incorrect ordering. She did not get the correct antibiotics on 8/24/20 at 9:00 PM as ordered (however she got one dose of correct Antibiotic 8/25/20 at midnight at ER) then she did not get her next scheduled dose due to infiltrated peripheral IV. The PICC was not replaced until 8/28/20. She missed a total of 6 doses of Cefepime and was given the incorrect antibiotic 2 times between 8/21/20 and 8/28/20.

10/1/20 2:13 PM an interview was conducted with the DON. She was asked the process for an admission. She stated that when an admission comes to the facility "we verify the orders with the physician to be sure she wants to keep stop or change any of the hospital discharge orders." When asked who input the orders into the computer for this admission she stated that she had done so. When asked why the Resident did not receive antibiotics for the first 3 days she said " I put the wrong orders in. I ordered the wrong antibiotic and then didn't click the box so the antibiotic never was sent from the pharmacy. " On 8/24/20 they discovered the Resident had not been given the Antibiotics and she contacted the

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pharmacy sent the script and gave the first dose of Cefazolin (the wrong antibiotic) from the stat box.

On 10/1/20 during end of day meeting the Administrator was made aware of the concerns and presented a Past Noncompliance plan dated including the following information:

1. On 8/24/20 it was discovered that the Resident had been given the wrong medication. This error happened when the DON entered the wrong orders into the computer and did not upload the hospital discharge summary so that the pharmacy could review it.
2. The DON will review the orders for Residents since 9/1/20 to ensure correct medications were ordered dispensed and given.
3. Review IV access devices for Antibiotic administration to ensure all orders were correctly entered.
4. Unit manager will review all medication orders for admitted residents to ensure the correct meds were transcribed.
5. Review and audits will be completed 3 x week X 4, weekly x 2, monthly x 1. Results will be presented during quarterly QAPI
Completion date 9/29/20

No further information was provided