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E 000	Initial Comments An unannounced abbreviated Emergency Preparedness COVID-19 Focused Survey was conducted on 6/14/21 through 6/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced abbreviated COVID-19 Focused Survey was conducted onsite from 6/14/21 through 6/17/21. Complaints were investigated during the survey. VA00051976, VA00051747, VA00051471and VA00051357 were substantiated with deficiencies. VA00051300 was substantiated with no deficiencies. VA00051006 and VA00051766 were unsubstantiated with unrelated deficiencies. VA00051390 was unsubstantiated. Corrections are required for compliance with F-883 of 42 CFR Part 483 Federal Long Term Care requirement(s). The census in this 225 certified bed facility was 196. Of the 199 current residents, no residents were positive for the COVID-19 virus. The survey sample consisted of 6 current residents and 6 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		7/28/21

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

Electronically Signed | 07/02/2021

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F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation it was determined that facility staff failed promote dignity for one of 12 residents in the survey sample, Resident # 1. The facility staff wrapped Resident # 1 in a bed sheet instead of providing a	F 550	Westport Rehabilitation and Nursing Center provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed as evidence to comply with the	

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coat/jacket when leaving the facility for a doctor's appointment.

The findings include:

Resident #1 was admitted to the facility with diagnoses that included but were not limited to: low hemiplegia [1], dementia [2] and benign prostatic hyperplasia [3].

Resident # 1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/06/2021, coded Resident # 1 as scoring a 5 [five] on the brief interview for mental status (BIMS) of a score of 0 - 15, five - being severely impaired of cognition for making daily decisions. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living.

The facility's "Progress Note" dated 04/13/2021 at 7:02 a.m., for Resident # 1 documented, "Resident left out via wheelchair fully clothed with pants, shirt, socks, shoes, he had no jacket, so a sheet was wrapped around him to keep him warm. Author [Name of Licensed Practical Nurse (LPN)] # 12."

On 06/14/2021 at 2:43 p.m., an interview was conducted with CNA [certified nursing assistant] 4. CNA #4 was asked to describe the procedure of care for a resident is leaving the facility for an appointment. CNA # 4 stated, "I provide ADL [activities of daily living] care, make sure they are washed, clean, have proper clothing for the weather, hair combed and teeth brushed and make sure they weren't soiled before leaving." When asked if they had been assigned to take care of Resident # 1, CNA # 4 stated, "Today was

requirements of participation and effort to provide high quality resident centered care.

1. Resident #1 continues to reside in facility and dons appropriate outerwear when leaving facility for appointments.
2. All residents leaving facility for appointments/outings have the potential to be affected by this alleged deficient practice. Facility has ensured all residents leaving for appointments/outings are wearing appropriate outerwear.
3. DON or designee will re-educate all nursing staff that all residents who are leaving facility for appointments/outings must don appropriate outwear, and also to contact family to notify if appropriate outerwear garments are needed.
4. DON or designee will randomly audit residents going out for appointments Weekly times 4 and monthly times 2 to ensure residents have on appropriate outerwear when leaving facility on appointments/outings. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.
5. Date of compliance will be July 28, 2021.

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my first day taking care of him, I usually work on another unit."

On 06/15/2021 at 10:20 a.m., an interview was conducted with RN [registered nurse] # 3, assistant director of nursing. RN #3 was asked to review the progress note documented above. After reviewing the note, RN # 3 was asked if it was dignified for Resident # 1 to leave the facility to an appointment wrapped in a bed sheet. RN stated, "No." When asked how Resident # 1 should have been dressed, RN # 3 stated, "They [nurse] should have given him [Resident #1] a jacket and if they did not find something appropriate, call the family to bring one." When asked to speak with LPN # 12, RN # 3 stated that LPN # 12 was not available due to being suspended for another issue.

The facility's policy "Resident's Rights in Nursing Homes" documented in part, "Quality of Life. The resident has the right to a dignified existence, self-determination, choice, communication with, and access to persons and services inside and outside the facility. The resident must be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. Each nursing home is required to "provide services and activities to attain or maintain the highest practicable, physical, mental and psychosocial well-being of each resident in accordance with a written plan of care which is initially prepared, with participation to the extent practicable of the resident, the resident's family or legal representative."

On 06/15/2021 at approximately 4:45 p.m., ASM [administrative staff member] # 1, the

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F 550	Continued From page 4 administrator and ASM # 2, director of nursing, were made aware of the above findings No further information was provided prior to exit. Complaint Deficiency References: [1] Also called: Hemiplegia, Palsy, Paraplegia, Quadriplegia. Paralysis is the loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. Paralysis can be complete or partial. It can occur on one or both sides of your body. It can also occur in just one area, or it can be widespread This information was obtained from the website: https://medlineplus.gov/paralysis.html. [2] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. [3] An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 550		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		7/28/21

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results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct

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F 580	Continued From page 6 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to notify the physician and/or responsible party of required changes and/or information, for three of 12 residents in the survey sample; Residents #4, #10, and #2. 1. A. The facility staff failed to notify the physician when Resident #4 missed doses of the medication Octreotide and a delay in receiving the prescribed medication. 1. B. The facility failed to consult and obtain orders from the physician to administer the medication Octreotide to Resident #4 at intervals and times that were not scheduled/approved by the physician. 1. C. The facility staff failed to consult, obtain an order for administering the medication Octreotide via a route that was not ordered by the physician and failed to notify the physician when the medication was not administered via the route and by a RN [registered nurse] as ordered. 2. The facility staff failed to notify the physician that wound care was not provided as ordered on 6/13/21 for Resident #10. 3. The facility staff failed to notify Resident # 2's responsible party of a urology appointment on 04/22/2021.	F 580	1. Resident #4 no longer resides in facility. The physician of resident #10 has been notified of missed treatment. The RP of resident #2 has been made aware of all future appointments. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that missed medication doses or treatments, delay in medication administration due to availability, need for change in delivery method or administration times of medications require notification of physician. Ward clerks will be educated that all appointments, whether made by facility or not, require notification and confirmation with RP of residents. 4. DON or designee will randomly audit medication orders and related MARs Weekly times 4 weeks and monthly times 2 to ensure medication is administered as ordered, at correct times, and by appropriate staff. DON or designee will randomly audit MARs/TARs weekly times 4 weeks and monthly times 2 to ensure physicians were notified if a medication or treatment was missed/delayed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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The findings include:

1. A. Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) was an Admission assessment with an ARD (Assessment Reference Date) of 3/2/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene.

A review of the clinical record revealed a hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..."

Note: The resident had a PICC (2) line IV site.

A review of the physician's orders revealed the following:

On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."

On 3/1/21: "Octreotide Acetate Solution 100

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MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

A review of the facility's "Standard Medication Pass Times" list, the schedule for "TID" medications was documented as 6:00 AM, 2:00 PM, and 10:00 PM.

A review of the pharmacy manifest document revealed the medication was not delivered to the facility until 2/25/21 at 11:00 AM and was documented as an 8 day supply.

A review of additional pharmacy manifests revealed two more deliveries, on 3/11/21 and 3/23/21. No time of delivery was documented on these two manifests. On 6/16/21 at 3:18 PM an interview was conducted with OSM #15, the

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Director of Pharmacy. She stated that these 2 deliveries were (1) requested on 3/10/21 and delivered on 3/10/21, and (2) requested on 3/23/21 and delivered on 3/23/21.

A review of the MAR for February 2021 revealed the following: The medication was initially scheduled for administration at 6:00 AM, 2:00 PM and 10:00 PM daily.

The February 2021 MAR documented that the medication was not administered as follows:

On 2/24/21 at 10:00 PM. A review of the nurse's notes documented "awaiting on pharmacy."

On 2/25/21 at 6:00 AM. A review of the nurse's notes documented "medication on order."

On 2/25/21 at 10:00 PM. A review of the nurses notes documented, "awaiting prior authorization." However, as the medication was delivered at 11:00 AM per the above pharmacy manifest and was administered at 2:00 PM, it therefore was available to be administered at 10:00 PM.

On 2/26/21 at 6:00 AM. A review of the nurse's notes documented, "pending pharmacy deliver." However, as the medication was delivered at 11:00 AM on 2/25/21, it was available to be administered at this time.

There was no evidence that the physician was notified of any of these missed doses or a delay in receiving the medication from the pharmacy.

On 5 occasions, on 3/3/21 at 6:00 AM, 3/5/21 at 6:00 AM and 10:00 PM, 3/6/21 at 10:00 PM, and 3/10/21 at 2:00 PM, the medication was not

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initialed as given, and was not documented as not given for some reason. The spot for documenting this administration was left blank. There were no supporting nurses' notes regarding this administration.

On 6/16/21 at 11:44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy, which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer.

On 6/16/21 at 4:28 PM in an interview with ASM #2, (Administrative Staff Member), the Director of Nursing, she stated that "If there are holes I can't determine if they gave it are not." When asked what does holes on the MAR mean, she stated, "If it was not documented, it was not administered."

There was no evidence the physician was notified of these missed doses.

On 3/8/21 at 6:00 AM the medication was documented as not administered. Supporting nurse's notes documented, "on order."

On 3/9/11 at 2:00 PM the medication was documented as not administered. Supporting nurse's notes documented, "awaiting arrival from pharmacy."

On 3/9/11 at 10:00 PM the medication was documented as not administered. Supporting nurse's notes documented, "awaiting arrival from pharm [pharmacy]."

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On 3/10/11 at 6:00 AM the medication was documented as not administered. Supporting nurse's notes documented, "Awaiting pharmacy."

According to the above documented pharmacy manifest review and interview with OSM #15, a reorder was requested on 3/10/21 and delivered on 3/10/21 (per interview) or 3/11/21 (per manifest). The above documentation reflected that there was a delay in the facility reordering the medication as nurses documented it was "on order" on 3/8/21, 3/9/21 and 3/10/21 when it had not been reordered, and there was no evidence the physician was notified when the facility did not have the medication to administer.

1. B. The facility failed to consult and obtain orders from the physician to administer the medication to Resident #4 at intervals and times that were not scheduled/approved by the physician.

As noted above, the facility's "Standard Medication Pass Times" list, the schedule for "TID" medications was documented as 6:00 AM, 2:00 PM, and 10:00 PM.

As noted above, the order was changed on 3/4/21 to reflect a change in diagnosis, only. However, a review of Resident #4's MAR for March 2021 revealed that with this change, additional administration times were added to the MAR on this date, through the next order change on 3/13/21. The March 2021 MAR documented additional administration times that this medication could be administered as: 6:00 AM, 10:00 AM, 2:00 PM, 8:00 PM and 10:00 PM.

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Further review of the March 2021 MAR revealed that even with 5 possible times available for administration of the medication, the resident never received more than the 3 doses as ordered on any given day.

On 3/11/21 the 6:00 AM dose was documented as administered. However the supporting administration note was documented at 4:42 AM and documented, "medication times adjusted for RN administration per order." Review of the clinical record failed to evidence an order approving this time change or that the physician was notified of a time change in administration of the medication.

On 3/12/21 the medication was documented as being administered at 10:00 AM, 2:00 PM and 8:00 PM. Review of the clinical record failed to evidence a physician order to administer the medication at these times and were not in line with the facility's policy of a TID schedule of 6:00 AM, 2:00 PM and 10:00 PM. The order was for 3 times a day, which was previously documented as being 6:00 AM, 2:00 PM and 10:00 PM per facility policy.

On 6/16/21 at 12:05 PM, LPN #5, who had entered this order, stated that she added the additional times to accommodate the RN's schedule. There was no documentation evidencing an ordered schedule change by the physician.

On 6/17/21 at 9:32 AM in an interview with ASM #2, she stated that the facility schedule for TID (3 times a day) medications was 6:00 AM, 2:00 PM, and 10:00 PM. ASM #2 the director of nursing) stated. "The above schedule with additional

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administration times added was not acceptable and that staff cannot pick and choose when to administer a medication." ASM #2 stated, "It was not ok for the staff to arbitrarily change these times to reflect a schedule that was not equally spaced without a physician's order and to accommodate the RN's schedule and not the resident."

There was no evidence that the physician was made aware of or ordered the time changes or allowed for additional administration times for staff to pick and choose which times to administer the medication.

As documented above, on 3/13/21 the order was changed to reflect that the medication may also be administered via subcutaneous injection as the only change in the order. Again, this order did not change administration times. However review of Resident #4's March 2021 MAR revealed documented new administration times of 10:00 AM, 2:00 PM, and 8:00 PM.

There was no evidence that the physician was aware of or ordered this change in administration times.

Review of Resident #4's March 2021 MAR revealed that the doses that were administered between the 3/13/21 10:00 PM dose and 3/24/21 2:00 PM dose, were administered per this unapproved schedule change.

As previously documented, on 6/17/21 at 9:32 AM in an interview with ASM #2, she stated that the facility schedule for TID (3 times a day) medications was 6:00 AM, 2:00 PM, and 10:00

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PM. ASM #2 stated that "it was not ok for the staff to arbitrarily change these times to reflect a schedule that was not equally spaced without a physician's order to accommodate the RN's schedule and not the resident."

In addition Resident #4's March 2021 MAR did not provide any means to document which route the medication was provided at each administration. It could not be determined which times, if any, the medication was administered via IV, and which times, if any, the medication was administered via SQ, as it was ordered for either route.

1. C. The facility staff failed to consult, obtain an order for administering the medication Octreotide via a route that was not ordered by the physician and failed to notify the physician when the medication was not administered via the route and by a RN [registered nurse] as ordered.

A review of Resident #4's February and March 2021 MAR revealed the following:

The resident actually received a total of 64 doses of the medication. Of these 64 opportunities, 41 were administered by an LPN.

On 6/16/21 at 2:29 PM an interview was conducted with LPN #2, who was the LPN that administered the medication on 15 of the 41 times it was administered by an LPN. When asked if she was an RN, LPN #2 stated, "No." When asked if she was aware that only an RN was allowed to administer the medication, given the route and physician's order, she stated that

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she was aware. When asked why she administered the medication, she stated that when she looked up the medication, the drug book documented that it could be given IM (intramuscularly), so she administered it IM instead of IV, as she was an LPN and an LPN could not give a medication via IV route. When asked if she called the physician to clarify if it could be given IM and get an order for IM, she stated she had not. LPN #2 stated, "From my understanding (from reading the drug book), it could be given both ways. I gave it IM over 3 minutes. Every time I gave it, I gave it IM." When asked about education and training for administering this medication, she stated that she was not provided any training or education for administering this medication, but that "It was one I was not familiar with." When asked how the medication was provided by the pharmacy, LPN #2 stated, "In a liquid in a vial. It did not need to be mixed."

On 6/16/21 at 3:18 PM an interview was conducted with OSM #15, the Director of Pharmacy. She stated that she "Could not find any implications for giving the medication IM. There is no safety issues. However, given IM it is not as effective as IV or SQ."

On 6/16/21 at 11:44 AM in an interview with ASM #4, the Medical Director, he stated that this medication has never been used in this facility before.

On 6/17/21 at 4:28 PM in an interview with ASM #2, she stated that she did not know how all the other LPNs who administered this medication did it (IV or IM or SQ). ASM #2 stated that "There was one incident (date and time unknown) where

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the doctor was notified and the nurse obtained an order to administer IM." ASM #2 stated, "She was awaiting a statement from the physician [which was never provided by the end of survey]. However, no orders ever reflected this." ASM #2 stated that the physician should have been made aware of all the other times.

It was also noted that the March 2021 MAR did not provide any means to document which route the medication Octreotide was provided at each administration, when the order was changed on 3/13/21 to administer via IV or SQ. It could not be determined which times, if any, the medication was administered via IV, and which times, if any, the medication was administered via SQ, between 3/13/21 and 3/24/21, as it was ordered for either route, but, the order documented an RN had to administer medication. Of the 31 times the medication was administered after this order change on 3/13/21 through 3/24/21 allowing for either an IV or SQ route, an LPN administered the medication 23 times.

A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, the information on this medication documented that the IV push route was to be administered over 3 minutes. The information documented for administering via IM route did not document it had to be over 3 minutes. The IM route documented, "Reconstitute with diluent provided, give in gluteal region, rotate injection sites." This was not the form provided by the pharmacy or ordered by the physician.

In total, 15 different LPN's administered this medication, at least 9 of which were identified as agency nurses.

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There was no evidence that the physician was notified that LPNs were administering the medication instead of an RN, and that at least one LPN (LPN #2) altered the route of administration to IM without an order on 15 occasions.

A review of the facility policy, "Guidelines for Notifying Physicians of Clinical Problems" documented, "....Non-Immediate Notification Situations:....3. Other...c. Medication errors that have not affected an individual's physical or mental condition."

A review of the facility policy, "Administering Medications" documented, "Medications shall be administered in a safe and timely manner, and as prescribed.....1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so....3. Medications must be administered in accordance with the orders, including any required time frames....7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication....17. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be "flagged." After completing the medication pass, the nurse will return to the missed resident to administer the medication....18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...."

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A review of the facility policy, "Miscellaneous Special Situations - Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailable....B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medications. 3) Notify the pharmacy of the replacement order."

No further information was provided by the end of the survey.

Complaint Deficiency

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some

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unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels.

(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748

2. The facility staff failed to notify the physician that wound care was not provided as ordered on 6/13/21 for Resident #10.

Resident #10 was admitted to the facility on 3/28/12, with the diagnoses of but not limited to cerebrovascular disease, stroke, contracture, mood disorder, dementia, depression, high blood

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pressure, atrial fibrillation, and lumbar disc degeneration. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 4/12/21, coded Resident #10 as moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only.

A review of the clinical record revealed a nurse's note dated 6/11/21 that documented, "....Change In Condition:....Skin wound or ulcer....Sacrum has some excoriation noted to bilateral sacrum. Primary Care Provider Feedback....A. Recommendations: Metta (sic) honey (1) applied to both areas and cover with a bordered gauze dressing...."

Further review revealed an evaluation from the facility's wound care provider dated 6/11/21. This evaluation documented, "Length: 1.37 cm. Width 1.39 cm.... Depth 0.10 cm....Etiology: Pressure Ulcer - Stage 2....Dressings: Medihoney. Secondary Dressing - Bordered gauze...."

A review of the clinical record revealed a physician's order dated 6/11/21 for "Bilateral buttocks cleanse with NS (normal saline), apply medihoney, cover with boarder gauze...."

A review of the June 2021 TAR (Treatment Administration Record) revealed this treatment was not documented as being completed on 6/13/21.

On 6/14/21 at 3:29 PM, an interview was conducted with LPN #3 (Licensed Practical

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Nurse), the nurse who was assigned to Resident #10 on 6/13/21. When asked if she did the wound care on 6/13/21, LPN #3 stated, "I did not do the wound care. It was a really, really busy day. I had three hospice residents and a lot of family here. I didn't get to it. I don't believe I tried for it....I did not do the wound care." When asked if she notified anyone (the physician, nurse supervisor, the next shift nurse) LPN #3 stated, "I did not notify anyone that the wound care was not done." When asked if anyone should have been notified, LPN #3 stated, "Yes."

A review of the comprehensive care plan revealed one dated 11/11/20 for "At risk for alteration in skin integrity..." This care plan included an intervention dated 11/11/20 for "Treatment as ordered."

A review of the facility policy, "Wound Care" documented, "Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice."

A review of the facility policy, "Guidelines for Notifying Physicians of Clinical Problems" documented, "....Non-Immediate Notification Situations:....3. Other...c. Medication errors that have not affected an individual's physical or mental condition."

On 6/15/21 at 4:34 PM, ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings.

No further information was provided by the end of

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the survey.

References:

(1) MEDIHONEY® Gel Wound & Burn Dressing contains 100% active Leptospermum honey in a hydrocolloidal suspension. Supports the removal of necrotic tissue and aids in wound healing. Thicker consistency than MEDIHONEY® paste provides more stability.
Information obtained from https://www.woundsource.com/product/medihoney-gel-wound-burn-dressing

3. The facility staff failed to notify Resident # 2's responsible party of a urology appointment on 04/22/2021.

Resident # 2 was admitted to the facility with diagnoses that included but were not limited to: intellectual disabilities [1], legal blindness, vision loss and benign prostatic hyperplasia [2].

Resident # 2's most recent MDS (minimum data set) assessment, an admission assessment with an ARD (assessment reference date) of 04/21/2021, coded Resident # 2 as scoring a 6 [six] on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being severely impaired of cognition for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

The "Skilled Nursing Facility Transfer Report" for Resident # 2 dated 04/15/2021 from [Name of

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Hospital] documented in part, "Follow-up Information. Follow up with [Name] of Urology. Go on 4/22/2021 at 2:30 pm [Name of Doctor]."

The facility's unit 2 desk calendar documented in part,
"Friday, April 16. 2021. Transport [Name of Resident # 2] on 4-22-21."
"Thursday, April 22. 2021. [Name of Resident # 2] / 2:30pm [Urology Office Address. Name of Transport Company.] P/u [pick up] 1:30 [p.m.]."

The [Name of Urology] office note for Resident # 2 dated 04/22/2021 documented in part Resident # 2's past medical history, urinalysis results and impressions indicating Resident # 2 was seen by the urologist on 04/22/2021.

On 06/14/2021 at 1:25 p.m., an interview was conducted with OSM [other staff member] # 2, social worker regarding Resident # 2 being unaccompanied to their urology appointment and left in the doctor's office alone on 04/22/2021. When asked to describe the procedure for a resident that has an appointment outside the facility, OSM # 8 stated, "After the appointment is set, someone from the unit will contact the RP [responsible party] and ask who going to accompany the resident." In regard to Resident # 2, OSM # 2 stated, "I was brought in after he was already there. The urology office called us [facility] and said he [Resident # 2] couldn't be seen because no one was there with him. From what I understand the case manager from the group home did show up at the urology office."

On 06/15/2021 at 12:42 an interview was conducted with ASM [administrative staff member] # 2, director of nursing regarding the

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procedure of sending a resident out of the facility for an appointment. ASM # 2 stated, "We call the doctor's office for the appointment, notify the RP [responsible party] of the appointment and they are responsible if the resident needs assistance, if the RP states that they cannot attend [the appointment] we will try to send a staff member and the transportation gets arranged by the ward clerks." When asked who was responsible for the resident between the facility and the doctor's office if there is no one accompanying the resident, ASM # 2 stated the transport company. ASM # 2 further stated, "If we don't make the appointment we don't contact the RP."

On 06/15/2021 at 3:51 p.m., an interview was conducted with CNA [certified nursing assistant] # 8, ward clerk for unit number two. When asked to describe the process followed for residents who have appointments CNA # 8 stated, "I set up transportation for the appointments." When asked if they arranged the transportation for Resident # 2's urology appointment on 4/22/2021 CNA # 8 stated yes. When asked if they contacted Resident # 2's RP about the appointment CNA # 8 stated no.

On 6/16/2021 at 8:08 a.m. an interview was conducted with LPN [licensed practical nurse] # 5, nurse manager for unit number two, regarding the notification of Resident # 2's responsible party and the supervision of Resident # 2 for a urology appointment on 04/22/2021. When asked to describe the process followed when a resident is scheduled for an outside appointment, LPN # 5 stated, "If the resident is a new admission I go through the orders and if there are any appointments made I put it on my calendar for the

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ward clerk and I go back five to seven days on the calendar as a reminder so the ward clerk has time to set up transportation. If the resident is already here and it is a new order for an appointment I do the same thing, put it on my calendar for the ward clerk and I go back five to seven days on the calendar as a reminder so the ward clerk has time to set up transportation. I also call the RP [responsible party] and let them know when and where the scheduled appointment is and ask them if they want to transport the resident or have us set up transportation. I also ask the RP if they are going to the appointment, most of the time they meet the resident at the appointment." When asked to describe the procedure followed when the RP is unable to meet the resident at the appointment, LPN # 5 stated, "I contact [CNA (certified nursing assistant) # 3], scheduler, to see if they have staff to free up to go to the appointment, they have been able to do it a few times in the past." When asked about documentation that a resident's RP was contact prior to an appointment, LPN # 5 stated that it would be documented in the progress notes. LPN #5 was asked to review the progress notes for Resident # 2 dated 04/15/2021 through 04/30/2021. After reviewing the notes, LPN # 5 stated, "There's nothing documented about contacting the RP." When informed of the concern that Resident # 2 was sent to their urology appointment and left in the doctor's office unaccompanied, LPN # 5 stated, "The RP should have been contacted and someone should have met the resident at the office."

The facility's policy "Transportation, Appointment" documented, "Policy Statement: Our facility will assist residents in arranging transportation to/from appointments when necessary. Policy

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F 580	Continued From page 26 Interpretation and Implementation: 1. Should it become necessary to transport a resident to an appointment outside the facility, the Social Service Designee or Charge Nurse shall notify the resident's representative (sponsor) and inform them of the appointment. 2. The resident's representative (sponsor) will be responsible for transporting the resident to his or her appointment. 3. Should it become necessary for the facility to provide transportation, the Social Service Designee will be responsible for arranging the transportation through the business office. 4. Requests for transportation should be made as far in advance as possible. 5. The use of volunteers to transport residents to appointments must be approved by the Administrator." On 06/16/2021 at approximately 10:15 a.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing, were made aware of the above findings No further information was provided prior to exit.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at	F 607		7/28/21

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F 607	Continued From page 27 paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to implement the facility abuse policy to report and investigate allegations of abuse to the state agency for one of 12 residents in the survey sample, Resident #9. The facility staff failed to report and investigate two allegations of abuse made by Resident #9 to therapy staff on 12/7/20 and 2/19/21. The findings include: Resident #9 was admitted to the facility on 8/31/20, and most recently readmitted on 10/12/20, with diagnoses including, but not limited to HIV (human immunodeficiency virus) (1), anoxic brain injury (2), and quadriplegia (3). On the most recent MDS (minimum data set) assessment, a quarterly assessment dated 3/10/21, Resident #9 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). During the survey, multiple attempts were made to interview Resident #9 and the resident declined to be interviewed. A review of the facility policy, "Abuse Investigation and Reporting," revealed, in part: "All reports of resident abuse, neglect...shall be promptly reported to local, state, and federal agencies...and thoroughly investigated by facility management. Findings of abuse investigations will also be reported...All alleged violations	F 607	1. Resident #9 continues to reside in facility. His reported grievances have been reported and investigated. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all staff on types of abuse, responsibility to report immediately, but not later than 2 hours after the allegation is made. Facility administrator, DON and social workers will be educated on conducting complete and thorough investigation of all allegations of abuse. 4. Administrator or designee will randomly audit grievances weekly times 4 weeks and monthly times 2 to ensure that any grievances alleging abuse have been reported and investigated timely. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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involving abuse, neglect...will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility...An alleged violation...will be reported immediately, but not later than a. Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury."

A review of facility grievance records revealed, in part, the following:

"12/7/20...Individual initiating concern...[Resident #9]...Concern reported to [OSM (other staff member) #14)], PTA (physical therapy assistant)...Describe concern using factual terms...Pt (patient) expressed continued concern about a CNA (certified nursing assistant). Pt stated, 'He didn't bathe me or clean me...'Individual designated to take action on this concern: Given to DON (director of nursing)...Results of action taken: Unable to identify CNA."

"2/19/21...Individual initiating concern... [Resident #9]...Staff member OSM #14, PTA...Describe concern using factual terms...Resident stated he 'no longer wants to see the male CNA (certified nursing assistant) who has been giving me care on the 3 to 11:00 p.m. shift.' Resident stated the CNA 'is rough with me' during ADLs (activities of daily living)/repositioning and is occasionally unresponsive to his requests...Individual(s) assigned to take action on this concern: Given to DON (director of nursing)...Results of action taken: CNA to not see resident."

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The DON at the time of these grievance submissions was no longer employed at the facility.

On 6/15/21 at 3:29 p.m., OSM #14 was interviewed. He stated if a resident reports an allegation of abuse to him, he would fill out a grievance form right away. OSM #14 stated the form is a facility form. OSM #14 stated, "I think we need to report it within a couple of hours." He stated if it was an allegation of abuse, he would notify the social worker. When asked to give some examples of abuse, he stated hitting, pushing, or anything that is physical and malicious. When asked if failure to provide care is a type of abuse, OSM #14 stated it is. When shown the above referenced grievance form dated 12/7/20, OSM #14 stated he did not specifically remember the conversation with Resident #9. He stated he would not consider this allegation abuse; he stated he would consider it neglect. When asked about the 2/19/21 form, OSM #14 stated he probably should have been more specific. He stated the term 'rough with me' referred to the resident being 'turned too hard,' and there was no indication that the CNA was malicious in his action. He stated the resident told him that when the resident asked the CNA to be gentler with him, the CNA was not responsive to this request. He stated the DON was informed of this concern. When asked about the resident's dependencies, OSM #14 stated the resident has hypoxic-induced quadriplegia, no control of his lower extremities, and minimal control of his upper extremities. He stated the resident is completely reliant on staff to help him with all ADLs (activities of daily living).

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On 6/15/21 at 3:34 p.m., ASM (administrative staff member) #2, the DON, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated if anyone reported the information contained in the above referenced grievance forms to her, she would interview the resident and try to get more information. She stated she would try to track down the circumstances, and identify the particular staff members who were mentioned by the resident. ASM #2 stated she would try to determine what the resident meant by 'rough.' She stated based on those findings, if she thought there was an issue, she would notify the administrator and investigate further. ASM #3 stated she agreed with this. ASM #2 was asked if these concerns should be reported to the state agency, ASM #2 stated, "If a resident is being harmed or any type of abuse" She stated, "If the resident says he feels like he was intentionally treated, I would say it is abuse." ASM #2 stated the facility has two hours to report an allegation of abuse to the state agency. When shown the 12/7/20 grievance form, ASM #2 stated this should have been investigated immediately and reported within two hours. When shown the 2/19/21 grievance form, ASM #2 stated this also should have been investigated and reported as an allegation of abuse or neglect. ASM #3 stated, "As the regional, I was not aware of this...This should have been reported."

On 6/16/21 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. ASM #1 stated he has only been employed in his current position for a few weeks, and was not working at the facility at the time of the grievance concerns reported by Resident #9.

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F 607	Continued From page 31 No further information was provided prior to exit. References: (1) "HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection." This information is taken from the website https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hivaids-basics. (2) "Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury or insult, or cardiac arrest." This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK539833/. (3) "Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury or insult, or cardiac arrest." This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK539833/.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		7/28/21

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F 609	Continued From page 32 §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. §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: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure reporting and investigation of allegations of abuse for one of 12 sampled residents, (Resident #9). The facility staff failed to report to the State Agency and other officials and failed to investigate two allegations of abuse made by Resident #9 to therapy staff on 12/7/20 and 2/19/21. The findings include:	F 609	1. Resident #9 continues to reside in facility. His reported grievances have been reported and investigated. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all staff on types of abuse, responsibility to report immediately, but not later than 2 hours after the allegation is made. Facility administrator, DON and social workers will be educated on conducting complete and thorough investigation of all allegations of abuse.	

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F 609	Continued From page 33 Resident #9 was admitted to the facility on 8/31/20, and most recently readmitted on 10/12/20, with diagnoses including, but not limited to HIV (human immunodeficiency virus) (1), anoxic brain injury (2), and quadriplegia (3). On the most recent MDS (minimum data set), a quarterly assessment dated 3/10/21, he was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). Multiple attempts were made to interview Resident #9 during the survey. The resident declined to be interviewed. A review of facility grievance records revealed, in part, the following: "12/7/20...Individual initiating concern...[Resident #9]...Concern reported to [OSM (other staff member) #14)], PTA (physical therapy assistant)...Describe concern using factual terms...Pt (patient) expressed continued concern about a CNA (certified nursing assistant). Pt stated, 'He didn't bathe me or clean me...'Individual designated to take action on this concern: Given to DON (director of nursing)...Results of action taken: Unable to identify CNA." "2/19/21...Individual initiating concern... [Resident #9]...Staff member OSM #14, PTA...Describe concern using factual terms...Resident stated he 'no longer wants to see the mal CNA (certified nursing assistant) who has been giving me care on the 3 to 11:00 p.m. shift.' Resident stated the CNA 'is rough with me' during ADLs (activities of daily living)/repositioning and is occasionally unresponsive to his requests...Individual(s)	F 609	4. Administrator or designee will randomly audit grievances weekly times 4 weeks and monthly times 2 to ensure that any grievances alleging abuse have been reported and investigated timely. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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assigned to take action on this concern: Given to DON (director of nursing)...Results of action taken: CNA to not see resident."

The DON at the time of these grievance submissions no longer works at the facility.

On 6/15/21 at 3:29 p.m., OSM #14 was interviewed. He stated if a resident reports an allegation of abuse to him, he would fill out a grievance form right away. OSM #14 stated the form is a facility form. OSM #14 stated, "I think we need to report it within a couple of hours." He stated if it was an allegation of abuse, he would notify the social worker. When asked to give some examples of abuse, he stated hitting, pushing, or anything that is physical and malicious. When asked if failure to provide care is a type of abuse, OSM #14 stated it is. When shown the above referenced grievance form dated 12/7/20, OSM #14 stated he did not specifically remember the conversation with Resident #9. He stated he would not consider this allegation abuse; he stated he would consider it neglect. When asked about the 2/19/21 form, OSM #14 stated he probably should have been more specific. He stated the term 'rough with me' referred to the resident being 'turned too hard,' and there was no indication that the CNA was malicious in his action. He stated the resident told him that when the resident asked the CNA to be gentler with him, the CNA was not responsive to this request. He stated the DON was informed of this concern. When asked about the resident's dependencies, OSM #14 stated the resident has hypoxic-induced quadriplegia, no control of his lower extremities, and minimal control of his upper extremities. He stated the resident is completely reliant on staff to help him with all

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ADLs (activities of daily living).

On 6/15/21 at 3:34 p.m., ASM (administrative staff member) #2, the DON, and ASM #3, the regional director of clinical services, were interviewed. ASM #2 stated if anyone reported the information contained in the above referenced grievance forms to her, she would interview the resident and try to get more information. She stated she would try to track down the circumstances, and identify the particular staff members who were mentioned by the resident. ASM #2 stated she would try to determine what the resident meant by 'rough.' She stated based on those findings, if she thought there was an issue, she would notify the administrator and investigate further. ASM #3 stated she agreed with this. ASM #2 was asked if these concerns should be reported to the state agency, ASM #2 stated, "If a resident is being harmed or any type of abuse" She stated, "If the resident says he feels like he was intentionally treated, I would say it is abuse." ASM #2 stated the facility has two hours to report an allegation of abuse to the state agency. When shown the 12/7/20 grievance form, ASM #2 stated this should have been investigated immediately and reported within two hours. When shown the 2/19/21 grievance form, ASM #2 stated this also should have been investigated and reported as an allegation of abuse or neglect. ASM #3 stated, "As the regional, I was not aware of this...This should have been reported."

A review of the facility policy, "Abuse Investigation and Reporting," revealed, in part: "All reports of resident abuse, neglect...shall be promptly reported to local, state, and federal agencies...and thoroughly investigated by facility

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management. Findings of abuse investigations will also be reported...All alleged violations involving abuse, neglect...will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The state licensing/certification agency responsible for surveying/licensing the facility...An alleged violation...will be reported immediately, but not later than a. Two hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or b. Twenty-four hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury."

On 6/16/21 at 5:15 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. ASM #1 stated he has only been employed in his current position for a few weeks, and was not working at the facility at the time of the grievance concerns reported by Resident #9.

No further information was provided prior to exit.

References:
(1) "HIV is the virus that causes HIV infection. AIDS is the most advanced stage of HIV infection." This information is taken from the website https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hivaids-basics.

(2) "Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury or insult, or cardiac arrest." This information is taken from the website

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F 609	Continued From page 37 https://www.ncbi.nlm.nih.gov/books/NBK539833/. (3) "Anoxic encephalopathy, or hypoxic-ischemic brain injury, is a process that begins with the cessation of cerebral blood flow to brain tissue, which most commonly results from poisoning, as is the case, for example with carbon monoxide poisoning or drug overdose, vascular injury or insult, or cardiac arrest." This information is taken from the website https://www.ncbi.nlm.nih.gov/books/NBK539833/.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-	F 655		7/28/21

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F 655	Continued From page 38 (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop a baseline care plan for one of 12 residents in the survey sample, Resident #4. The facility staff failed to develop a baseline care plan for Resident #4 to address the use, administration and monitoring criteria of the physician prescribed medication Octreotide. (1) The findings include: A review of the facility policy, "Care Plans - Baseline" documented, "A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight (48)	F 655	1. Resident #4 no longer resides in facility. 2. All residents newly admitted to the facility have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that a baseline care plan must be developed for each resident within 48 hours of admission to the facility and is separate from the comprehensive care plan, and that the baseline care plan must address the care to meet the resident□s immediate needs. 4. DON or designee will randomly audit baseline care plans weekly times 4 weeks and monthly times 2 to ensure residents have a baseline care plan present and developed appropriately. Any identified issues will be immediately corrected.	

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F 655	Continued From page 39 hours of admission." Note: The facility's care plan was maintained electronically, started at admission as the baseline, and further developed into the comprehensive care plan. They were not maintained as 2 separate care plans. Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) assessment, an admission assessment with an ARD (Assessment Reference Date) of 3/2/21, coded Resident #4 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene. A review of the clinical record revealed physician's orders as follows: A hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..." Note: The resident had a PICC [peripherally inserted central catheter] (2) line IV site. On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."	F 655	Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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F 655	Continued From page 40	F 655		

On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI (gastrointestinal) Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

On 6/16/21 at 11:44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy (which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer.

A review of the February and March 2021 MAR revealed the resident actually received a total of 64 doses of the medication.

A review of the clinical record failed to reveal any

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F 655	Continued From page 41	F 655		

evidence that the use of this medication, an IV medication, along with its associated administration and monitoring requirements related to the criteria of an RN only administration, and associated side effects and complications, was ever developed or addressed on Resident #4's care plan, either the admission baseline care plan or the comprehensive care plan.

A review of the care plan revealed the following: One dated 3/12/21, (resident was admitted on 2/24/21 with the IV site in place) for "Potential for complications at IV insertion site...." This care plan only included interventions related to the IV site, dressing, and tubing management and did not include any interventions related to the use, and the administration and monitoring requirements of the physician prescribed medication Octreotide.

One dated 2/25/21 for "At risk for falls due to unsteady gait, generalized weakness, new environment, medication side effect." Interventions included one dated 2/25/21 to "Administer medication per physician's order." There were no interventions related to the use, administration and monitoring requirements of the physician prescribed medication Octreotide.

One dated 3/12/21 (resident was admitted on 2/24/21 with the ostomy site in place) for "Bowel Ostomy related to disease process cancer Resident fondles with ostomy appliances." The resident was on the Octreotide related to the presence of the ostomy. The care plan did not include any interventions related to the use, and the administration and monitoring requirements of the physician prescribed medication Octreotide.

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F 655	Continued From page 42	F 655		

One dated 3/12/21 (resident was admitted on 2/24/21 with a risk for GI distress) for "G.I. distress related to nausea/vomiting." Interventions included interventions dated 3/12/21 for "Administer medications per physician orders" and "Evaluate medications, diet, environment and lab results for possible causes." The interventions did not include any interventions related to the use, and the administration and monitoring requirements of the Octreotide.

On 6/16/21 at 3:00 PM an interview was conducted with RN #2 (Registered Nurse), the QA nurse (Quality Assurance). RN #2 stated a care plan should have been developed regarding the use of any IV medication; and for a medication that had not been used in the facility before, which the staff was not familiar with, and that required specific administration and monitoring criteria. RN #2 stated there definitely should have been a care plan.

On 6/17/21 at 4:28 PM in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing) she stated that it should have been care planned. ASM #2 stated she reviewed Resident #4's care plan and it was not done.

No further information was provided by the end of the survey.

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for

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F 655	Continued From page 43 symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels. (2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748	F 655		
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	F 656		7/28/21

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F 656	Continued From page 44 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 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 staff interview, facility document	F 656	1. Residents #4 and #5 no longer reside	

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F 656	Continued From page 45 review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to develop and/or implement the comprehensive care plan for three of 12 residents in the survey sample, Residents #4, #10 and #5. 1. The facility staff failed to develop a comprehensive care plan for the use, administration and monitoring criteria of Octreotide (1) for Resident #4. 2. The facility staff failed to implement the comprehensive care plan for the provision of wound care to Resident #10 on 6/13/21. 3. The facility failed to implement the comprehensive care plan for the administration of medications to Resident #5 as ordered by the physician on 2/19/21 and 2/20/21. The findings include: 1. Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) assessment, an admission assessment with an ARD (Assessment Reference Date) of 3/2/21, coded Resident #4 as cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene.	F 656	in facility. The care plan of resident #10 has been reviewed to ensure comprehensive care plan has been developed and implemented. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that care plans should be comprehensive to include the provision of wound care and the administration of medications, and also must be implemented. 4. DON or designee will randomly audit care plans and related MARs and TARs weekly times 4 weeks and monthly times 2 to ensure that care plans address provision of wound care, medication administration and are being implemented. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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A review of the facility policy, Care Plans, Comprehensive Person-Centered" documented, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet a resident's physical, psychosocial and functional needs is developed and implemented for each resident....Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change...."

A review of the clinical record revealed physician's orders as follows:

A hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..." Note: The resident had a PICC [peripherally inserted central catheter] (2) line IV [IV [intravenous line] site.

On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."

On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a

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day for GI (gastrointestinal) Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

On 6/16/21 at 11:44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy (which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer.
A review of the February and March 2021 MAR revealed the resident actually received a total of 64 doses of the medication.

A review of the clinical record failed to reveal any evidence that the use of this medication, an IV medication, along with its associated administration and monitoring requirements related to the criteria of an RN only administration, and associated side effects and complications, was ever developed on care plan, either the admission baseline care plan or the comprehensive care plan.

A review of the care plan revealed the following:

One dated 3/12/21 (resident was admitted on 2/24/21 with the IV site in place) for "Potential for

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complications at IV insertion site...." This care plan only included interventions related to the IV site, dressing, and tubing management and did not include any interventions related to the use, and the administration and monitoring requirements of the Octreotide.

One dated 2/25/21 for "At risk for falls due to unsteady gait, generalized weakness, new environment, medication side effect." Interventions included one dated 2/25/21 to "Administer medication per physician's order." It did not include any interventions related to the use, and the administration and monitoring requirements of the Octreotide.

One dated 3/12/21 (resident was admitted on 2/24/21 with the ostomy site in place) for "Bowel Ostomy related to disease process cancer Resident fondles with ostomy appliances." The resident was on the Octreotide related to the presence of the ostomy. It did not include any interventions related to the use, and the administration and monitoring requirements of the Octreotide.

One dated 3/12/21 (resident was admitted on 2/24/21 with a risk for GI distress) for "G.I. distress related to nausea/vomiting." Interventions included interventions dated 3/12/21 for "Administer medications per physician orders" and "Evaluate medications, diet, environment and lab results for possible causes." The interventions did not include any interventions related to the use, and the administration and monitoring requirements of the Octreotide.

On 6/16/21 at 3:00 PM in an interview with RN #2

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(Registered Nurse), the QA nurse (Quality Assurance) she stated that a care plan should have been developed regarding the use of any IV medication; and for a medication that had not been used in the facility before, for which the staff was not familiar with, and required specific administration and monitoring criteria, there definitely should have been a care plan.

On 6/17/21 at 4:28 PM in an interview with ASM #2 (Administrative Staff Member, the Director of Nursing) she stated that it should have been care planned. ASM #2 stated she reviewed Resident #1's care plan and it was not done.

No further information was provided by the end of the survey.

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels.

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(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748.

2. Resident #10 was admitted to the facility on 3/28/12, with the diagnoses of but not limited to cerebrovascular disease, stroke, contracture, mood disorder, dementia, depression, high blood pressure, atrial fibrillation, and lumbar disc degeneration. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 4/12/21, coded Resident #10 as moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only.

A review of the comprehensive care plan revealed one dated 11/11/20 for "At risk for alteration in skin integrity..." This care plan included an intervention dated 11/11/20 for "Treatment as ordered."

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A review of the clinical record revealed an evaluation from the facility's wound care provider dated 6/11/21. This evaluation documented, "Length: 1.37 cm. Width 1.39 cm.... Depth 0.10 cm....Etiology: Pressure Ulcer - Stage 2....Dressings: Medihoney (1). Secondary Dressing - Bordered gauze...."

Further review of the clinical record revealed a physician's order dated 6/11/21 for "Bilateral buttocks cleanse with NS (normal saline), apply medihoney, cover with boarder gauze...."

A review of the June 2021 TAR (Treatment Administration Record) on 6/14/21 revealed this treatment was not documented as being completed on 6/13/21.

On 6/14/21 at 3:29 PM, an interview was conducted with LPN #3 (Licensed Practical Nurse), the nurse who was assigned to Resident #10 on 6/13/21. When asked if she did the wound care on 6/13/21, LPN #3 stated, "I did not do the wound care. It was a really, really busy day. I had three hospice residents and a lot of family here. I didn't get to it. I don't believe I tried for it....I did not do the wound care." When asked if she notified anyone (the physician, nurse supervisor, the next shift nurse) LPN #3 stated, "I did not notify anyone that the wound care was not done." When asked if anyone should have been notified, LPN #3 stated, "Yes." When asked if Resident #10's care plan was followed, LPN #3 stated that it was not.

On 6/15/21 at 4:34 PM, ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was

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provided by the end of the survey.

References:

(1) MEDIHONEY® Gel Wound & Burn Dressing contains 100% active Leptospermum honey in a hydrocolloidal suspension. Supports the removal of necrotic tissue and aids in wound healing. Thicker consistency than MEDIHONEY® paste provides more stability.
Information obtained from https://www.woundsource.com/product/medihoney-gel-wound-burn-dressing

3. Resident #5 was admitted to the facility on 2/8/21. Resident #5's diagnoses included but were not limited to: pulmonary embolus (blockage of pulmonary artery by foreign matter or thrombus 'blood clot') (1), respiratory failure (inability of the heart and lungs to maintain adequate gas exchange) (2) and dementia (progressive state of mental decline) (3).

Resident #5's most recent MDS (minimum data set) assessment, a 5 day admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status: coded the resident as extensive assistance with bed mobility, transfers, locomotion, dressing, personal hygiene and bathing; eating is independent and walking did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as receiving oxygen therapy.

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Resident #5's comprehensive care plan dated 2/13/21, documented in part, "FOCUS-At risk for falls due to impaired balance/poor coordination. Resident at risk for increase bleeding and bruising due to Rivaroxaban (anticoagulant) (4) usage. INTERVENTIONS-Administer medications per physician orders."

The physician orders dated 2/8/21, documented in part, "Rivaroxaban (anticoagulant) (4) give 20 milligram by mouth in the evening for DVT (deep vein thrombosis) prophylaxis. Gabapentini (antiepileptic and neuralgia) (5) 300 milligram capsule, give 1 capsule by mouth two times a day for neuralgia. Levothyroxine (thyroid hormone) (6) tablet 25 micrograms by mouth in the morning for hypothyroidism."

A review of the MAR (medication administration record) for Resident #5 with start dates of 2/9/21, failed to evidence documentation for the administration of Rivaroxaban 20 milligram in the evening of 2/19/21, Gabapentin 300 milligram in the evening of 2/19/21 and Levothyroxine 25 micrograms in the morning of 2/20/21.

A review of the nursing progress notes dated 2/20/21 at 1:32 PM, documented in part, "Resident pronounced at 1:32 PM."

An interview was conducted on 6/14/21 at 1:53 PM with LPN (licensed practical nurse) #2. When asked the purpose of the comprehensive care plan, LPN #2 stated, "The purpose is to direct the plan of care for the resident." When asked what blanks on the MAR mean, LPN #2 stated, "It could mean that the meds [medications] weren't documented or that they weren't given." When

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asked what blank documentation means, LPN #2 stated, "It usually means if it wasn't documented, it wasn't done."

An interview was conducted on 6/15/21 at 3:45 PM with ASM (administrative staff member) #2, the director of nursing. When asked the purpose of the comprehensive care plan, ASM #2 stated, "The care plan is individualized to the unique needs of the resident". When asked what it means if there is blank documentation on the MAR, ASM #2 stated, "Blank documentation means there is no way to prove it was given".

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concern on 4/21/21 at 5:40 PM.

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 6/15/21 at 4:45 PM.

The facility's "Using the Care Plan" policy dated 8/2016, documents in part, "Documentation must be consistent with the resident's care plan".

The facility's "Care Plans, Comprehensive Person-Centered" policy dated 12/2016, documents in part, "Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making."

No further information was provided.

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F 656	Continued From page 55 References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 482. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (4) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 338. (5) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 168. (6) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 215.	F 656		
F 658 SS=E	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 staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to follow professional standards of practice for one of 12 residents in the survey sample; Resident #4. 1A. The facility staff failed to follow professional standards of practice for clarifying a physician's order for the proper route of administration of a medication; and (B) when an IV medication was administered by an LPN (Licensed Practical	F 658	1. Resident #4 no longer resides in the facility. 2. All residents requiring specialized care that may be unfamiliar to facility staff have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all facility nurses providing specialized care to residents to ensure that they understand the provision of care. 4. DON or designee will audit orders of residents requiring specialized care and	7/28/21

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F 658	Continued From page 56 Nurse) instead of an RN (Registered Nurse) as ordered by the physician; and the LPN administered it by the incorrect route without an order. The findings include: Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) was an Admission assessment with an ARD (Assessment Reference Date) of 3/2/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene. 1A. The facility staff failed to clarify the physician's order for what method of IV administration Octreotide was to be administered (IV push or intermittent IV route). A review of the clinical record revealed a hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..." Note: The resident had a PICC (2) line IV site. This order did not clarify what IV method to utilized; via IV push over 3 minutes, or via	F 658	related MARs weekly times 4 weeks and monthly times 2 to ensure facility staff are following orders and working within their scope of practice. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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intermittent infusion of a specific amount of milliliters over a specified period of time.

(1) According to the facility's drug book, Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide is used to treat symptoms of carcinoid tumors and vasoactive intestinal peptide tumors. This medication may be administered via IV, SQ, or IM (intramuscularly). It was documented that the IV route may be administered via direct IV over 3 minutes, or by an intermittent route diluted in 50 to 200 milliliters of an IV fluid and administered over 15 to 30 minutes.

A review of the physician's orders revealed the following:

On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."

On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

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On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

None of the above orders clarified what IV infusion method was to be utilized.

A review of the pharmacy manifests dated 2/25/21, 3/11/21 and 3/23/21 revealed the medication was provided in single dose vials.

Further review of the clinical record failed to reveal any evidence that the facility staff ever obtained any clarification from the physician as to which IV route was intended.

On 3/16/21 at 3:27 PM an interview was conducted with LPN #11 (Licensed Practical Nurse). She stated that she was the nurse supervisor at the time Resident #4 was admitted. LPN #11 stated she entered the orders on admission. She stated that she did not clarify if it should be push or pump. LPN #11 stated that she just put the orders in as it was written on the hospital record. She stated that it should be clarified if required pieces of information are not included in an order. She stated that she never administered the medication because "everyone knew that an RN had to administer it because it was being given via IV push."

A review of facility policies for "Administering Medications" and "Guidelines for Notifying Physicians of Clinical Problems" did not include any direction for clarifying incomplete or unclear

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F 658	Continued From page 59 orders. According to Fundamentals of Nursing, Lippincott, Williams & Wilkins 5th edition, 2007, page 553, was documented, "Always clarify with the prescriber any medication order that is unclear or seems inappropriate." On 6/17/21 at 4:28 PM in a end of day meeting, ASM #1 and ASM #2 (Administrative Staff Member, the Administrator and Director of Nursing) was made aware of the findings. No further information was provided. 1B. The facility staff failed to follow Professional Standards of Practice when an IV medication was administered by an LPN (Licensed Practical Nurse) instead of an RN (Registered Nurse) as ordered by the physician; and the LPN administered it by the incorrect route without an order. According to the practical nursing (LPN) website https://www.practicalnursing.org/can-lpns-administer-medication, it was documented under "Medications You Cannot Administer" that, "The Licensed Practical Nurse is not permitted to give any type of drug through an IV line (depending on the state). The LPN may flush a peripheral IV line in preparation for the Registered Nurse to give an IV medication, but the LPN cannot actually give it....Different employers have different regulations. For some medications that you could freely give at one institution, another employer may require you to undergo some type of training before you can actually administer it. RNs are able to give medications with a higher risk of unknown	F 658		

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outcomes such as IV medications, while it would be out of the scope of practice for LPNs...."

A review of the February and March 2021 MAR revealed the following:

The resident actually received a total of 64 doses of the medication. Of these 64 opportunities, 41 were administered by an LPN.

On 6/16/21 at 2:29 PM an interview was conducted with LPN #2, who was the LPN that administered the medication on 15 of the 41 times it was administered by an LPN. When asked if she was an RN, LPN #2 stated, "No." When asked if she was aware that only an RN was allowed to administer the medication, given the route and physician's order, she stated that she was aware. When asked why she administered the medication, LPN #2 stated that when she looked up the medication, the drug book documented that it could be given IM (intramuscularly), so she administered it IM instead of IV, as she was an LPN and an LPN could not give a medication via IV route. When asked if she called the physician to clarify if it could be given IM and to obtain an order for IM administration of the medication, she stated she had not. LPN #2 stated, "From my understanding (from reading the drug book), it could be given both ways. I gave it IM over 3 minutes. Every time I gave it, I gave it IM." When asked about education and training for administering this medication, LPN #2 stated that she was not provided any training or education for administering this medication, but that "It was one I was not familiar with." When asked how was the medication provided by the pharmacy, LPN #2 stated, "In a liquid in a vial. It did not need to

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be mixed."

On 6/16/21 at 11:44 AM in an interview with ASM #4, the Medical Director, he stated that this medication has never been used in this facility before.\

On 6/16/21 at 3:18 PM an interview was conducted with OSM #15, the Director of Pharmacy. She stated that she "Could not find any implications for giving the medication IM. There is no safety issues. However, given IM it is not as effective as IV or SQ."

A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, the information on this medication documented that the IV push route was to be administered over 3 minutes. The information documented for administering via IM route did not document it had to be over 3 minutes. The IM route documented, "Reconstitute with diluent provided, give in gluteal region, rotate injection sites." This was not the form provided by the pharmacy or ordered by the physician.

On 6/17/21 at 4:28 PM in an interview with ASM #2, she stated that she did not know how all the other LPNs who administered this medication did it (IV or IM or SQ). ASM #2 stated that "There was one incident (date and time unknown) where the doctor was notified and the nurse obtained an order to administer IM." ASM #2 stated, "She was awaiting for a statement from the physician [which was never provided by the end of survey]." However, no orders ever reflected this and ASM #2 stated that the physician should have been made aware of all the other times.

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It was also noted that the March 2021 MAR did not provide any means to document which route was provided at each administration, when the order was changed on 3/13/21 to administer via IV or SQ. It could not be determined which times, if any, the medication was administered via IV, and which times, if any, the medication was administered via SQ, between 3/13/21 and 3/24/21, as it was ordered for either route, but, an RN had to administer it. Of the 31 times the medication was administered after this order change on 3/13/21 through 3/24/21 allowing for either an IV or SQ route, an LPN administered the medication 23 times.

In total, 15 different LPN's administered this medication, at least 9 of which were identified as agency nurses.

There was no evidence that the physician was notified that LPNs were administering the medication instead of an RN, and that at least one LPN (LPN #2) altered the route of administration to IM without an order on 15 occasions.

A review of the facility policy, "Guidelines for Notifying Physicians of Clinical Problems" documented, "....Non-Immediate Notification Situations:....3. Other...c. Medication errors that have not affected an individual's physical or mental condition."

A review of the facility policy, "Administering Medications" documented, "Medications shall be administered in a safe and timely manner, and as prescribed.....1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so....3. Medications must be administered in

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accordance with the orders, including any required time frames....7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication....17. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be "flagged." After completing the medication pass, the nurse will return to the missed resident to administer the medication....18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...."

A review of the facility policy, "Miscellaneous Special Situations - Unavailable Medications" documented, "Medications used by residents in the nursing facility may be unavailable for dispensing from the pharmacy on occasion. This situation may be due to the pharmacy being temporarily out of stock of a particular product, a drug recall, manufacturer's shortage of an ingredient, or the situation may be permanent because the drug is no longer being made. The facility must make every effort to ensure that medications are available to meet the needs of each resident. A. The pharmacy staff shall: 1) Call or notify nursing staff that the ordered product(s) is/are unavailable....B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the facility Medical Director for orders

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and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medications. 3) Notify the pharmacy of the replacement order."

No further information was provided by the end of the survey.

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels.

(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of

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F 658	Continued From page 65 irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure treatment and care in accordance with professional standards of practice, and the comprehensive person-centered care plan for two of 12 residents in the survey sample, (Residents #4 and #5). The facility staff failed to administer Octreotide as ordered for Resident #4 and failed to administer physician prescribed medications to Resident #5 as ordered on 2/19/21 and 2/20/21. The findings include:	F 684	1. Residents #4 and #5 no longer reside in the facility. 2. All residents have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses on completing MAR documentation daily, following orders, and ensuring that they practice within their scope of practice. 4. DON or designee will randomly audit MARs weekly times 4 weeks and monthly times 2 to ensure timely documentation, medication is administered as ordered, at correct times, and by appropriate staff. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months.	7/28/21

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F 684	Continued From page 66 1. Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) was an Admission assessment with an ARD (Assessment Reference Date) of 3/2/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene. A review of the clinical record revealed a hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..." Note: The resident had a PICC (2) line IV site. A review of the physician's orders revealed the following: On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer." On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN	F 684	5. Date of compliance will be July 28, 2021.	

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(Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

Note: On 6/16/21 at 11:44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy (which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer.)

On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

A review of the February and March 2021 MAR (Medication Administration Record) revealed the following:

February 2021:

On 2/26/21 at 6:00 AM, the dose of Octreotide was not administered. A review of the nurses notes documented, "pending pharmacy deliver." However, as the medication was delivered at 11:00 AM on 2/25/21, it was available to be

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administered at this time.

March 2021:

1. Missing documentation:

On 5 occasions, on 3/3/21 at 6:00 AM, 3/5/21 at 6:00 AM and 10:00 PM, 3/6/21 at 10:00 PM, and 3/10/21 at 2:00 PM, the medication was not initialed as given, and was not documented as not given for some reason. The spot for documenting this administration was left blank. There were no supporting nurses notes regarding this administration.

On 6/16/21 at 4:30 PM in an interview with ASM #2, (Administrative Staff Member), the Director of Nursing, she stated that "If there are holes I can't determine if they gave it are not." When asked what does holes on the MAR mean, she stated, "If it was not documented, it was not administered."

2. Improper administration route / staff credentials:

A review of the February and March 2021 MAR revealed the following:

The resident actually received a total of 64 doses of the medication. Of these 64 opportunities, 41 were administered by an LPN.

On 6/16/21 at 2:29 PM an interview was conducted with LPN #2, who was the LPN that administered the medication on 15 of the 41 times it was administered by an LPN. When

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asked if she was an RN, she stated, "No." When asked if she was aware that only an RN was allowed to administer the medication, given the route and physician's order, she stated that she was aware. When asked why she administered it, she stated that when she looked up the medication, the drug book documented that it could be given IM (intramuscularly), so she administered it IM instead of IV, as she was an LPN and an LPN could not give a medication via IV route. When asked if she called the physician to clarify if it could be given IM and get an order for IM, she stated she had not. She stated, "From my understanding (from reading the drug book), it could be given both ways. I gave it IM over 3 minutes. Every time I gave it, I gave it IM." When asked about education and training for administering this medication, she stated that she was not provided any training or education for administering this medication, but that "It was one I was not familiar with." When asked how was the medication provided by the pharmacy, she stated, "In a liquid in a vial. It did not need to be mixed."

Note: A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, the information on this medication documented that the IV push route was to be administered over 3 minutes. The information documented for administering via IM route did not document it had to be over 3 minutes. The IM route documented, "Reconstitute with diluent provided, give in gluteal region, rotate injection sites." This was not the form provided by the pharmacy or ordered by the physician.

On 6/17/21 at 4:28 PM in an interview with ASM

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#2, she stated that she did not know how all the other LPNs who administered this medication did it (IV or IM or SQ). She stated that "There was one incident (date and time unknown) where the doctor was notified and the nurse obtained an order to administer IM." She stated she was awaiting for a statement from the physician (which was never provided by the end of survey). However, no orders ever reflected this and she stated that the physician should have been made aware of all the other times.

It was also noted that the March 2021 MAR did not provide any means to document which route was provided at each administration, when the order was changed on 3/13/21 to administer via IV or SQ. It could not be determined which times, if any, the medication was administered via IV, and which times, if any, the medication was administered via SQ, between 3/13/21 and 3/24/21, as it was ordered for either route, but, an RN had to administer it. Of the 31 times the medication was administered after this order change on 3/13/21 through 3/24/21 allowing for either an IV or SQ route, an LPN administered the medication 23 times.

In total, 15 different LPN's administered this medication, at least 9 of which were identified as not being facility staff, but were agency nurses.

There was no evidence that the physician was notified that LPNs were administering the medication instead of an RN, and that at least one LPN (LPN #2) altered the route of administration to IM without an order on 15 occasions.

No further information was provided by the end of

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the survey.

Related policies:

A review of the facility policy, "Administering Medications" documented, "Medications shall be administered in a safe and timely manner, and as prescribed.....1. Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so....3. Medications must be administered in accordance with the orders, including any required time frames....7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication....17. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be "flagged." After completing the medication pass, the nurse will return to the missed resident to administer the medication....18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose...."

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication

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documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels.

(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748

COMPLAINT DEFICIENCY

2. Resident #5 was admitted to the facility on 2/8/21. Resident #5's diagnoses included but were not limited to: pulmonary embolus (blockage of pulmonary artery by foreign matter or thrombus 'blood clot') (1), respiratory failure (inability of the heart and lungs to maintain

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adequate gas exchange) (2) and dementia (progressive state of mental decline) (3).

Resident #5's most recent MDS (minimum data set) assessment, a 5 day admission assessment, with an assessment reference date of 2/13/21, coded the resident as scoring 04 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. MDS Section G- Functional Status: coded the resident as extensive assistance with bed mobility, transfers, locomotion, dressing, personal hygiene and bathing; The resident was coded as independent for eating and walking did not occur. A review of MDS Section O- Special treatments, procedures and programs: coded the resident as receiving oxygen therapy.

A review of Resident #5's comprehensive care plan dated 2/13/21, documented in part, "FOCUS-At risk for falls due to impaired balance/poor coordination. Resident at risk for increase bleeding and bruising due to Rivaroxaban (anticoagulant) (4) usage. INTERVENTIONS-Administer medications per physician orders."

The physician orders dated 2/8/21, documented in part, "Rivaroxaban (anticoagulant) (4) give 20 milligram by mouth in the evening for DVT (deep vein thrombosis) prophylaxis. Gabapentini (antiepileptic and neuralgia) (5) 300 milligram capsule, give 1 capsule by mouth two times a day for neuralgia. Levothyroxine (thyroid hormone) (6) tablet 25 micrograms by mouth in the morning for hypothyroidism.

A review of Resident #5's MAR (medication administration record) with start dates of 2/9/21,

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failed to evidence documentation for the administration of Rivaroxaban 20 milligram in the evening of 2/19/21, Gabapentin 300 milligram in the evening of 2/19/21 and Levothyroxine 25 micrograms in the morning of 2/20/21.

A review of the nursing progress notes dated 2/20/21 at 1:32 PM, documented in part, "Resident pronounced at 1:32 PM."

An interview was conducted on 6/14/21 at 1:53 PM with LPN (licensed practical nurse) #2. When asked what blanks on the MAR mean, LPN #2 stated, "It could mean that the meds [medications] weren't documented or that they weren't given." When asked what blank documentation means, LPN #2 stated, "It usually means if it wasn't documented, it wasn't done." When asked if the nurse is responsible for documenting medication administration, LPN #2 stated, "Yes, the nurse is responsible".

An interview was conducted on 6/15/21 at 3:45 PM with ASM (administrative staff member) #2, the director of nursing. When asked what it means if there is blank documentation on the MAR, ASM #2 stated, "Blank documentation means there is no way to prove it was given".

ASM #1, the administrator, ASM #2, the director of nursing and ASM #3, the quality consultant, were made aware of the above concern on 4/21/21 at 5:40 PM.

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 6/15/21 at 4:45 PM.

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F 684	Continued From page 75 The facility's "Administering Medications" policy dated 12/2012, documented in part, "Medications must be administered in accordance with the orders, including any required time frame. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose." No further information was provided. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 482. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 502. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 7th edition, Rothenberg and Chapman, page 154. (4) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 338. (5) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 168. (6) Lippincott Pocket Drug Guide for Nurses, 2019, Wolters Kluwer, page 215.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	F 686		7/28/21

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F 686	Continued From page 76 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (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. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide the necessary treatment and services to promote healing of a pressure ulcer for one of 12 residents in the survey sample, Resident #10. The facility staff failed to provide wound care as ordered by the physician to Resident #10's pressure ulcer on 6/13/21. The findings include: The National Pressure Ulcer Advisory Panel identifies a Stage 2 pressure ulcer as: Stage II: Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Further description: Presents as a shiny or dry shallow ulcer without slough or bruising.* This stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.	F 686	1. Resident #10 continues to reside in facility and is receiving prescribed treatments for pressure ulcer. 2. All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that treatments must be delivered as prescribed and that TAR documentation must be completed timely. 4. DON or designee will randomly audit pressure ulcer TARs weekly times 4 weeks and monthly times 2 to ensure that treatments were delivered as prescribed and documentation completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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*Bruising indicates suspected deep tissue injury

Resident #10 was admitted to the facility on 3/28/12, with the diagnoses of but not limited to cerebrovascular disease, stroke, contracture, mood disorder, dementia, depression, high blood pressure, atrial fibrillation, and lumbar disc degeneration. The most recent MDS (Minimum Data Set) assessment, a quarterly assessment with an ARD (Assessment Reference Date) of 4/12/21, coded Resident #10 as moderately impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only.

A review of the clinical record revealed a nurse's note dated 6/11/21 that documented, "....Change In Condition:....Skin wound or ulcer....Sacrum has some excoriation noted to bilateral sacrum. Primary Care Provider Feedback....A. Recommendations: Metta (sic) honey (1) applied to both areas and cover with a bordered gauze dressing...."

Further review revealed an evaluation from the facility's wound care provider dated 6/11/21. This evaluation documented, "Length: 1.37 cm. Width 1.39 cm.... Depth 0.10 cm....Etiology: Pressure Ulcer - Stage 2....Dressings: Medihoney. Secondary Dressing - Bordered gauze...."

A review of the clinical record revealed a physician's order dated 6/11/21 for "Bilateral buttocks cleanse with NS (normal saline), apply medihoney (1), cover with boarder gauze...."

A review of the June 2021 TAR (Treatment

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Administration Record) for Resident #10 revealed this treatment was not documented as being completed on 6/13/21.

On 6/14/21 at 3:29 PM, an interview was conducted with LPN #3 (Licensed Practical Nurse), the nurse who was assigned to Resident #10 on 6/13/21. When asked if she did the wound care on 6/13/21, LPN #3 stated, "I did not do the wound care. It was a really, really busy day. I had 3 hospice residents and a lot of family here. I didn't get to it. I don't believe I tried for it....I did not do the wound care." When asked if she notified anyone (the physician, nurse supervisor, the next shift nurse), LPN #3 stated, "I did not notify anyone that the wound care was not done."

A review of the comprehensive care plan revealed one dated 11/11/20 for "At risk for alteration in skin integrity..." This care plan included an intervention dated 11/11/20 for "Treatment as ordered."

On 6/15/21 at 4:34 PM, ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.

COMPLAINT DEFICIENCY

References:

(1) MEDIHONEY® Gel Wound & Burn Dressing contains 100% active Leptospermum honey in a hydrocolloidal suspension. Supports the removal of necrotic tissue and aids in wound healing. Thicker consistency than MEDIHONEY® paste

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F 686	Continued From page 79 provides more stability. Information obtained from https://www.woundsource.com/product/medihoney-gel-wound-burn-dressing	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility document review and staff interview, it was determined that facility staff failed to provide adequate supervision and failed to ensure an environment free of accident hazards to prevent accidents for one of 12 residents in the survey sample, Resident # 2. The facility staff failed to ensure supervision of Resident # 2 while the resident was at a urology appointment on 04/22/2021. Resident #2, with diagnoses, including intellectual disabilities [1], legal blindness, and vision loss, who was assessed as moderately impaired of cognition for making daily decisions, was sent by the facility to the urology appointment without RP (responsible party) notification of the appointment and without a staff member, and was left unattended in the physician's office. The findings include:	F 689	1. Resident #2 continues to reside in facility and has appropriate supervision at appointments. 2. All residents requiring supervision at medical appointments have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate ward clerks and unit managers to check for need of supervision at appointments and confirm necessary supervision is in place. 4. DON or designee will randomly audit residents going out for appointments weekly times 4 weeks and monthly times 2 to ensure residents in need of supervision have it lined up and confirmed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28,	7/28/21

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Resident # 2 was admitted to the facility with diagnoses that included but were not limited to: intellectual disabilities [1], legal blindness, vision loss and benign prostatic hyperplasia [2].

Resident # 2's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 04/21/2021, coded Resident # 2 as scoring a 6 [six] on the brief interview for mental status (BIMS) of a score of 0 - 15, six - being moderately impaired of cognition for making daily decisions. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living.

The "Skilled Nursing Facility Transfer Report" for Resident # 2 dated 04/15/2021 from [Name of Hospital] documented in part, "Follow-up Information. Follow up with [Name of Urology. Go on 4/22/2021 at 2:30 pm [Name of Doctor]."

The facility's unit 2 desk calendar documented in part,
"Friday, April 16. 2021. Transport [Name of Resident # 2] on 4-22-21."
"Thursday, April 22. 2021. [Name of Resident # 2] / 2:30pm [Urology Office Address. Name of Transport Company.] P/u [pick up] 1:30 [p.m.]."

The [Name of Urology] office note for Resident # 2 dated 04/22/2021 documented in part Resident # 2's past medical history, urinalysis results and impressions indicating Resident # 2 was seen by the urologist on 04/22/2021.

On 06/14/2021 at 1:25 p.m., an interview was conducted with OSM [other staff member] # 2, social worker regarding Resident # 2 being unaccompanied to their urology appointment and

2021.

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left in the doctor's office alone on 04/22/2021. When asked to describe the procedure for a resident that has an appointment outside the facility, OSM # 8 stated, "After the appointment is set, someone from the unit will contact the RP [responsible party] and ask who going to accompany the resident." In regard to Resident # 2, OSM # 2 stated, "I was brought in after he was already there. The urology office called us [facility] and said he [Resident # 2] couldn't be seen because no one was there with him. From what I understand the case manager from the group home did show up at the urology office."

On 06/15/2021 at 3:51 p.m., an interview was conducted with CNA [certified nursing assistant] # 8, ward clerk for unit number two. When asked to describe the procedure and process for residents who have appointments, CNA # 8 stated, "I set up transportation for the appointments." When asked if they arranged the transportation for Resident # 2's urology appointment on 4/22/2021 CNA # 8 stated yes. When asked if they contacted Resident # 2's RP about the appointment CNA # 8 stated no.

On 6/16/2021 at 8:08 a.m. an interview was conducted with LPN [licensed practical nurse] # 5, nurse manager for unit number two regarding the notification of Resident # 2's responsible party and the supervision of Resident # 2 for a urology appointment on 04/22/2021. When asked to describe the process when a resident is scheduled for an outside appointment, LPN # 5 stated, "If the resident is a new admission I go through the orders and if there are any appointments made I put it on my calendar for the ward clerk and I go back five to seven days on the calendar as a reminder so the ward clerk has

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time to set up transportation. If the resident is already here and it is a new order for an appointment I do the same thing, put it on my calendar for the ward clerk and I go back five to seven days on the calendar as a reminder so the ward clerk has time to set up transportation. I also call the RP [responsible party] and let them know when and where the appointment and ask them if they want to transport the resident or have us set up transportation. I also ask the RP if they are going to the appointment, most of the time they meet the resident at the appointment."
When asked to describe the procedure when the RP is unable to meet the resident at the appointment, LPN # 5 stated, "I contact [CNA (certified nursing assistant) # 3], scheduler, to see if they have staff to free up to go to the appointment, they have been able to do it a few times in the past." When asked about documentation that a resident's RP was contacted prior to an appointment, LPN # 5 stated that it would be documented in the progress notes. LPN #5 was asked to review the progress notes for Resident # 2 dated 04/15/2021 through 04/30/2021. After reviewing the progress noted, LPN # 5 stated, "There's nothing documented about contacting the RP." When informed of the concern that Resident # 2 was sent to their urology appointment and left in the doctor's office unaccompanied, LPN # 5 stated, "The RP should have been contacted and someone should have met the resident at the office."

On 06/16/2021 at approximately 10:15 a.m., ASM [administrative staff member] # 1, the administrator and ASM # 2, director of nursing, were made aware of the above findings

No further information was provided prior to exit.

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F 689	Continued From page 83 Complaint Deficiency References: [1] Refers to a group of disorders characterized by a limited mental capacity and difficulty with adaptive behaviors such as managing money, schedules and routines, or social interactions. Intellectual disability originates before the age of 18 and may result from physical causes, such as autism or cerebral palsy, or from nonphysical causes, such as lack of stimulation and adult responsiveness. This information was obtained from the website: https://www.report.nih.gov/NIHfactsheets/ViewFactSheet.aspx?csid=100 [2] An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 689		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that	F 726		7/28/21

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F 726	Continued From page 84 licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that the facility staff failed to provide training and education for the use of a medication that required specific administration and monitoring criteria, that facility staff were not familiar with, for one of 12 residents in the survey sample; Resident #4. Resident #4 was admitted on 2/24/21 with orders for the use of Octreotide (1), to be administered via IV (intravenous) push through a PICC (2) site, by an RN (Registered Nurse) only. Facility staff were not familiar with and were not provided education and training for administering this medication. The findings include:	F 726	1. Resident #4 no longer resides in the facility. 2. All residents requiring specialized care that may be unfamiliar to facility staff have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all facility nurses providing specialized care to residents to ensure that they understand the provision of care. 4. DON or designee will audit facility staff working with residents receiving specialized care weekly times 4 weeks and monthly times 2 to ensure education/competency. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, the medication was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Documented side included diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels, which the resident was prescribed.

Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) was an Admission assessment with an ARD (Assessment Reference Date) of 3/2/21. The resident was coded as being cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene.

A review of the clinical record revealed a hospital discharge document dated 2/24/21 that documented, "Start taking these medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml

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(milliliter) by intravenous (IV) route three times daily for 30 days..."

A review of the physician's orders revealed the following:

On 2/24/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."

On 3/1/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for cancer (RN to administer)." The only change from the original order was the addition that an RN (Registered Nurse) had to administer the medication. This meant that an LPN (Licensed Practical Nurse) could not administer the medication.

On 3/4/21: "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer)." The only change from the previous order was the change of diagnosis as to why the medication was being given.

On 3/13/21: Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day for GI Fistula (RN to administer) MAY GIVE SQ (subcutaneous) PER (name of physician). The only change from the previous order was the ability to also administer the medication via subcutaneous route.

On 6/16/21 at 11:44 AM in an interview with ASM #4, the facility's medical director, he stated that the medication had never been used in this facility

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before. ASM #4, stated that the medication was not being administered for cancer, but was ordered to treat the resident's GI symptoms related to a recently acquired ostomy, which was in turn related to intestinal obstruction, peritoneal adhesions and anal cancer.

On 6/16/21 at 2:29 PM an interview was conducted with LPN #2, who was the LPN that administered the medication on 15 of the 41 times it was administered by an LPN. When asked if she was an RN, LPN #2 stated, "No." When asked if she was aware that only an RN was allowed to administer the medication, given the route and physician's order, she stated that she was aware. When asked why she administered the medication, LPN #2 stated that "when she looked up the medication, the drug book documented that it could be given IM (intramuscularly), so she administered it IM instead of IV, as she was an LPN and an LPN could not give a medication via IV route." When asked if she called the physician to clarify if the medication could be given IM and to obtain an order for IM administration, LPN #2 stated she had not. LPN #2 stated, "From my understanding (from reading the drug book), it could be given both ways. I gave it IM over 3 minutes. Every time I gave it, I gave it IM." When asked about education and training for administering this medication, she stated that she was not provided any training or education for administering this medication, but that "It was one I was not familiar with."

On 6/16/21 at 3:00 PM an interview was conducted with RN (registered nurse) #2, the QA nurse (Quality Improvement). She stated that education was not provided. RN #2 stated that "It

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is a chemo med [medication], you need to know about side effects, why it is being used, what you have to check, like the PICC [peripherally inserted central catheter] line, etc., how often, how to push - time and duration. Only an RN can administer - and that was in the order. I just heard that an LPN administered it. An LPN should not have administered it. If the order was for the medication to be given IM or SQ an LPN can give it. She should have called the doctor to make sure it could be given that way. I looked it up and saw what ways it could be given, how long to push, but you would need a doctors order to be given IM. I would have to look in the book to see if the same formulation can be given IV or IM. I gave the medication once. I did the IV push. I was not provided education and training. I looked it up and read it. There should be more (education). You would have to check to see if the medication provided can be given that route with that formulation. Reading the information I knew it had to be via IV push over 3 minutes."

On 6/17/21 at 8:25 AM an interview was conducted with RN #4, the staff educator. She stated that she was not the staff educator at the time of this resident, and did not think the facility actually had one at that time. She reviewed training and in-services she had access to and did not locate any evidence that training was provided for the use of, administration of and monitoring of the Octreotide. RN #4 stated that for a medication that had never been used in the facility before and had specific administration and monitoring requirements, training and education should have been provided.

A review of the facility policy, "Competency of Nursing Staff" documented, "The following factors

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are considered in the creation of the competency-based staff development and training program:....c. Specialized skills or training needed based on the resident population....Facility and resident-specific competency evaluations will be conducted upon hire, annually, and as deemed necessary based on the facility assessment...."

The policy did not specifically address training as needed based on an individual resident's needs that were unusual or different from the everyday normal resident needs encountered by facility staff.

On 6/17/21 at 9:52 AM, ASM #1 and ASM #2 (Administrative Staff Member, the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.

References:

(1) Octreotide - used to treat symptoms of carcinoid tumors and vasoactive intestinal peptide tumors.
Information obtained from Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950.

(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of

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F 726	Continued From page 90 frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748	F 726		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and	F 755		7/28/21

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F 755	Continued From page 91 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a medication was available for administration for one of 12 residents in the survey sample; Resident #4. The facility staff failed to ensure the physician prescribed medication/ Octreotide was available for administration upon admission on 2/24/21 for Resident #4. The findings include: Resident #4 was admitted to the facility on 2/24/21 and discharged on 3/24/21. The resident had the diagnoses of but not limited to intestinal obstruction, peritoneal adhesions, anal cancer, diabetes, morbid obesity, diverticulosis, and high blood pressure. The most recent MDS (Minimum Data Set) assessment, an admission assessment with an ARD (Assessment Reference Date) of 3/2/21, coded Resident # 4 cognitively intact in ability to make daily life decisions. The resident was coded as requiring total care for eating; extensive assistance for transfers, dressing, toileting and bathing; and limited assistance for hygiene. A review of the clinical record revealed a hospital discharge document dated 2/24/21 that documented, "Start taking these	F 755	1. Resident #4 no longer resides in the facility. 2. All residents prescribed IV medications requiring RN administration have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all admissions staff and nurse management on reviewing medication orders prior to admission to the facility and ensuring pharmacy can fill prescribed medications. 4. DON or designee will audit new admissions orders and MARs weekly times 4 weeks and monthly times 2 to ensure medication has been delivered as required. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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medications....Octreotide (1) 100 mcg/ml (micrograms per milliliter) injection. 1 ml (milliliter) by intravenous (IV) route three times daily for 30 days..." Note: The resident had a PICC (2) line IV site.

A review of the physician's orders revealed an order dated 2/24/21 for "Octreotide Acetate Solution 100 MCG/ML Use 1 ml intravenously three times a day (TID) for cancer."

A review of the February 2021 MAR (Medication Administration Record) documented that the medication was not administered as follows:

On 2/24/21 at 10:00 PM. A review of the nurses notes documented "awaiting on pharmacy."

On 2/25/21 at 6:00 AM. A review of the nurses notes documented "medication on order."

A review of the pharmacy manifest dated 2/27/21, documented the medication was not delivered to the facility until 2/25/21 at 11:00 AM.

On 6/16/21 at 3:18 PM an interview was conducted with OSM #15, the Director of Pharmacy. She stated that Octreotide was not a medication that the pharmacy routinely kept in stock. OSM #15 stated that, We received the order electronically at 9:13 p.m. on 2/24/21. She stated that on 2/24/21 at 10:44 PM, "Our pharmacist attempted to contact the facility to let them know we did not have it in stock. Our pharmacist was unable to reach anyone at that time....We had to order it from our distributor. Due to some challenges with our distributor, we received the medication from them on 2/26/21. Once we received it, we prepared it and delivered

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it to the facility on 2/26/21 at 7:34 PM on 2/26/21.

While this interview conflicted with the data on the pharmacy manifest above, it still reflected a delay in obtaining and delivering the medication to the facility in a timely manner.

On 6/16/21 at 4:28 PM in an interview with ASM #2, (Administrative Staff Member), the Director of Nursing, she stated that "We were initially told that it would be here but pharmacy had complications in getting it."

No further information was provided by the end of the survey.

References:

(1) A review of the facility's drug book, "Mosby's 2020 Nursing Drug Reference, 33rd Edition" pages 948-950, Octreotide was used for symptoms of carcinoid tumors, vasoactive intestinal peptide tumors, as well as some unlabeled uses including GI (gastrointestinal) fistulas, diarrheal conditions, and dumping syndrome. The information on this medication documented that the IV push route was to be administered over 3 minutes. Storage of this medication was documented as storage in the refrigerator for unopened vials or at room temperature up to 2 weeks, protected from light. Multiple side effects was documented, including diarrhea. Interactions included decreased effect of insulin which required monitoring of glucose levels.

(2) PICC - A peripherally inserted central catheter (PICC), also called a PICC line, is a long, thin

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F 755	Continued From page 94 tube that's inserted through a vein in your arm and passed through to the larger veins near your heart. Very rarely, the PICC line may be placed in your leg. A PICC line gives your doctor access to the large central veins near the heart. It's generally used to give medications or liquid nutrition. A PICC line can help avoid the pain of frequent needle sticks and reduce the risk of irritation to the smaller veins in your arms. A PICC line requires careful care and monitoring for complications, including infection and blood clots. Information obtained from https://www.mayoclinic.org/tests-procedures/picc-line/about/pac-20468748	F 755		
F 842 SS=D	COMPLAINT DEFICIENCY Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		7/28/21

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F 842	Continued From page 95 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 96 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that the facility staff failed to ensure a complete and accurate clinical record for one of 12 residents in the survey sample, Residents #10. The facility staff failed to document administered treatments for Resident #10 on 6/13/21. The findings include: Resident #10 was admitted to the facility on 3/28/12 and had the diagnoses of but not limited to cerebrovascular disease, stroke, contracture, mood disorder, dementia, depression, high blood pressure, atrial fibrillation, and lumbar disc degeneration. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 4/12/21. The resident was coded as being moderately impaired in ability to make daily life decisions. Resident #10 was coded as requiring extensive assistance for all areas of activities of daily living, except for eating, which required supervision only. A review of the June 2021 TAR (Treatment Administration Record) revealed multiple	F 842	1. Resident #10 continues to reside in facility and is receiving prescribed treatments for pressure ulcer. 2. All residents with pressure ulcers have the potential to be affected by this alleged deficient practice. 3. DON or designee will educate all nurses that treatments must be delivered as prescribed and that TAR documentation must be completed timely. 4. DON or designee will randomly audit pressure ulcer TARs weekly times 4 weeks and monthly times 2 to ensure that treatments were delivered as prescribed and documentation completed. Any identified issues will be immediately corrected. Results will be reported to Quality Assurance committee for analysis and revision x 3 months. 5. Date of compliance will be July 28, 2021.	

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treatments were not documented as being provided on 6/13/21. The following items were not documented as being completed:

"Cleanse s/p (supra pubic) cath (catheter) soap & water QD (every day) & PRN (and as needed)."

"1, 1/2 side rails up in bed as enablers to turn and reposition due to weakness related to deconditioning every shift."

"Bed against the wall to promote clutter free environment every shift."

"Elevate legs when up in chair as tolerated every shift."

"House Barrier Cream - Apply To Buttocks/sacrum and Peri Area QS (every shift) PRN Incontinence every shift...."

"Left palm guard on at all times as tolerated every shift."

"Monitor bruising/bleeding Q (every) shift...."

"Suprapubic catheter: Document output Q shift..."

"Wedge to back when in bed as tolerated every shift."

On 6/14/21 at 3:29 PM , an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked about the above missing documentation on the TAR, LPN #3 stated that she did all the items listed above but did not document any of them. LPN #3 stated, "It was a really, really busy day. I had 3 hospice residents

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and a lot of family here. I did not do my treatment check offs....I was bombarded. It should have been documented."

A review of the facility policy, "Charting and Documentation" documented, "All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychological conditions, shall be documented in the resident's medical record...."

On 6/15/21 at 4:34 PM, ASM #1 and ASM #2 (Administrative Staff Member - the Administrator and Director of Nursing, respectively) were made aware of the findings. No further information was provided by the end of the survey.