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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 8/17/21 through 8/19/21. Four complaints were investigated during survey: VA00052777 was substantiated with deficiencies. VA00050417 was substantiated with deficiencies. VA0005114 was substantiated with deficiencies. VA00049709 was substantiated with deficiencies. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements.

The census in this 60 certified bed facility was 44 at the time of the survey. The survey sample consisted of 8 current resident reviews (Residents #1 through #8) and 3 closed record reviews (Resident #9 through #11).

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 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

F 580

1. Notification of unusual occurrence with Resident #2 was given to RP on 9-9-2021. Notification regarding COC on PICC line bleeding on to bed with Resident #1 was given to NP on 9-9-2021. Notification of missed medications on listed dates for Resident #1 was given to NP on 9-9-2021. Notification of missed medications on listed date for Resident #3 occurred with MD on 9-9-2021. Notification of missed medications on listed date for Resident #4 was given to NP on 9-9-2021.

2. All residents are at risk when timely notifications of changes in condition are not completed.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/10/21

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F 580	Continued From page 1 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 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 resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation, it was determined that facility staff failed to notify the physician and/or responsible party of an incident of unusual occurrence for one of 11 residents in the survey sample, Resident #2; of a change in resident condition related to a PICC	F 580	3. The DON will conduct an audit of all documented incidents for the past 30 days to ensure proper assessment, documentation and notifications were completed. Education will be provided to licensed staff at the facility on Change of Condition process, incident reporting, notification of changes, and escalation of adverse events. Regional Director of Clinical Services will provide education to the Nursing Administrative staff on the process for daily clinical start up, incident reporting and escalating adverse events to the Regional Support Team. Regional Director of Clinical Services will provide education to Department leaders on Incident Reports and conducting facility Investigations. Job Aids for COC notification will be available at each nursing station 4. DON or designee to audit incident reports and 24 hour nursing reports 3 x per week x 4 weeks for completion, accuracy, and notification of Change of condition. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance. 5. DOC 10/3/21	

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line for one of 11 residents, Resident #1; AND regarding missed medications per physician's orders for five of 11 residents in the survey sample, Resident #1, #3, #4, #5 and #11.

The findings include:

1. Facility staff failed to notify the responsible party when a stranger outside the facility had entered the building and handed Resident #2 a weapon in the form of a shank (1).

Resident #2 was admitted to the facility on 3/13/19 and readmitted on 2/15/20 with diagnoses that included but were not limited to high blood pressure, dementia, anxiety, and depression. Resident #2's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/8/21. Resident #2 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #2 was coded as not having any behaviors during the 7 day look back period.

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1, another sampled resident. Resident #1 stated that last Sunday on 8/22/21 at approximately 6 p.m., a stranger from off the street was able to enter the building with what appeared to be a shank in his hand. Resident #1 stated that he was in the hallway when he saw the gentleman come onto the nursing unit, walk down the hall and hand the shank to a resident (Resident #2) who was sitting in her wheelchair on the hallway. Resident #1 stated that a nursing aide who was also a witness to this incident, immediately intervened and

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removed the shank from the resident.

Review of the Facility Reported Incidents (FRIS) revealed no evidence that this incident has occurred.

On 8/18/21 at 11:15 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #3, the CNA who was witness to the above incident per Resident #1. When asked what had occurred on Sunday 8/22/21, CNA #3 stated that a gentleman was seen on the nursing unit with what appeared to be a shank in his hand. CNA #3 stated that she witnessed the man hand the shank to a resident sitting in her wheelchair on the hallway. When asked if the resident and man knew each other, CNA #3 stated that she was not sure. CNA #3 stated that she immediately removed the shank from the resident's (Resident #2's) hands. CNA #3 stated that the Director of Nursing (DON) was also present in the building and a witness. CNA #3 stated that the DON called the police immediately and the man had left the building before the police had arrived. CNA #3 stated that she wasn't sure what door the man entered from, but that the front lobby was always locked. CNA #3 denied having to write a witness statement. CNA #3 could not recall the exact time the man had entered the building.

On 8/18/21 at 1:17 p.m., an interview was conducted with Administrative Staff Member (ASM) #2, the Director of Nursing (DON). When asked if a FRI or incident report was completed regarding an incident on Sunday, 8/22/21 regarding a man entering the building with a weapon, ASM #2 stated, "No, because I took care of it immediately." When asked if she figured out what door the man entered from, ASM #2 stated,

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"No."

On 8/18/21 at 2:24 p.m., further interview was conducted with ASM #2. When asked if she could recall the events on 8/22/21, ASM #2 stated that she was in the building working on a medication cart because a nurse had called out. ASM #2 stated that at approximately 6 p.m., she was sitting at the nurses station when she saw an unidentified gentleman enter the nursing unit and walked down the green hall. ASM #2 stated that she quickly got up to follow the man as he was walking really fast. ASM #2 stated that she kept asking "Can I help you with something?" and he continued to walk to the therapy department and then turned around and walked quickly to the end of the pink hall. ASM #2 stated that the man kept saying that he was looking for someone, that it was personal. ASM #2 stated that (Name of Resident #2) was sitting in her wheelchair at the end of the pink hall when she introduced herself to the man. ASM #2 stated that was when the man handed the resident a screwdriver. ASM #2 stated that the nursing aide was right there and immediately took the screwdriver away. ASM #2 stated that she was calling the police and that the man then stated, "Go ahead, I am leaving and I am walking toward tidewater drive." ASM #2 stated the man then left the building. ASM #2 stated that the police had arrived and she gave a description to the police. ASM #2 stated that the police told her to just throw the object away. When asked if this object was more like a shank and not a screwdriver, ASM #2 stated, "It was very pointy and sharp." When asked the orientation of Resident #2, ASM #2 stated that Resident #2 was pleasantly confused and had dementia. When asked if the resident could have potentially harmed herself with this object, ASM

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#2 stated that it was taken out of her hands immediately; that it wasn't even in her hands for a second. When asked if Resident #2 could have hurt herself if staff were not present, ASM #2 stated, "Possibly if no one was there." When asked if she had notified Resident #2's responsible party (RP), ASM #2 stated that she did not because staff had immediately intervened. When asked if Resident #2's RP would probably want to know if someone had handed her mother a weapon, ASM #2 stated, "Yes, she would probably want to be aware of that."

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

Facility policy titled, "Notification of Changes" did not address the above concerns. No further information was presented prior to exit.

(1) Shank- a makeshift, knife like weapon. This information was obtained from https://lawenforcementmuseum.org/2010/01/20/contraband-weaponsshivs-and-shanks-a/.

2. The facility staff failed to notify the physician of a change in Resident #1's condition realated to his peripherally inserted central catheter (PICC) line on 7/23/21.

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot,

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complete traumatic amputation of one right lesser toe, acute osteomyelitis of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded in Section N (Medications) as receiving antibiotics. Resident #1 was coded in Section O (Special Treatments and Programs) as receiving intravenous (IV) medications.

Review of Resident #1's July 2021 POS (Physician Order Summary) documented the following orders:

1) "Zosyn (1) (antibiotic) 3-0.375 grams (GM). Use 3.375 gram intravenously every 6 hours for infection for 150 administrations." This order was discontinued on 8/12/21.

2) Heparin Lock Flush (2) solution 1 UNIT/ML (unit/milliliter). Use 1 unit intravenously every 6 hours for PICC (3) maintenance. This order was discontinued on 7/23/21. This order was changed to PRN (as needed) on 7/23/21.

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1. Resident #1 had discussed his concern that he didn't feel like in the beginning of his stay, staff were properly flushing, clamping and monitoring his PICC line. Resident #1 had stated that on the evening of 7/23/21, the 7 am to 7 pm nurse; who he could not identify forgot to clamp his PICC line.

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Resident #1 stated as a result of this incident, a large amount of blood had come out of his line and went all over his bed, siderail and floor. Resident #1 denied any further episodes of bleeding prior to and after 7/23/21.

Review of Resident's #1 clinical record revealed no documentation regarding the incident on 7/23/21; 7 a.m. to 7 p.m. shift.

Review of Resident #1's care plan dated 7/25/21 documented in part, the following: "(Name of Resident #1) has potential for infection related to catheter direct access to blood r/t (related to) PICC IV...Monitor for hemorrhage due to dislodgement of catheter, broken or disconnected lines. Report any abnormal findings to physician..."

Further review of Resident #1's clinical record revealed vital signs were obtained on 7/23/21 at 2:02 p.m. The following was recorded: BP (blood pressure): 124 / 63 mmhg; 67 beats per minute, 96 percent room air oxygen saturation. No further vital signs were recorded for 7/23/21.

A nursing note dated 7/23/21 night shift (7 p.m. to 7 a.m.) documented in part, the following: "Continues IV Pip/Tazo 3.375 (Zosyn). no adverse reactions. double lumen picc to RUE (Right Upper Extremity), patent. blood return present. no s/s (signs and symptoms) of irritation or infection noted. blood noted to bedsheets (sic), per patient site was bleeding earlier. this nurse insisted on changing sheets more than once, patient declined multiple times."

Further review of Resident #1's clinical record revealed no prior incidences of bleeding from his

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PICC line. There was no evidence of any bleeding from his PICC line after 7/23/21.

There was no evidence of an assessment done on Resident #1 regarding the incident or any follow-up assessments thereafter.

A physician note could not be found in Resident #1's clinical record regarding the above incident on 7/23/21.

On 8/18/21 at approximately 2:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, the nurse who worked on 7/23/21 7 a to 7 p shift. When asked if she could recall an incident where Resident #1's had blood coming out of his PICC line and had leaked all over his bed, bed rail and floor, LPN #1 stated that this had happened on one occasion. LPN #1 stated that she could not recall the exact time she saw the blood but that the blood was dried on the floor, bed rail and on his sheets. LPN #1 stated it was a large amount of blood that had leaked from his PICC line. LPN #1 stated that she was not sure if this had happened on the previous shift 7 p to 7 a and she walked into his room on her first rounds or if it had happened later on her shift. LPN #1 was not quite sure because she stated her first rounds may have been late. LPN #1 did not recall making rounds prior to seeing the blood all over the resident's bed, floor and rail. LPN #1 stated that she recalled cleaning up the blood with bleach from the floor and rail. LPN #1 stated that she assessed the PICC line and stated that it was clamped at that time. LPN #1 stated that the PICC line was not actively bleeding at the time of her assessment. LPN #1 stated that she flushed the line with normal saline and she had no issues with the flush. LPN #1 stated that Resident #1

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was also had no changes to his mental status or anything that would alert her that he was having a change in condition. LPN #1 stated that the bleeding may have been from the Heparin flushes that were scheduled every shift and now were ordered for PRN (as needed). When asked if she had documented her assessment in the clinical record, LPN #1 stated that if it wasn't in the clinical record then she didn't document her assessment. When asked if she had notified the physician of this incident, LPN #1 stated that she did not because the Resident was not having any changes in his condition. LPN #1 stated that she kept checking on the resident to see if he had any changes. When asked what checking entailed, LPN #1 stated she would pop in his room and check in on him. When asked if vital signs were obtained at the time she discovered the blood or thereafter for monitoring, LPN #1 stated she just looked at the vital signs that were already obtained earlier in the shift by the Certified Nursing Assistant. When asked if the discontinued Heparin flushes were in response to the bleeding episode on 7/23/21, LPN #1 stated that she thought that may have already been an order prior to the incident.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

Facility policy titled, "Notification of Changes" documents in part, the following: "The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her

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authority, resident's representatives when there is a change requiring notification...Circumstances requiring notification include:..Significant change in the resident's physical, mental, or psychosocial condition such as deterioration of health, mental or psychosocial status. This may include...Clinical Complications...b. discontinuation of current treatment due to adverse consequences."

(1) Zosyn- also known as Tazocin® piperacillin/tazobactam is an intravenously administered antibiotic. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504059/.

(2) Heparin Lock Flush- Heparin flush belongs to the family of drugs called anticoagulants. This is used to prevent blood from clotting or "stopping up" your intravenous (IV) line. Heparin, in the doses used to flush IV lines, should not normally keep your blood from clotting elsewhere in your body. This information was obtained from https://cookchildrens.org/SiteCollectionDocuments/HomeHealth/Education/InfusionTherapy/CCHH_Infusion_HeparinandSodiumChlorideFlush.pdf.

(3) PICC (peripherally inserted central catheter)- Central catheter is a venous access device that ultimately terminates in the superior vena cava (SVC) or right atrium (RA). They can be inserted centrally (centrally inserted venous catheter; CICC) or peripherally (PICC). PICCs are placed through the basilic, brachial, cephalic, or medial cubital vein of the arm. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK459338/
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3. The facility staff failed to notify the physician when medication was not administered for nerve pain on 7/26/21; scheduled insulin on 8/2/21; and sliding scale insulin on 8/6/21 for Resident #1 per physician's order.

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser toe, acute osteomyelitis (bone infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded in Section N (Medications) as receiving insulin injections.

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1. Resident #1 stated that he was out of his medication for nerve pain for two days and also that facility staff sometimes forget to check his blood sugar or give him insulin prior to his meals. Resident #1 stated he sometimes misses his scheduled insulin injections.

Review of Resident #1's July 2021 orders revealed the following medication for nerve pain: "Gabapentin (1) Tablet 600 mg (milligrams) Give 1 tablet by mouth two times a day for pain."

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Review of the narcotic logs for Gabapentin revealed that 30 tablets arrived to the building on 7/12/21 from pharmacy. The count went to 0 (zero) on 7/26/21 at 9:00 a.m.

Further review of the narcotic logs revealed that 60 tablets were sent to the building on 7/27/21. The first dose administered from this pack was on 7/28/21 at 9:00 a.m.

Further Review of Resident #1's July MAR revealed that staff documented that they had administered the Gabapentin on 7/26/21 at 5 p.m. and 7/27/21 at 9:00 a.m. and 5 p.m.

Review of the emergency STAT box list revealed that Gabapentin 300 mg (milligrams) was a medication in the STAT box.

Review of the emergency STAT box pull list from pharmacy revealed that the only time staff had accessed the STAT box for the Gabapentin was on 7/27/21 for both the morning and evening shifts. 2 tablets were pulled to equal 600 mg. There was no evidence that staff attempted to access the emergency STAT box list on 7/26/21 at 5 p.m.

There was no evidence that Resident #1 experienced any pain or negative outcomes on 7/26/21 when his Gabapentin was missed x 1 dose.

On 8/18/21 at 12:53 p.m., an interview was conducted with Other Staff Member (OSM) #6 the lead pharmacist. OSM #6 confirmed that the only time facility staff tried to access the STAT box was on 7/27/21. OSM #6 stated that staff did not access the STAT box on 7/26/21.

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On 8/18/21 at 1:31 p.m. and 4:22 p.m. an interview was attempted with the nurse who failed to administer the Gabapentin on 7/26/21 at 5 p.m. She could not be reached for an interview.

Review of Resident #1's August 2021 POS (Physician Order Sheet) revealed the following insulin orders:

"Admelog SoloStar Solution Pen Injector (2) 100 Unit/ML Inject 4 units subcutaneously with meals for DM (Diabetes Mellitus.

"Admelog SoloStar Solution Pen Injector 100 Unit/ML (Insulin Lispro (1 Unit Dial) Inject as per sliding scale; if
201-250 = 2 units;
251-300 = 4 units;
301-350 = 6 units;
351-400 = 8 units;
401-550 = 10 units of not resolved in 2 hours, call MD (medical doctor). Subcutaneously (under the skin) before meals and at bedtime for diabetes, low blood sugar."

Review of Resident #1's August 2021 MARs revealed that his scheduled insulin was missed on 8/2/21 at 4:00 p.m. Resident #1's sliding scale insulin and blood sugar check was not completed on 8/2/21 as well at 4:30 p.m. Resident #1's blood sugar was documented at "301" at the next glucose check on 8/2/21 at 10:00 p.m.

Further review of Resident #1's August 2021 MAR revealed that he missed his sliding scale insulin on 8/6/21 at 11:30 a.m. The following nursing note was documented: "PATIENT HAD EATEN."

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The nurse who failed to administer the scheduled and sliding scale insulin on 8/2/21 and 8/6/21 had passed away suddenly and could not be reached for an interview.

On 8/18/21 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse #2, a nurse who worked 7 p to 7 a with Resident #1 frequently. When asked what blanks or no signatures meant on the MAR, LPN #2 stated that no signatures meant the medication was not given. When asked if Resident #1 had ever made her aware that the 7 a to 7 p shift forgot to administer insulin, LPN #2 stated that she did recall the resident making her aware of that. LPN #2 stated that the nurse who failed to administer the insulin had suddenly passed away but she recalled that he was slower with passing out medications and may not have had the time to do a blood sugar check and administer insulin before the resident's meals. When asked if she ever recalled the resident having a high blood sugar level related to his insulin being missed the shift prior, LPN #2 stated that she couldn't recall. When asked if a blood sugar level of 300 was high for Resident #1, LPN #2 stated, "That is pretty high for him." When asked if the physician should be made aware of any missed medication, LPN #2 stated that the physician should be made aware and a note should be documented of all missed medications.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

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Facility policy titled, "Medication Errors" documents in part, the following: "...The facility will consider factors in medication administration, including but not limited to, the following: "a. Medication administered not in accordance with the prescriber's order. Examples include...Medication omission...If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible..."

(1) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/28597471/.

(2) Admelog SoloStar Solution Pen Injector- is a rapid-acting human insulin analog indicated to improve glycemic control in adults and pediatric patients 3 years and older with type 1 diabetes mellitus and adults with type 2 diabetes mellitus. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0691def8-4a7b-4de3-866f-a280989f47f1.

4. Facility staff failed to notify the physician that all 9 p.m. medications were not administered to Resident #3 on 12/26/20 per physician's order.

Resident #3 was admitted to the facility on 10/6/20 with diagnoses that included but were not limited to type two diabetes mellitus, major depressive disorder, and high blood pressure.

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Resident #3's most recent Minimum Data Set MDS (assessment) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/5/21. Resident #3 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the Brief Interview for Mental Status (BIMS) Exam.

During the course of a complaint investigation, it was alleged that residents did not receive medications and treatments on 12/26/20 night shift due to the lack of staffing.

Review of Resident #3's December 2020 Medication Administration Record (MAR) for 9/26/20; revealed that Resident #3 missed the following ordered medications at 9 p.m.:

1) "Atorvastin Calcium (Lipitor) 40 mg (milligrams) Give 1 tablet by mouth at bedtime for high cholesterol.
2) Melatonin Tablet Give 6 mg by mouth at bedtime for insomnia.
3) Remeron 15 MG Give 1 tablet by mouth at bedtime for depression.
4) Trazadone HCl Tablet 50 MG Give 1 tablet at bedtime for depression.
5) Metformin HCL 500 MG Give 1 tablet by mouth two times a day for diabetes mellitus."

Further review of Resident #3's December 2020 MAR revealed that he has missed his 6:30 a.m. blood sugar check and sliding scale insulin. The following order was documented:
"Humalog Solution (Insulin Lispro) Inject as per sliding scale:
If 150-199 = 2 units give 2 units;
200-249 = 4 units give 4 units;
250-299 = 6 units give 6 units;

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300-349 = 10 units give 10 units;
350-399 = 12 units 12 units;
400 - 450 = 14 units 14 units;
subcutaneously three times a day for diabetes mellitus call md (Medical Doctor) if blood sugar is greater or equal to 400 mg/dl."

Review of Resident #3's December 2020 MAR revealed that his next blood sugar check on 12/27/20 was at 11:30 a.m., where he read at a level of 202. 4 units of Humalog were administered.

There was no evidence in his clinical record of any negative outcome related to the above missed medications.

There was no evidence that the physician was notified regarding the above medication missed.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020 MAR was reviewed with the DON. The DON stated that she expected staff to administer all medications as ordered by the physician. The DON stated that she was not employed with the facility in December and was not sure why the medications were not administered. The DON stated she expected staff to notify the physician and resident representative of all medications not administered.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

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5. Facility staff failed to notify the physician that all 9 p.m. medications were not administered to Resident #4 on 12/26/20 per physician's order.

Resident #4 was admitted to the facility on 8/18/17 with diagnoses that included but were not limited to non- traumatic brain dysfunction, high blood pressure, high cholesterol, dementia, depression, and glaucoma. Resident #4's most recent Minimum Data Set (MDS) assessment was an annual assessment with an Assessment Reference Date of 6/4/21. Resident #4 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) Exam.

During the course of a complaint investigation, it was alleged that residents did not receive medications and treatments on 12/26/20 night shift due to the lack of staffing.

On 8/18/21 an interview was conducted with Resident #4. She could not recall if she missed medications on 12/26/20 and 12/27/20. She could not recall not having a nurse on that day.

Review of Resident #3's December 2020 Medication Administration Record (MAR) for 9/26/20; revealed that Resident #4 missed the following ordered medications at 9 p.m.:

1) "Atorvastin Calcium (Lipitor) 20 mg (milligrams) Give 1 tablet by mouth at bedtime for high cholesterol.
2) Lantanprost 0.005 % (percent) Instill 1 drop in both eyes at bedtime for glaucoma.
3) Remeron 30 MG Give 1 tablet by mouth at

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bedtime related to Major Depressive Disorder. 4) Tylenol 8 hour Tablet Extended Release 650 MG Give 2 tablets by mouth every 8 hours for pain related to LOW BACK PAIN." The Tylenol 8 hour tablet was missed at 10 p.m. and at 6:00 a.m. on 9/27/20.

Further review of Resident #3's clinical record revealed no negative outcomes related to the above medications not being administered.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020 MAR was reviewed with the DON. The DON stated that she expected staff to administer all medications as ordered by the physician. The DON stated that she was not employed with the facility in December and was not sure why the medications were not administered. The DON stated she expected staff to notify the physician and the resident representative of all medications not administered.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

6. The facility staff failed to notify the physician and Resident Representative (RR) that Resdient #5 was not administered the following medication on 12/26/20 at 9:00 p.m,: Lantus insulin 40 units, Atarvastatin Calcium 10 mg, Trazadone 25 mg, Trazadone 50 mg and Nifedipine Extended Release (ER) 60 mg for Resident #5. Diagnosis for Resident #5 included but not limited to Hyperlipidemia, Insomnia and Hypertension.

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Resident #5's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 07/09/21 coded Resident #5's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment.

Resident #5's person-centered care plan with a revision date 12/41/19 documented resident is an insulin dependent diabetic. The goal: will remain adequate glucose levels and experience no signs/symptoms (s/s) of hypo/hyperglycemia episodes. One intervention/approaches to manage goal included: please give me medication as ordered. The care plan also included Resident #5 at risk for complications related to my high blood pressure. The goal: will remain free from my complications related to high blood pressure. One intervention/approaches to manage goal included: give the medications as ordered by the physician/nurse practitioner.

During the review of Resident #5's Medication Administration Record (MAR) for December 2020 revealed the following medication orders:
Insulin Glargine Solution - inject 40 units subcutaneously at bedtime for (Type II Diabetes.)
Atarvastatin Calcium tablet 10 mg - give 1 tablet by mouth at bedtime for (hyperlipidema.)
Trazadone 50 mg - give 0.5 mg (25mg) by mouth at bedtime for (insomnia.)
Trazadone 50 mg - give 1 tablet by mouth at bedtime for (insomnia.)
Nifedipine Extended Release (ER) - give 60 mg every 12 hours for (high blood pressure.)

Further review of the December 2020 MAR, revealed evidenced there were no initials by the

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nurse; indicating the mentioned medications above were not administered on 12/26/20 at 9:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020, MAR was reviewed with the DON. After the DON reviewed the MAR, she stated, "I was not here in December 2020, but I expect for the nurses to notify the physician and RR of any and all missed doses of medications."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

7. The facility staff failed to notify Resident #11's Responsible Party (RP) and physician of a missed dose of medication (Albuterol nebulizer treatment) on 04/10/20. Resident #11 was originally admitted to nursing facility on 05/24/19. Diagnosis for Resident #11 include but not limited to Heart Failure and Chronic Obstructive Pulmonary Disease (COPD.)

Resident #11's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 11/30/19 coded Resident #11's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment.

Resident #11's person-center comprehensive care plan with a revision date of 09/14/20

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documented resident with COPD and at risk for exacerbation and respiratory distress. The goal: will not experience any signs or symptoms of respiratory distress such as restlessness, shortness of breath, crackles, tachycardia or show symptoms of being cyanotic (turning blue). Some of the intervention/approaches to manage goal include: give me my medications as ordered by my physician/nurse practitioner and monitor me for adverse effects and/or effectiveness of my medications and report adverse effects to my physician/nurse practitioner.

Review of Resident #11's Medication Administration Record (MAR) for April 2020, included the following order: Albuterol Sulfate Nebulization Solution 0.63 mg/ml - one vial inhaler orally twice a day for COPD. Further review of the April 2020 MAR, revealed evidenced there were no initials by the nurse; indicating the mentioned medication was not administered on 04/10/20 at 4:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020, MAR was reviewed with the DON. After the DON reviewed the MAR, she stated, "I was not here in December 2020, but I expect for the nurses to notify the physician and RR of any and all missed doses of medications.

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

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F 609 Reporting of Alleged Violations
SS=D CFR(s): 483.12(c)(1)(4)

§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:

§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

F 609

1. FRI sent to State on 8-26-2021 for unusual incident.
2. All residents have the potential to be affected by this deficient practice
3. Education will be provided to staff in all departments on guidelines for reporting Abuse and Neglect.
4. Admin or designee will audit incident report 3 x per week X 4 weeks to ensure an FRI is submitted for reportable incidents. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance.
5. DOC 10/3/21

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appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, it was determined that facility staff failed to submit an initial Facility Reported Incident (FRI) to the appropriate state agencies regarding an unusual incident where a stranger had walked into the nursing facility on Sunday, 8/22/21 with a weapon in the form of a shank (1) and handed this weapon to Resident #2.

The findings included:

Resident #2 was admitted to the facility on 3/13/19 and readmitted on 2/15/20 with diagnoses that included but were not limited to high blood pressure, dementia, anxiety, and depression. Resident #2's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/8/21. Resident #2 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #2 was coded as not having any behaviors during the 7 day look back period.

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1, another sampled resident. Resident #1 stated that he had made an addendum to his filed complaint and added new information regarding Sunday (8/22/21). Resident #1 stated that last Sunday on 8/22/21 at approximately 6 p.m., a stranger from off the street was able to enter the building with what appeared to be a shank in his hand. Resident #1

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stated that he was in the hallway when he saw the gentleman come onto the nursing unit, walk down the hall and hand the shank to a resident (Resident #2) who was sitting in her wheelchair on the hallway. Resident #1 stated that a nursing aide who was also a witness to this incident, immediately intervened and removed the shank from the resident.

Review of the Facility Reported Incidents (FRIS) revealed no evidence that this incident has occurred.

On 8/18/21 at 11:15 a.m., an interview was conducted with Certified Nursing Assistant (CNA) #3, the CNA who was witness to the above incident per Resident #1. When asked what had occurred on Sunday 8/22/21, CNA #3 stated that a gentleman was seen on the nursing unit with what appeared to be a shank in his hand. CNA #3 stated that she witnessed the man hand the shank to a resident sitting in her wheelchair on the hallway. When asked if the resident and man knew each other, CNA #3 stated that she was not sure. CNA #3 stated that she immediately removed the shank from the resident's (Resident #2's) hands. CNA #3 stated that the DON was also present in the building and a witness. CNA #3 stated that the DON called the police immediately and the man had left the building before the police had arrived. CNA #3 stated that she wasn't sure what door the man entered from, but that the front lobby was always locked. CNA #3 denied having to write a witness statement. CNA #3 could not recall the exact time the man had entered the building.

On 8/18/21 at 1:17 p.m., an interview was conducted with Administrative Staff Member #2,

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the Director of Nursing (DON). When asked if a FRI or incident report was completed regarding an incident on Sunday, 8/22/21 regarding a man entering the building with a weapon, ASM #2 stated, "No, because I took care of it immediately." When asked if she figured out what door the man entered from, ASM #2 stated, "No."

On 8/18/21 at 2:24 p.m., further interview was conducted with ASM #2. When asked if she could recall the events on 8/22/21, ASM #2 stated that she was in the building working on a medication cart because a nurse had called out. ASM #2 stated that at approximately 6 p.m., she was sitting at the nurses station when she saw an unidentified gentleman enter the nursing unit and walked down the green hall. ASM #2 stated that she quickly got up to follow the man as he was walking really fast. ASM #2 stated that she kept asking "Can I help you with something?" and he continued to walk to the therapy department and then turned around and walked quickly to the end of the pink hall. ASM #2 stated that the man kept saying that he was looking for someone, that it was personal. ASM #2 stated that (Name of Resident #2) was sitting in her wheelchair at the end of the pink hall when she introduced herself to the man. ASM #2 stated that was when the man handed the resident a screwdriver. ASM #2 stated that the nursing aide was right there and immediately took the screwdriver away. ASM #2 stated that she was calling the police and that the man then stated, "Go ahead, I am leaving and I am walking toward tidewater drive." ASM #2 stated the man then left the building. ASM #2 stated that the police had arrived and she gave a description to the police. ASM #2 stated that the police had told her to just throw the object away. When asked if this object was more like a shank

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and not a screwdriver, ASM #2 stated, "It was very pointy and sharp." When asked the orientation of Resident #2, ASM #2 stated that Resident #2 was pleasantly confused and had dementia. When asked if the resident could have potentially harmed herself with this object, ASM #2 stated that it was taken out of her hands immediately; that it wasn't even in her hands for a second. ASM #2 stated that the police stated that if man returns, they will arrest him for trespassing. ASM #2 stated that all the doors were locked to the building at all times so she was not sure how this man got in.
ASM #2 stated that she believed someone may have let him in as they were walking out of the facility. When asked what time family visits stopped on the weekend, ASM #2 stated that she would have to check with activities but that window visits can still occur after 6 p.m. on weekends. When asked if a FRI for this unusual occurrence should have been submitted to the appropriate state agencies, ASM #2 stated that it wasn't that unusual. When stated that it wasn't unusual for a stranger to enter the building with a weapon, ASM #2 clarified and stated that homeless people are always in the parking lot. ASM #2 stated that this man was not aggressive towards the staff or the residents. ASM #2 also stated that the incident did not involve a resident. When asked if Resident #2 was handed the shank, ASM #2 stated, "Yes". When asked if Resident #2 could have hurt herself if staff were not present, ASM #2 stated, "Possibly if no one was there."

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM

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F 609	Continued From page 28 #5, the corporate nurse were made aware of the above concerns. Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g.. law enforcement when applicable) within specified time frames...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: ...Defining how care and provisions will be changed and or improved to protect residents receiving services..." (1) Shank- a makeshift, knife like weapon. This information was obtained from https://lawenforcementmuseum.org/2010/01/20/contraband-weaponsshivs-and-shanks-a/.	F 609		
F 610 SS=D	COMPLAINT DEFICIENCY Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 610		

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§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 resident interview, staff interview, facility document review, clinical record review and in the course of a complaint investigation, it was determined that facility staff failed to initiate a facility investigation regarding an unusual incident where a stranger had walked into the nursing facility on Sunday, 8/22/21 with a weapon in the form of a shank (1) and handed this weapon to Resident #2; AND failed to put interventions in place to ensure safety to all residents in response to this incident.

The findings included:

Resident #2 was admitted to the facility on 3/13/19 and readmitted on 2/15/20 with diagnoses that included but were not limited to high blood pressure, dementia, anxiety, and depression. Resident #2's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 6/8/21. Resident #2 was coded as being moderately impaired in cognitive function scoring 11 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #2 was coded as not having any behaviors during the 7 day look back period.

On 8/17/21 at 10:55 a.m., an interview was

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1. Investigation regarding the unusual event was completed on 8-23-2021 and an action plan was initiated.
2. Although no resident was harmed all residents are at risk when the facility fails to complete a thorough investigation following an unusual occurrence
3. Education was provided to licensed staff on the investigation of resident incidents and escalation of adverse events to the facility leadership. Staff received education on the process of responding to door alarms and ensuring building is secure.
4. Incident reports will be audited 3 x per week for 4 weeks to ensure thorough investigation are completed for any reported or risk incidents. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
5. DOC 10/3/21

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conducted with Resident #1, another sampled resident. Resident #1 stated that he had made an addendum to his filed complaint and added new information regarding Sunday (8/22/21). Resident #1 stated that last Sunday on 8/22/21 at approximately 6 p.m., a stranger from off the street was able to enter the building with what appeared to be a shank in his hand. Resident #1 stated that he was in the hallway when he saw the gentleman come onto the nursing unit, walk down the hall and hand the shank to a resident (Resident #2) who was sitting in her wheelchair on the hallway. Resident #1 stated that a nursing aide who was also a witness to this incident, immediately intervened and removed the shank from the resident.

Review of Resident #2's clinical record failed to evidence any documentation that this incident had occurred. There was no further evidence in the clinical record indicating that Resident #2 was at risk for harming herself or others.

Review of the Facility Reported Incidents (FRIS) revealed no evidence that this incident has occurred.

On 8/18/21 at 11:15 a.m., an interview was conducted with CNA Certified Nursing Assistant (CNA) #3, the CNA who was witness to the above incident per Resident #1. When asked what had occurred on Sunday 8/22/21, CNA #3 stated that a gentleman was seen on the nursing unit with what appeared to be a shank in his hand. CNA #3 stated that she witnessed the man hand the shank to a resident sitting in her wheelchair on the hallway. When asked if the resident and man knew each other, CNA #3 stated that she was not sure. CNA #3 stated that she immediately

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removed the shank from the resident's (Resident #2's) hands. CNA #3 stated that the DON was also present in the building and a witness. CNA #3 stated that the DON called the police immediately and the man had left the building before the police had arrived. CNA #3 stated that she wasn't sure what door the man entered from, but that the front lobby was always locked. CNA #3 denied having to write a witness statement. CNA #3 could not recall the exact time the man had entered the building.

On 8/18/21 at 1:17 p.m., an interview was conducted with Administrative Staff Member #2, the Director of Nursing (DON). When asked if a FRI or incident report was completed regarding an incident on Sunday, 8/22/21 regarding a man entering the building with a weapon, ASM #2 stated, "No, because I took care of it immediately." When asked if she figured out what door the man entered from, ASM #2 stated, "No."

On 8/18/21 at 2:24 p.m., further interview was conducted with ASM #2. When asked if she could recall the events on 8/22/21, ASM #2 stated that she was in the building working on a medication cart because a nurse had called out. ASM #2 stated that at approximately 6 p.m., she was sitting at the nurses station when she saw an unidentified gentleman enter the nursing unit and walked down the green hall. ASM #2 stated that she quickly got up to follow the man as he was walking really fast. ASM #2 stated that she kept asking "Can I help you with something?" and he continued to walk to the therapy department and then turned around and walked quickly to the end of the pink hall. ASM #2 stated that the man kept saying that he was looking for someone, that it was personal. ASM #2 stated that (Name of

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Resident #2) was sitting in her wheelchair at the end of the pink hall when she introduced herself to the man. ASM #2 stated that was when the man handed the resident a screwdriver. ASM #2 stated that the nursing aide was right there and immediately took the screwdriver away. ASM #2 stated that she was calling the police and that the man then stated, "Go ahead, I am leaving and I am walking toward tidewater drive." ASM #2 stated the man then left the building. ASM #2 stated that the police had arrived and she gave a description to the police. ASM #2 stated that the police told her to just throw the object away. When asked if this object was more like a shank and not a screwdriver, ASM #2 stated, "It was very pointy and sharp." When asked the orientation of Resident #2, ASM #2 stated that Resident #2 was pleasantly confused and had dementia. When asked if the resident could have potentially harmed herself with this object, ASM #2 stated that it was taken out of her hands immediately; that it wasn't even in her hands for a second. ASM #2 stated that the police stated that if man returns, they will arrest him for trespassing. ASM #2 stated that all the doors were locked to the building at all times so she was not sure how this man got in the building. ASM #2 stated that she believed someone may have let him in as they were walking out of the facility. When asked what time family visits stopped on the weekend, ASM #2 stated that she would have to check with activities but that window visits can still occur after 6 p.m. on weekends. When asked if a FRI for this unusual occurrence should have been submitted to the appropriate state agencies, ASM #2 stated that it wasn't that unusual. When stated that it wasn't unusual for a stranger to enter the building with a weapon, ASM #2 clarified and stated that

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homeless people are always in the parking lot. ASM #2 stated that this man was not aggressive towards the staff or the residents. ASM #2 also stated that the incident did not involve a resident. When asked if Resident #2 was handed the shank, ASM #2 stated yes. When asked if Resident #2 could have hurt herself if staff were not present, ASM #2 stated, "Possibly if no one was there." ASM #2 stated that the doors were always locked and could not be entered from the outside unless let in. When asked if there was receptionist who saw this man come into the building, ASM #2 stated that there was no receptionist at this time in the building. When asked if she obtained witness statements on this incident or started an investigation to determine how this man entered the building; ASM #2 stated that she did not. When asked if anything was put into place to prevent this from occurring again, ASM #2 stated that the facility Administrator implemented new hours at the front desk but she didn't know the details of the hours. ASM #2 also stated that she did a walk through of the building after the incident to ensure all doors remained locked. ASM #2 stated that evening shift nurses are also supposed to check all doors. ASM #2 stated that if a door is not shut all the way, it will alarm except the front lobby doors. ASM #2 stated that that night, no alarms were going off so it had to have been the front lobby doors. ASM #2 stated that there is no way to disable the lock to the front lobby doors that is why she believes the man came in while someone was going out. When asked if she provided any in services or education on securing the building or ensuring unauthorized guests are not entering the building as staff/visitors go out, ASM #2 stated that she did not do any in services or education.

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On 8/18/21 at 4:00 p.m., a tour and observation of all the facility exit doors were conducted by two surveyors. All doors including the lobby doors were unabled to be opened from the outside except one door closest to the facility dumpsters. This door was observed at 4:00 p.m. with a code lock. The door was able to be opened, however an alarm had sounded. It took staff one minute (4:01 p.m.) to respond to this alarm. Other Staff Member (OSM) #5, the Dietary Manager stated that the door was not supposed to open unless a code was entered into the keypad. OSM #4, the Director of Maintenance then arrived and stated that the door should not have opened from the outside. OSM #4 stated that he wondered if the door did not latch properly when staff went out of it. When asked what the exit door was used for, OSM #4 stated that housekeeping used that door to get to the facility dumpsters. OSM #4 then shut the exit door tightly and it did not reopen from the outside on the second or third attempt. OSM #5 then stated that kitchen staff used another door directly from the kitchen to access the facility dumpsters. This door that led directly to the kitchen was then observed. This door was not alarmed and did not have a code lock. OSM #5 stated that there is always staff in the kitchen and that the door must be locked using a bolt lock before they leave. OSM #5 stated kitchen staff are not allowed to exit that door for the night, as there is no way to lock it from the outside.

On 8/18/21 at 4:44 p.m., an interview was conducted with the Cook, OSM #3, who was present on Sunday 8/22/21 during the evening shift. OSM #3 stated that he stays in the kitchen until about 7:30 to 8 p.m. on the weekends. OSM #3 did not recall seeing a man enter through the kitchen door or the housekeeping exit door. OSM

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#3 stated that he has to make sure the kitchen door is locked up prior to leaving. OSM #3 then stated that the housekeeping exit door will open without a pass code if the door is not latched properly when staff exit the door. OSM #3 stated that the door however will alarm if the door is opened or left opened.

On 8/18/21 at approximately 5 p.m., an interview was conducted with ASM #1, the Administrator. When asked what was done in response to the incident this past Sunday on 8/22/21, ASM #1 stated that she extended the hours for the front lobby from 9 a.m. to 4 p.m. on the weekends, which meant a staff member would be at the front desk during those times. When asked how this would help when the man had entered the building at approximately 6 p.m., ASM #1 stated that she is also having activities stay until 7 p.m. to watch the front desk and to monitor who comes through the front lobby.

On 8/19/21 at 11:27 a.m., an interview was conducted with OSM #2, the Activities Director. OSM #2 stated that she does work the weekends that was recently told her hours will be extended during the weekends. When asked why her hours are being extended, OSM #2 stated to provide more activities to residents. When asked when she was told her hours would be extended, OSM #2 stated that it was sometime last week. When asked if she was told this past Sunday, OSM #2 stated that she was told before Sunday.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the

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F 610	Continued From page 36 above concerns. Facility policy titled, "Abuse, Neglect and Exploitation" documents in part, the following: "...Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g.. law enforcement when applicable) within specified time frames...Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury...Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: ...Defining how care and provisions will be changed and or improved to protect residents receiving services..." (1) Shank- a makeshift, knife like weapon. This information was obtained from https://lawenforcementmuseum.org/2010/01/20/contraband-weaponsshivs-and-shanks-a/.	F 610		
F 658 SS=D	COMPLAINT DEFICIENCY 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, facility document review and clinical record review, it was determined that facility staff failed to follow professional standards of practice and documented Gabapentin (1) was administered to Resident #1 when it was not sent	F 658		

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F 658	Continued From page 37			

to the facility from pharmacy and not accessed from the emergency STAT box on 7/26/21.

The findings include:

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser toe, acute osteomyelitis (bone infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS).

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1. Resident #1 stated that he was out of his medication for nerve pain for two days.

Review of Resident #1's July 2021 orders revealed the following medication for nerve pain: "Gabapentin Tablet 600 mg (milligrams) Give 1 tablet by mouth two times a day for pain."

Review of the narcotic logs for Gabapentin revealed that 30 tablets arrived to the building on 7/12/21 from pharmacy. The count went to 0 (zero) on 7/26/21 at 9:00 a.m.

Further review of the narcotic logs revealed that 60 tablets were sent to the building on 7/27/21. The first dose administered from this pack was

F 658

1. Medication Gabapentin was received at facility for Resident #1 on 8/28/21.
2. All residents have the potential to be affected when professional standards of practice are not followed
3. Education will be provided to licensed nursing staff on medication administration and documentation and notification of MD if medication is unable to be given.
4. DON will conduct audits of 5 medications on 10 residents weekly x 4 weeks comparing MAR against medication availability. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
5. DOC 10/3/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 38 on 7/28/21 at 9:00 a.m.	F 658		

Further Review of Resident #1's July MAR revealed that staff documented that they had administered the Gabapentin on 7/26/21 at 5 p.m. and 7/27/21 at 9:00 a.m. and 5 p.m.

Review of the emergency STAT box list revealed that Gabapentin 300 mg (milligrams) was a medication in the STAT box.

Review of the emergency STAT box pull list from pharmacy revealed that the only time staff tried to access the STAT box for the Gabapentin was on 7/27/21 for both the morning and evening shifts. 2 tablets were pulled to equal 600 mg. There was no evidence that staff attempted to access the emergency STAT box list on 7/26/21 at 5 p.m.

There was no evidence that Resident #1 experienced any pain or negative outcomes on 7/26/21 when his Gabapentin was missed x 1 dose.

On 8/18/21 at 1:31 p.m. and 4:22 p.m. an interview was attempted with the nurse who failed to administer the Gabapentin on 7/26/21 at 5 p.m. She could not be reached for an interview.

On 8/18/21 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse #2, a nurse who worked 7 p to 7 a with Resident #1 frequently. When asked the process for obtaining a medication from emergency STAT box, LPN #2 stated that nurses have to call pharmacy to obtain a code in order to pull medications out of the emergency STAT box. When asked if it was ever okay to sign off that a medication was administered to a resident when it was not given,

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F 658	Continued From page 39 LPN #2 stated, "You're not supposed to sign off if it wasn't given." On 8/18/21 at 12:53 p.m., an interview was conducted with Other Staff Member (OSM) #6 the lead pharmacist. OSM #6 confirmed that the only time facility staff tried to access the STAT box was on 7/27/21. OSM #6 stated that staff did not access the STAT box on 7/26/21. On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns. Facility policy titled, "Medication Administration" documents in part, the following: "Sign MAR after administered." (1) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health. https://pubmed.ncbi.nlm.nih.gov/28597471/.	F 658		
F 677 SS=E	COMPLAINT DEFICIENCY ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		

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F 677	Continued From page 40	F 677		

Based on observation, resident and staff interviews and clinical record review the facility staff failed to ensure 3 of 11 residents (Resident #6, Resident 11 and Resident #8) in the survey sample who were unable to carry out activities of daily living (ADL) receives the necessary care services.

The findings included:

1. The facility staff failed to ensure Resident #6 received showers twice a week. Resident #6 was originally admitted to the nursing facility on 05/11/21. Diagnosis for Resident #6 included but not limited to Congestive Heart Failure (CHF.)

Resident #6's Minimum Data Set (MDS - an assessment protocol) an annual assessment with an Assessment Reference Date of 05/18/21 coded Resident #6's Brief Interview for Mental Status (BIMS) scored a 13 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #6 total dependence of one with bathing, extensive assistance of one with bed mobility and dressing, limited assistance of one with transfer, eating, toilet use and personal hygiene for Activities of Daily Living (ADL) care.

The care plan dated 05/27/21 identified Resident #6 with ADL self-care performance deficit. The goal set for the resident by the staff was that the resident will maintain and improve current level of function. One of the interventions/approaches the staff would use to accomplish this goal for a dependent resident is that staff is to provide bath/shower (specify frequency) and as necessary.

F 677

1. Shower room was cleared and cleaned 8-20-2021. Shower schedule in place 8-20-2021 for indicated residents. Resident #6 shower completed on 8-24-2021 and 9-1-2021 and Resident #8 on 9-7-2021. Resident #11 was discharged on 1-29-2021. Resident #8 nails were trimmed on 8-18-2021. Residents with shower preferences were added to current shower schedule.

2. All residents who are dependent on staff for ADL's are at risk when care is not provided/offered.

3. 100% of Residents will be surveyed regarding shower vs bathing preferences and care plans will be updated to reflect resident's bathing/shower preference. Staff education will be provided to certified staff to include; provision of nail care, following resident shower schedule and how to address resident refusals.

4. Audits will be conducted to ensure shower and nail care is being provided according to schedule 3 X a week for 4 weeks. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance.

5. DOC 10/3/21

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On 08/17/21 at approximately 11:05 a.m., an interview was conducted with Resident #6 who stated, "I have only had one shower since I've been admitted to the facility." The resident proceeded to say, "I have never refused my showers and the staff don't ask."

Review of Resident #6's documentation survey report for bathing revealed the following: Showers were not given for the entire month of July 2021 and has not been given for the month of August as of 08/17/21.

On 08/18/21, the facility provided documentation of resident #6's shower scheduled: Resident #6 was scheduled to receive showers every Tuesday and Friday (7a-7p shift).

An interview was conducted with Certified Nursing Assistant (CNA) #5 on 08/19/21 at approximately 8:30 a.m. The CNA was assigned to provide Resident #6 her shower on 08/13/21. She stated, "I don't remember if Resident #6 refused her shower but if she did, the refusal was reported to the charge nurse so it could be charted in her record." During the review of Resident #6's clinical record for July and August 2021 revealed that Resident #6 has never refused her showers.

On 08/19/21, an interview was conducted with CNA #6 at approximately 8:52 a.m. CNA #6 was assigned to provide a shower to Resident #6 on 08/17/21. The CNA said Resident #6 is usually sleepy and will sometimes refuse her showers. The CNA stated, "If a resident refuse their shower, it's reported to the nurse and they will document the refusal." Review of Resident #6's clinical record revealed there were no refusal of

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care to include showers for Resident #6.

An interview was conducted with the Director of Nursing (DON) on 08/19/21 at approximately 9:13 a.m. The DON said she expect for the CNA's to follow the resident's shower schedule and notify the charge nurse if the resident refuses. The CNA is also to document the refusal in Point Click Care (PCC) and the nurse is to document the refusal in the resident's clinical record.

2. The facility staff failed to ensure Resident #11 received showers twice a week. Resident #11 was originally admitted to the nursing facility on 05/24/19. Diagnosis for Resident #11 included but not limited to muscle weakness.

Resident #11's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date (ARD) of 11/30/19 coded Resident #11's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. In addition, the MDS coded Resident #11 limited assistance of one with bed mobility and toilet use, supervision with dressing, toilet use, personal hygiene and bathing for Activities of Daily Living (ADL) care.

The care plan dated 05/25/19 with a revision date identified Resident #11 requiring assistance with ADL's at times. The goal set for the resident by the staff was that the resident abilities will be maximized, remain clean and free of body odor, will be groomed and well-nourished with your assistance. One of the interventions/approaches the staff would use to accomplish this goal is that staff to assist bathing when needed.

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Review of Resident #11's documentation survey report for bathing revealed the following: Showers were not given for the entire month of December 2020 and only given twice for the month of November 2020; on 11/03 and 11/22/20.

An interview was conducted with the Director of Nursing (DON) on 08/19/21 at approximately 9:13 a.m. The DON said she expect for the CNA's to follow the resident's shower schedule and notify the charge nurse if the resident refuses. The CNA is also to document the refusal in Point Click Care (PCC) and the nurse is to document the refusal in the resident's clinical record.

3. The facility staff failed to ensure that fingernail care was provided to Resident #8. Resident #8 was originally admitted to the facility on 10/23/17. Diagnosis for Resident #8 included but not limited to Heart Failure and Type II Diabetes.

The current Minimum Data Set (MDS) a quarterly assessment with an Assessment Reference Date (ARD) of 07/06/21 coded Resident #8 with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) indicating no cognitive impairment. In addition, the MDS coded Resident #8 requiring total dependence of one with bathing, extensive assistance of two with transfer and toilet use, limited assistance of two with bed mobility and dressing, limited assistance of one with personal hygiene.

The care plan with a revision date of 10/23/20 identified Resident #8 with ADL self-care performance deficit related to fatigue and impaired balance. The goal set for the resident by the staff was that the resident will maintain

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current level of function with ADL's. One of the interventions/approaches the staff would use to accomplish this goal is
during bathing/showering to check nail length and trim and clean on bath day as necessary; report any changes to the nurse. Resident #8's showers days are scheduled every Monday and Thursday (7a-7p) shift.

During the initial tour on 08/17/21 at approximately 10:50 a.m. Resident #8 was observed lying in bed with her hands on the outside of her covers. The surveyor observed Resident #8's fingernails were very long with a brown substance under the nails. On the same day at approximately 1:42 p.m., Resident #8 fingernails remained unchanged. Resident #8 said my fingernails are long and nasty, they need to be cut/soaked and filed. Resident #8 stated, "Can someone cut my fingernails?" On the same day at approximately 1:50 p.m., License Practical Nurse (LPN) #4 assessed Resident #8's fingernails with the surveyor present. The LPN stated, "Yes, Resident #8's fingernails need to be cleaned/cut and trimmed, I'll take care of it today."

On 08/18/21 at approximately 9:10 a.m., Resident #8's fingernails had be cleaned/cut and filed. Resident #8 stated, "Thank you for getting my fingernails taken care of so quickly, I've been trying for weeks to have the staff cut my fingernails."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

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F 684 SS=E	Complaint deficiency Quality of Care CFR(s): 483.25	F 684		

§ 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 resident interview, staff interview, clinical record review, facility document review, and in the course of a complaint investigation it was determined that facility staff failed to adequately assess and monitor a diabetic foot ulcer and obtain a new treatment in a timely manner for one of 11 sample residents, Resident #1; failed to follow wound care orders for one of 11 residents, Resident #1; failed to adequately assess and monitor a resident's change in condition related to a PICC line for one of 11 residents, Resident #1; AND failed to follow physician orders for five of 11 sampled residents; Resident #1, #3, #4, #5 and #11.

The findings include:

1. Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser

1. Resident #1 had no further episode with PICC line after 7/23/21. PICC line was flushed at time of incident, patient was monitored for signs of adverse effects, no negative signs and symptoms was indicated. PICC line was discharged on 9/1/21. Resident #3 received Metformin HCL on 12/26/20, remaining medications were all administered on 12/28/20. Resident #3 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #4, all medications were administered on 12/27/20. Resident #4 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #5 received all medication on 12/27/20, except for Trazodone which was administered on 12/28/20. Resident #5 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #11 received medication on 4/11/20. Resident #11 was monitored for signs of adverse effects; no negative signs and symptoms was indicated. Resident #1 had skin assessment completed on 7-26-2021. Resident #1 wound care orders were completed on 7/25/21. Resident #1 received nerve pain and insulin per physician's orders on 7/30/21.

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toe, acute osteomyelitis (bone infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded as requiring extensive assistance from one staff with bed mobility, and toileting; total dependence with two staff with transfers and bathing; limited assistance from one staff with personal hygiene; and supervision only with locomotion on and off the unit. Resident #1 was coded in Section M (Skin Conditions) as having two (2) arterial ulcers and having a surgical wound.

Review of Resident #1's hospital discharge summary dated 7/9/21 documented in part, the following: "Chief Complaint: Foul smelling blood blister to right foot...history of spinal cord injury with residual right-sided weakness, currently in acute rehab (other nursing facility at the time), resents (sic) with the above complaint...The patient had started to stand and work with physical therapy at the acute rehab. When at some point in time he bumped his right foot. Over the course of time this led to a red blistering and began to have malodorous smell to it. He subsequently went to this podiatrist (Name) who sent him to the emergency department...Osteomyelitis right foot. Plantar forefoot soft tissue ulceration and evidence of osteomyelitis/septic joint involving the fourth MTP (big toe) joint. Patient surgery by podiatry on 7/2: Amputation of right 4th toe at the MTP (big toe

2. All residents are at risk when changes in condition are not assessed and monitored timely and when MD orders are not followed
3. Education was provided to licensed staff on the facility Change of Condition process and following MD/RP orders. Staff to be educated on wound vacs and on call resources for questions they have on using device
4. DON or designee will review new MD orders 3 x per week X 4 weeks to ensure all new MD orders have been implemented. Audits will be completed weekly X 4 weeks to ensure residents who are experiencing a change in condition are being identified, assessed, and monitored. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance
5. DOC 10/3/21

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joint), Partial 4th metatarsal resection right foot and excisional debridement of open wound right foot to level of muscle- post debridement measurements approximately 7 cm x 6 cm x 0.3 cm (centimeters)...wound vac (1) applied...on Zosyn (2) (antibiotic) until August 13th...follow up with Infectious Disease and podiatrist...Discharge: Follow up with surgeon in 1 week...Discharge Wound VAC...Discharge Activity: As per podiatrist recommendation, please make sure patient gets PT (Physical Therapy)...Home Health Services: Skilled Nursing ONLY Wound VAC: Suction frequency: Continuous, Place suction to area of body: right plantar foot. Wound VAC suction to 125 mmHg (millimeters of mercury). Change Wound VAC: Every other day at 0900 (9:00 a.m.). Change Canister: When Full."

Review of Resident #1's July 2021 admission orders revealed the following order was initiated on 7/11/21: "Change wound vac every other day at 0900 Suction at 125 mmHg apply wet to dry dressing if wound vac not in place."

Review of a note from the physician dated 7/11/21 documented in part, the following: "...7/2...Excisional debridement of open wound right foot to level of muscle - post debridement measurements approximately 7 cm x 6 cm x 0.3 cm...on Zosyn until August 13th...wound vac applied...follow up with Infection Disease and podiatrist..."

Review of Resident #1's clinical record revealed a note from the wound care physician on 7/12/21 that documented in part, the following: "Chief Complaint: Comprehensive skin and wound evaluation for new admission to facility for Right

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foot fourth toe amputation surgical and right plantar foot surgical...Current conditions: Acute osteomyelitis, right ankle and foot...Plan: Wound plan of care: Patient wearing fleece lined surgical boots. Intravenous (IV) antibiotics for osteomyelitis to right foot. PICC (peripherally inserted central catheter) line (3) to right upper arm. Wound VAC to plantar right foot per surgeon order. Patient will follow up with surgeon. See Tissue Analytics Documentation for full wound description and recommended nursing plan of care. Plan of Care Assessment and (&) Plan - Patient with diabetic ulcer noted, discussed case in depth with staff and patient. Patient needs extensive off loading of foot ulcer, hyperglycemia (high blood glucose) control, and aggressive wound care dressing management. Consults: I recommended to patient and staff today to F/U (follow up) with operating surgeon as ordered."

Review of the wound care physician's observations to Resident #1's right plantar foot revealed that measurements and a description of the diabetic foot ulcer was not provided. The following was documented in part, "7/12/21...Length: 0.00 cm, Width: 0.00 cm, Depth --, Red: 0.00 cm2, Black: 0.00 cm2, Yellow: 0.00 cm2, Pink: 0.00 cm2. Other: 0.00 cm2...Wound VAC per surgical orders. Monitor for infection. Follow up with surgeon...Present upon admission. Etiology: Surgical Wound."

Review of Resident #1's July 2021 Treatment Administration Record (TAR) revealed that staff were implementing the above orders for the wound vac until 7/19/21 when a blank (no staff signature) was noted on the TAR for 7/19/21.

A nursing note dated for 7/20/21 documented in

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part, the following: "...wound vac changed. irregular borders, light drainage noted upon removal of sponge. slight bleeding noted near stitches upon removal. pressure applied x 5min, bleeding stopped. tissue pink with little necrosis (dead tissue) noted. removed canister look new, no drainage inside. patient tolerated treatment well. new system suctioning fine, no issues noted."

There was no evidence in the clinical record of a description of what the right plantar wound had looked like in appearance directly prior to 7/20/21.

There was no evidence in the clinical record that the nurse on duty notified the physician and obtained a new treatment order for the necrotic tissue present as documented in her note.

Further review of the July 2021 TAR revealed that Resident #1's wound vac was not changed on 7/21/21 (the next scheduled day) due to it being changed on 7/20/21. The following Electronic Treatment Note (eTAR) was documented by the nurse on duty: "Treatment was provided 07/20/21."

Due to the treatment not being provided on 7/21/21 it was also not provided on 7/22/21 because this was not a scheduled treatment day (No treatment was provided for two days in a row).

Review of a nursing note dated 7/23/21 documented the following: "Resident noted with necrotic area and slough to the surgical wound on the right foot. Area cleansed and new order for alginate (4) and santyl (5). Resident phoned his podiatrist and made an appointment for Monday

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July 26, 2021 @ (at) 1:00 pm. Resident also scheduled transportation. Provider made aware of clinical situation."

The only non-pressure weekly wound assessment found in Resident #1's clinical record was on 7/23/21. The following was documented: Type of wound: Surgical. Location: right foot. Date wound noted: 7/1/21. Visible tissue overall impression: worsening. Drainage: none. Wound Measurements (Length x Width x Depth): 5.2 centimeters (cm) x 3.5 x (no depth documented). Description of peri (around) wound tissue: necrotic slough. Describe wound edges and shape: irregular..."

A nursing note dated 7/26/21 documented the following: "Returned from foot appt (appointment), MD (Medical Doctor) order to replace wound vac. site debrided."

An after visit summary from podiatry dated 7/26/21 could not be found in Resident #1's clinical record. Attempts were made from this writer to obtain visits from Resident #1's podiatry office during the course of survey. The podiatry office would not provide this information.

There was no evidence of any further missed dressing changes to Resident #1's plantar foot wound after 7/23/21.

An after visit summary obtained from this writer from Resident #1's Foot and Ankle Specialist (not the podiatrist) documented in part the following measurements on 8/9/21: "Right fourth incision completely healed. The plantar foot wound measures 4.5 cm x 3.5 cm x 0.4 cm in depth. The wound is 70 percent granular (red healing tissue)

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30 percent fibrotic islands (healing tissue). There is no exposed bone or tendon. No malodor (odor). no erythema (redness) or acute sign of infection...return in about 4 weeks (9/6/2021)."

On 8/18/21 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse (LPN) #2, a nurse who worked 7 p to 7 a with Resident #1 frequently. LPN #2 was an agency nurse. The first time LPN #2 had seen Resident #2's right plantar wound was on 8/6/21 due to the dressing being placed on "Sloppy" by the day shift nurse. LPN #2 stated that on 8/6/21 Resident #1's wound vac had been beeping that night indicating there was no suction. LPN #2 stated that nursing staff did not receive training from the facility on how to properly apply wound vacs; although she knew the basics as a licensed nurse. When asked what the nurses were classifying Resident #1's wound as, LPN #2 stated, "I want to say it is a pressure ulcer. I am not entirely sure." When asked if his wound was aterial, diabetic or surgical as the MDS documents his right plantar wound as arterial but the wound care physician documents both surgical and then diabetic, LPN #2 stated again that she was not exactly sure. When asked if nurses were expected to do any type of monitoring of a wound that is identified to a resident, LPN #2 stated that she didn't know much about the facility's policies and procedures regarding wounds, but that she was never made aware as a night shift nurse to conduct any type of weekly or biweekly skin assessments. LPN #2 stated that she is used to conducting either weekly or biweekly skin assessments at other nursing facilities for wounds. When asked if this included non pressure ulcers, LPN #2 stated that it did. When asked the purpose of the weekly or biweekly skin assessments; LPN #2 stated that

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the purpose was to ensure healing or to see if the wound was getting worse. When asked if she knew if his wound had deteriorated since his admission into the facility; LPN #2 stated that she was not sure that she usually just goes by what Resident #1 says. LPN #2 stated that Resident #1 had told her that nursing staff missed his wound vac dressing for a couple of days and that necrotic tissue had formed. LPN #2 stated that Resident #1 had to go out to an appointment to get the necrotic tissue removed. LPN #2 denied seeing any further necrotic tissue when she had to redress his wound on 8/6/21.

On 8/18/21 at 2:00 p.m., an interview was conducted with Administrative Staff Member (ASM) #2, the DON (Director of Nursing). When asked how often wound assessments were conducted on residents with wounds, ASM #2 stated that wound assessments should be conducted by nursing staff weekly. When asked what would be included in a wound assessment, ASM #2 stated that measurements would be obtained and the description of the wound such as signs/symptoms of infection/drainage would be documented. When asked if the same process would be followed for non-pressure wounds, ASM #2 stated that all wounds would be assessed monitored. When asked the etiology of Resident #1's right plantar wound, ASM #2 stated that his wound started at another nursing facility as a diabetic ulcer. ASM #2 was made aware by this writer that the only assessment found to Resident #1's right plantar wound was on 7/23/21 when necrosis was found. ASM #2 stated that she would go look for any other wound assessments. ASM #2 was also shown the assessment from the wound care physician that documented "zeros" for all measurements on 7/12/21 for

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Resident #1's right plantar wound. ASM #2 stated again that she will try to find documentation "especially if it was not being followed by the wound specialist who comes in weekly." ASM #2 stated that the wound care specialist may have documented all zeros because the right plantar wound was also surgical and being followed by a foot specialist. When asked if she also expected her nurses to do a wound assessment on residents coming in with wounds, ASM #2 stated that she would expect the admission nurse who was doing all the admission paperwork to assess the wound. When asked the purpose of conducting wound assessments, ASM #2 stated that the purpose was to monitor and to keep track to make sure the wound was healing. When asked who found the necrotic tissue on 7/23/21, ASM #2 stated that the day shift nurse had called her in Resident #1's room because of the necrotic tissue. ASM #2 stated that the nurse informed her that she could not apply the wound vac back onto his foot because of the necrosis. ASM #2 stated that anytime necrotic tissue is present, a wound vac will not help the wound. ASM #2 stated that a wound vac only works with good granulation tissue. ASM #2 stated that she obtained an order for santyl and calcium alginate and that the resident had immediately made an appointment with his ortho podiatrist for 7/26/21. ASM #2 stated that the wound was then debrided at his appointment on 7/26/21 and an order to reapply the wound vac was sent back with the resident. When asked if all nursing staff knew that a wound vac should not be applied to necrotic tissue, ASM #2 stated, "Probably not." When asked if necrotic tissue was present before 7/23/21 such as on 7/20/21 when the nurse documented that she applied the wound vac to the necrotic tissue, ASM #2 stated that she could not speak for that nurse,

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that she wasn't sure if the nurse was really looking at necrotic tissue. When asked if all nurses were trained on wound vacs, ASM #2 stated that not all nurses were trained on wound vacs especially because majority of staff were agency but that she expected nursing staff to come get her or someone who is familiar with wound vacs if they have questions or did not feel comfortable with wound vacs.

On 8/18/21 at 2:30 p.m., an interview was conducted with LPN #1, an agency nurse who changed Resident #1's dressing on Friday 7/16/21; four days prior to necrotic tissue being documented as found on 7/20/21. LPN #1 stated that on 7/16/21 Resident #1's wound was not necrotic. LPN #1 stated, "It looked like really good pink tissue." LPN #1 stated that there was a little bit of slough present but not nearly what it was on 7/23/21. When asked what necrotic tissue meant, LPN #1 stated that necrotic tissue was dead tissue. LPN #1 stated that she had heard the resident's dressing change was missed on one of the scheduled days throwing off his entire schedule for wound vac changes. LPN #1 stated that a new dressing was not placed on the last scheduled day (7/21/21) prior to 7/23/21 and that the wound was necrotic on 7/23/21 when she saw it. LPN #1 stated that she called the DON and the DON had made an assessment. LPN #1 stated that wound vac does not work on necrotic tissue and a new dressing was obtained. When asked if she was made aware that his wound was documented as necrotic on 7/20/21, LPN #1 stated that she was not aware. LPN #1 then stated, "I guess they shouldn't have put the vac back on it then." When asked how often wounds were assessed by nursing staff, LPN #1 stated that in other nursing facilities she was used to

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doing wound assessments on a weekly basis. When asked if this was true for non- pressure wounds such as diabetic, arterial or surgical, LPN #1 stated that it was. LPN #1 stated that she didn't think nurses did weekly wound assessments on non-pressure wounds at the current facility because she has never had to do one.

On 8/18/21 at 4:32 p.m., further interview was conducted with ASM #2. ASM #2 stated that there were no weekly wound measurements for Resident #2's right plantar wound because the wound was surgical and being followed by the outside specialist. ASM #2 stated that the wound was originally a diabetic ulcer that was surgically debrided now making the wound a surgical wound. When asked how staff were monitoring this wound if there are no assessments on the wound, ASM #2 stated that staff look at the wound with dressing changes. When asked how we know when the necrotic tissue started to the right plantar foot if there are no assessments prior to 7/20/21, ASM #2 stated that she was first made aware of the necrotic tissue on 7/23/21 and that she expected staff to get her for an assessment if they notice changes like necrotic tissue. When asked if all after visit summaries from outside providers should be placed on Resident #1's medical record to help with the coordination of care and the management of his wound, ASM #2 stated that they usually get orders back but not necessarily the after visit summary for each visit.

On 8/18/21 at 1:31 p.m. and 4:22 p.m. an interview was attempted with the nurse who documented Resident #1's wound as having necrotic tissue on 7/20/21. She could not be

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reached for an interview.

On 8/19/21 at 11:55 a.m., an interview was conducted with ASM #4, the wound care physician. ASM #4 stated that she was not allowed to conduct assessments on any resident that does not have a pressure ulcer. ASM #4 stated in other facilities she is allowed to measure and assess other wounds including surgical wounds even if the resident is being seen by an outside provider as a second pair of eyes on the wound. ASM #4 stated that Resident #1's wound first started out as a diabetic ulcer. ASM #4 stated that because his right plantar wound was surgically debrided to the level of the muscle, it was classified as a surgical wound upon admission into the facility.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns. When asked ASM #2 if necrosis was documented as being present on 7/20/21 to Resident #1's wound bed if a new order should have been obtained at that time, ASM #2 agreed that it should have been. ASM #2 agreed that this was also a delay in treatment.

The only wound policy that could be provided as a facility policy titled, "Wound Treatment Management" that documents in part, the following: "To promote the healing of various types of wounds, it is the policy of this facility to provide evidence based treatments in accordance with current standards of practice and physician orders...Wound treatments will be provided in accordance with physician orders, including the

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cleansing method, type of dressing, and frequency of dressing change...The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: a. Lack of progression towards healing. b. Changes in the characteristics of the wound. c. Changes in the resident's goals and preferences, such as end of life or in accordance with his/her rights."

(1) A wound vacuum (Wound Vacuum Assisted Closure) is a device that assists in wound closure by applying localized negative pressure to draw the edges of the wound together....accelerates wound healing...."
This information was obtained from Fundamentals of Nursing 6th Edition, Potter & Perry, 2005. Page 1536,

(2) Zosyn also known as Tazocin® piperacillin/tazobactam is an intravenously administered antibiotic. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504059/.

3) PICC (peripherally inserted central catheter)- Central catheter is a venous access device that ultimately terminates in the superior vena cava (SVC) or right atrium (RA). They can be inserted centrally (centrally inserted venous catheter; CICC) or peripherally (PICC). PICCs are placed through the basilic, brachial, cephalic, or medial cubital vein of the arm. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK459338/ >

(4) Calcium Alginate- Alginate dressings are

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indicated for use as a primary dressing in the treatment of moderately to heavily exuding partial- and full-thickness draining wounds such as stage III-IV pressure ulcers, dermal wounds, surgical incisions, dehisced wounds, tunneling wounds, sinus tracts, and donor sites. This information was obtained from https://www.woundsource.com/product-category/dressings/alginates.

(5) *SANTYL® Ointment is an FDA-approved active enzymatic therapy that continuously removes necrotic tissue from wounds at the microscopic level. This works to free the wound bed of microscopic cellular debris, allowing granulation to proceed and epithelialization to occur. (<http://www.santyl.com/about>)

2. The facility staff failed to adequately assess and monitor a resident's change in condition related to a PICC (peripherally inserted central catheter) line for Resident #1.

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser toe, acute osteomyelitis (bone infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS).

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Resident #1 was coded in Section N (Medications) as receiving antibiotics. Resident #1 was coded in Section O (Special Treatments and Programs) as receiving intravenous (IV) medications.

Review of Resident #1's July 2021 POS (Physician Order Summary) documented the following orders:

1) "Zosyn (antibiotic) (1) 3-0.375 grams (GM). Use 3.375 gram intravenously every 6 hours for infection for 150 administrations." This order was discontinued on 8/12/21.

2) Heparin Lock Flush solution (2) 1 UNIT/ML (unit/milliliter). Use 1 unit intravenously every 6 hours for PICC (3) maintenance. This order was discontinued on 7/23/21. This order was changed to PRN (as needed) on 7/23/21.

On 8/17/21 at 10:55 a.m., an interview was conducted with Resident #1. Resident #1 had discussed his concern that he didn't feel like in the beginning of his stay, staff were properly flushing, clamping and monitoring his PICC line. Resident #1 had stated that on the evening of 7/23/21, the 7 am to 7 pm nurse; who he could not identify forgot to clamp his PICC line. Resident #1 stated as a result of this incident, a large amount of blood had come out of his line and went all over his bed, siderail and floor. Resident #1 denied any further episodes of bleeding prior to and after 7/23/21.

Review of Resident's #1 clinical record revealed no documentation regarding the incident on 7/23/21; 7 a.m. to 7 p.m. shift.

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Review of Resident #1's care plan dated 7/25/21 documented in part, the following: "(Name of Resident #1) has potential for infection related to catheter direct access to blood r/t (related to) PICC IV...Monitor for hemorrhage due to dislodgement of catheter, broken or disconnected lines. Report any abnormal findings to physician..."

Further review of Resident #1's clinical record revealed vital signs were obtained on 7/23/21 at 2:02 p.m. The following was recorded: BP (blood pressure): 124 / 63 mmhg; 67 beats per minute, 96 percent room air oxygen saturation. No further vital signs were recorded for 7/23/21.

A nursing note dated 7/23/21 night shift, (7 p.m. to 7 a.m.) documented in part, the following: "Continues IV Pip/Tazo 3.375 (Zosyn). no adverse reactions. double lumen picc to RUE (Right Upper Extremity), patent. blood return present. no s/s (signs and symptoms) of irritation or infection noted. blood noted to bedsheets, per patient site was bleeding earlier. this nurse insisted on changing sheets more than once, patient declined multiple times."

Further review of Resident #1's clinical record revealed no prior incidences of bleeding from his PICC line. There was no evidence of any bleeding from his PICC line after 7/23/21.

There was no evidence of an assessment done on Resident #1 regarding the incident or an follow-up assessments thereafter.

A physician note could not be found in Resident #1's clinical record regarding the above incident on 7/23/21.

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On 8/18/21 at approximately 2:30 p.m., an interview was conducted with Licensed Practical Nurse (LPN) #1, the nurse who worked on 7/23/21 7 a to 7 p shift. When asked if she could recall an incident where Resident #1's had blood coming out of his PICC line and had leaked all over his bed, bed rail and floor, LPN #1 stated that this had happened on one occasion. LPN #1 stated that she could not recall the exact time she saw the blood but that the blood was dried on the floor, bed rail and on his sheets. LPN #1 stated it was a large amount of blood that had leaked from his PICC line. LPN #1 stated that she was not sure if this had happened on the previous shift 7 p to 7 a and she walked into his room on her first rounds or if it had happened on her shift. LPN #1 was not quite sure because she stated her first rounds may have been late. LPN #1 did not recall making rounds prior to seeing the blood all over the resident's bed, floor and rail. LPN #1 stated that she recalled cleaning up the blood with bleach from the floor and rail. LPN #1 stated that she assessed the PICC line and stated that it was clamped at that time. LPN #1 stated that the PICC line was not actively bleeding at the time of her assessment. LPN #1 stated that she flushed the line with normal saline and she had no issues with the flush. LPN #1 stated that Resident #1 was also had no changes to his mental status or anything that would alert her that he was having a change in condition. LPN #1 stated that the bleeding may have been from the Heparin flushes that were scheduled every shift and now were ordered for PRN (as needed). When asked if she had documented her assessment in the clinical record, LPN #1 stated that if it wasn't in the clinical record then she didn't document her assessment. When asked if she had notified the

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physician of this incident, LPN #1 stated that she did not because the Resident was not having any changes in his condition. LPN #1 stated that she kept checking on the resident to see if he had any changes. When asked what checking entailed, LPN #1 stated she would pop in his room and check in on him. When asked if vital signs were obtained at the time she discovered the blood or thereafter for monitoring, LPN #1 stated she just looked at the vital signs that were already obtained earlier in the shift by the CNA (Certified Nursing Assistant). When asked if the discontinued Heparin flushes were in response to the bleeding episode on 7/23/21, LPN #1 stated that she thought that may have already been an order prior to the incident.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

(1) Zosyn- also known as Tazocin® piperacillin/tazobactam is an intravenously administered antibiotic. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504059/.

(2) Heparin Lock Flush- Heparin flush belongs to the family of drugs called anticoagulants. This is used to prevent blood from clotting or "stopping up" your intravenous (IV) line. Heparin, in the doses used to flush IV lines, should not normally keep your blood from clotting elsewhere in your body. This information was obtained from https://cookchildrens.org/SiteCollectionDocument

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s/HomeHealth/Education/InfusionTherapy/CCHH_Infusion_HeparinandSodiumChlorideFlush.pdf.

(3) PICC (peripherally inserted central catheter)- Central catheter is a venous access device that ultimately terminates in the superior vena cava (SVC) or right atrium (RA). They can be inserted centrally (centrally inserted venous catheter; CICC) or peripherally (PICC). PICCs are placed through the basilic, brachial, cephalic, or medial cubital vein of the arm. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/books/NBK459338/ >

3. The facility staff failed to administer medication for nerve pain on 7/26/21; scheduled insulin on 8/2/21; and sliding scale insulin on 8/6/21 for Resident #1 per physician's order.

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser toe, acute osteomyelitis (bone infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded in Section N (Medications) as receiving insulin injections.

On 8/17/21 at 10:55 a.m., an interview was

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conducted with Resident #1. Resident #1 stated that he was out of his medication for nerve pain for two days and also that facility staff sometimes forget to check his blood sugar or give him insulin prior to his meals. Resident #1 stated he sometimes misses his scheduled insulin injections.

Review of Resident #1's July 2021 orders revealed the following medication for nerve pain: "Gabapentin (1) Tablet 600 mg (milligrams) Give 1 tablet by mouth two times a day for pain."

Review of the narcotic logs for Gabapentin revealed that 30 tablets arrived to the building on 7/12/21 from pharmacy. The count went to 0 (zero) on 7/26/21 at 9:00 a.m.

Further review of the narcotic logs revealed that 60 tablets were sent to the building on 7/27/21. The first dose administered from this pack was on 7/28/21 at 9:00 a.m.

Further Review of Resident #1's July MAR revealed that staff documented that they had administered the Gabapentin on 7/26/21 at 5 p.m. and 7/27/21 at 9:00 a.m. and 5 p.m.

Review of the emergency STAT box list revealed that Gabapentin 300 mg (milligrams) was a medication in the STAT box.

Review of the emergency STAT box pull list from pharmacy revealed that the only time staff had accessed the STAT box for the Gabapentin was on 7/27/21 for both the morning and evening shifts. 2 tablets were pulled to equal 600 mg. There was no evidence that staff attempted to access the emergency STAT box list on 7/26/21

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at 5 p.m.

There was no evidence that Resident #1 experienced any pain or negative outcomes on 7/26/21 when his Gabapentin was missed x 1 dose.

On 8/18/21 at 12:53 p.m., an interview was conducted with Other Staff Member (OSM) #6 the lead pharmacist. OSM #6 confirmed that the only time facility staff tried to access the STAT box was on 7/27/21. OSM #6 stated that staff did not access the STAT box on 7/26/21.

On 8/18/21 at 1:31 p.m. and 4:22 p.m. an interview was attempted with the nurse who failed to administer the Gabapentin on 7/26/21 at 5 p.m. She could not be reached for an interview.

Review of Resident #1's August 2021 POS (Physician Order Sheet) revealed the following insulin orders:

"Admelog SoloStar Solution Pen Injector (2) 100 Unit/ML Inject 4 units subcutaneously with meals for DM (Diabetes Mellitus.

"Admelog SoloStar Solution Pen Injector 100 Unit/ML (Insulin Lispro (1 Unit Dial) Inject as per sliding scale; if
201-250 = 2 units;
251-300 = 4 units;
301-350 = 6 units;
351-400 = 8 units;
401-550 = 10 units of not resolved in 2 hours, call MD (medical doctor). Subcutaneously (under the skin) before meals and at bedtime for diabetes, low blood sugar."

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Review of Resident #1's August 2021 MARs revealed that his scheduled insulin was missed on 8/2/21 at 4:00 p.m. Resident #1's sliding scale insulin and blood sugar check was not completed on 8/2/21 as well at 4:30 p.m. Resident #1's blood sugar was documented at "301" at the next glucose check on 8/2/21 at 10:00 p.m.

Further review of Resident #1's August 2021 MAR revealed that he missed his sliding scale insulin on 8/6/21 at 11:30 a.m. The following nursing note was documented: "PATIENT HAD EATEN."

The nurse who failed to administer the scheduled and sliding scale insulin on 8/2/21 and 8/6/21 had passed away suddenly and could not be reached for an interview.

On 8/18/21 at 11:38 a.m., an interview was conducted with Licensed Practical Nurse #2, a nurse who worked 7 p to 7 a with Resident #1 frequently. When asked what blanks or no signatures meant on the MAR, LPN #2 stated that no signatures meant the medication was not given. When asked if Resident #1 had ever made her aware that the 7 a to 7 p shift forgot to administer insulin, LPN #2 stated that she did recall the resident making her aware of that. LPN #2 stated that the nurse who failed to administer the insulin had suddenly passed away but she recalled that he was slower with passing out medications and may not have had the time to do a blood sugar check and administer insulin before the resident's meals. When asked if she ever recalled the resident having a high blood sugar level related to his insulin being missed the shift prior, LPN #2 stated that she couldn't recall. When asked if a blood sugar level of 300 was

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high for Resident #1, LPN #2 stated, "That is pretty high for him." When asked if the physician should be made aware of any missed medication, LPN #2 stated that the physician should be made aware and a note should be documented of all missed medications.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

Facility policy titled, "Medication Administration" documents in part, the following: "Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice in a manner to prevent contamination or infection...Administer medication per order..."

Facility policy titled, "Medication Errors" documents in part, the following: "...The facility will consider factors in medication administration, including but not limited to, the following: "a. Medication administered not in accordance with the prescriber's order. Examples include...Medication omission...If a medication error occurs, the following procedure will be initiated: a. The nurse assesses and examines the resident's condition and notifies the physician or health care practitioner as soon as possible..."

(1) Gabapentin is commonly used to treat neuropathic pain (pain due to nerve damage). This information was obtained from the National Institutes of Health.

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https://pubmed.ncbi.nlm.nih.gov/28597471/.

(2) Admelog SoloStar Solution Pen Injector- is a rapid-acting human insulin analog indicated to improve glycemic control in adults and pediatric patients 3 years and older with type 1 diabetes mellitus and adults with type 2 diabetes mellitus. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=0691def8-4a7b-4de3-866f-a280989f47f1.

4. Facility staff failed to administer all 9 p.m. medications per physician's orders to Resident #3 on 12/26/20.

Resident #3 was admitted to the facility on 10/6/20 with diagnoses that included but were not limited to type two diabetes mellitus, major depressive disorder, and high blood pressure. Resident #3's most recent Minimum Data Set MDS (assessment) was a quarterly assessment with an Assessment Reference Date (ARD) of 5/5/21. Resident #3 was coded as being severely impaired in cognitive function scoring 06 out of possible 15 on the Brief Interview for Mental Status (BIMS) Exam.

During the course of a complaint investigation, it was alleged that residents did not receive medications and treatments on 12/26/20 night shift due to the lack of staffing.

Review of Resident #3's December 2020 Medication Administration Record (MAR) for 9/26/20; revealed that Resident #3 missed the

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following ordered medications at 9 p.m.:

1) "Atorvastin Calcium (Lipitor) 40 mg (milligrams) Give 1 tablet by mouth at bedtime for high cholesterol.
2) Melatonin Tablet Give 6 mg by mouth at bedtime for insomnia.
3) Remeron 15 MG Give 1 tablet by mouth at bedtime for depression.
4) Trazadone HCl Tablet 50 MG Give 1 tablet at bedtime for depression.
5) Metformin HCL 500 MG Give 1 tablet by mouth two times a day for diabetes mellitus."

Further review of Resident #3's December 2020 MAR revealed that he has missed his 6:30 a.m. blood sugar check and sliding scale insulin. The following order was documented:
"Humalog Solution (Insulin Lispro) Inject as per sliding scale:
If 150-199 = 2 units give 2 units;
200-249 = 4 units give 4 units;
250-299 = 6 units give 6 units;
300-349 = 10 units give 10 units;
350-399 = 12 units 12 units;
400 - 450 = 14 units 14 units;
subcutaneously three times a day for diabetes mellitus call md (Medical Doctor) if blood sugar is greater or equal to 400 mg/dl."

Review of Resident #3's December 2020 MAR revealed that his next blood sugar check on 12/27/20 was at 11:30 a.m., where he read at a level of 202. 4 units of Humalog were administered.

There was no evidence in his clinical record of any negative outcome related to the above missed medications.

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On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020 MAR was reviewed with the DON. The DON stated that she expected staff to administer all medications as ordered by the physician. The DON stated that she was not employed with the facility in December and was not sure why the medications were not administered.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.

5. Facility staff failed to administer all 9 p.m. medications per physician's order to Resident #4 on 12/26/20.

Resident #4 was admitted to the facility on 8/18/17 with diagnoses that included but were not limited to non- traumatic brain dysfunction, high blood pressure, high cholesterol, dementia, depression, and glaucoma. Resident #4's most recent Minimum Data Set (MDS) assessment was an annual assessment with an Assessment Reference Date of 6/4/21. Resident #4 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status (BIMS) Exam.

During the course of a complaint investigation, it was alleged that residents did not receive medications and treatments on 12/26/20 night shift due to the lack of staffing.

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On 8/18/21 an interview was conducted with Resident #4. She could not recall if she missed medications on 12/26/20 and 12/27/20. She could not recall not having a nurse on that day.

Review of Resident #3's December 2020 Medication Administration Record (MAR) for 9/26/20; revealed that Resident #4 missed the following ordered medications at 9 p.m.:

1) "Atorvastin Calcium (Lipitor) 20 mg (milligrams) Give 1 tablet by mouth at bedtime for high cholesterol.
2) Lantanprost 0.005 % (percent) Instill 1 drop in both eyes at bedtime for glaucoma.
3) Remeron 30 MG Give 1 tablet by mouth at bedtime related to Major Depressive Disorder.
4) Tylenol 8 hour Tablet Extended Release 650 MG Give 2 tablets by mouth every 8 hours for pain related to LOW BACK PAIN." The Tylenol 8 hour tablet was missed at 10 p.m. and at 6:00 a.m. on 9/27/20.

Further review of Resident #3's clinical record revealed no negative outcomes related to the above medications not being administered.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020 MAR was reviewed with the DON. The DON stated that she expected staff to administer all medications as ordered by the physician. The DON stated that she was not employed with the facility in December and was not sure why the medications were not administered.

On 8/19/21 at 2:49 p.m., Administrative Staff

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Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns.
6. The facility staff failed to follow physician orders to administer Atarvastatin Calcium, Trazadone and Nifedipine as ordered for Resident #5. Diagnosis for Resident #5 included but not limited to Hyperlipidemia, Insomnia and Hypertension.

Resident #5's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 07/09/21 coded Resident #5's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment.

Resident #5's person-centered care plan with a revision date 12/17/20 documented resident is at risk for complications related to (r/t) high blood pressure. The goal: will remain free from any complications r/t my high blood pressure. One intervention/approaches to manage goal included: please give me medication as my physician/nurse practitioner ordered.

During the review of Resident #5's Medication Administration Record (MAR) for December 2020 revealed the following medication orders: Atarvastatin Calcium tablet 10 mg - give 1 tablet by mouth at bedtime for (hyperlipidema), Trazadone 50 mg - give 0.5 mg (25mg) by mouth at bedtime for (insomnia), Trazadone 50 mg - give 1 tablet by mouth at bedtime for (insomnia) and Nifedipine Extended Release (ER) - give 60 mg every 12 hours for (high blood pressure.) Further review of the December 2020 MAR,

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revealed evidenced there were no initials by the nurse; indicating the mentioned medications were not administered on 12/26/20 at 9:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The December 2020, MAR was reviewed with the DON, who stated, "I was not here in December 2020, but I expect for the nurses to administer all medication as ordered by the physician."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled: Medication Administration - date implemented (11/01/20.) Medications are administered by license nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

7. The facility staff failed to follow physician order to administer (Albuterol nebulizer treatment) as ordered for Resident #11. Resident #11 was originally admitted to nursing facility on 05/24/19. Diagnosis for Resident #11 include but not limited to Heart Failure and Chronic Obstructive Pulmonary Disease (COPD.)

Resident #11's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment

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with an Assessment Reference Date (ARD) of 11/30/19 coded Resident #11's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment.

Resident #11's person-center comprehensive care plan with a revision date of 09/14/20 documented resident with COPD and at risk for exacerbation and respiratory distress. The goal: will not experience any signs or symptoms of respiratory distress such as restlessness, shortness of breath, crackles, tachycardia or show symptoms of being cyanotic (turning blue). Some of the intervention/approaches to manage goal include: give me my medications as ordered by my physician/nurse practitioner and monitor me for adverse effects and/or effectiveness of my medications and report adverse effects to my physician/nurse practitioner.

Review of Resident #11's Medication Administration Record (MAR) for April 2020, included the following order: Albuterol Sulfate Nebulization Solution 0.63 mg/ml - one vial inhaler orally twice a day for COPD. Further review of the April 2020 MAR, revealed evidenced there were no initials by the nurse; indicating the mentioned medication was not administered on 04/10/20 at 4:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The April 2020, MAR was reviewed with the DON, who stated, "I was not here in April 2020, but I expect for the nurses to administer all medication as ordered by the physician."

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F 684	Continued From page 75 A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit. The facility's policy titled: Medication Administration - date implemented (11/01/20.) Medications are administered by license nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Compliant deficiency	F 684		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on facility information obtained during the complaint investigation, staff interview and facility	F 727	1. No immediate correction can initiated be completed for this area. 2. All residents have the potential to be affected by this deficient practice. 3. Daily and weekly staffing schedules will be reviewed by DON and Administrator to ensure adequate RN staff coverage. Building will work with agency staffing to assist in providing RN coverage where needed. 4. BOM will audit payroll reports to ensure all RN hours are captured in the payroll system. Results of audits will be reported monthly to the QAPI Committee. The QAPI committee is responsible for the on-going monitoring for compliance 5. DOC 10/3/21	

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documentation, the facility staff failed to staff a Registered Nurse (RN - Charge Nurse/Supervisor) for at least 8 consecutive hours a day, 7 days a week.

The findings included:

The facility staff failed to staff a RN-Charge Nurse/Supervisor, for at least 8 consecutive hours on 12/26/20, 07/10/21, 07/24/21 and 08/07/21.

A review of the facility as-worked staffing on 12/26/21 and documentation during a 60-day lookback indicated the nurses worked 12 hours shifts (7a-7p) and (7p-7a.)

1.) On 12/26/20, RN #1 worked 4.00 hours (entered the facility at 7:00 p.m.)

2.) On 07/10/21, RN #1 worked 4.25 hours (entered the facility at 6:43 p.m.)

3.) On 07/24/21, RN #1 worked 4.25 hours (entered the facility at 6:51 p.m.)

4.) On 08/07/21, RN #1 worked 4.25 hours (entered the facility at 6:52 p.m.)

A interview was conducted with the Director of Nursing (DON) on 08/19/2021 at approximately 9:10 a.m. When asked about the facility not having 8 hours of RN coverage on 12/26/20, 07/10/21, 07/24/21 and 08/07/21, the DON stated, "I expect RN coverage 8 hours and day, every day."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate

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F 727	Continued From page 77 on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.	F 727		
F 760 SS=D	Compliant deficiency Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and facility documentation review the facility's staff failed to ensure 2 of 11 residents (Resident #5 and Resident #1) in the survey sample was free from significant medication errors. The findings included: 1. The facility staff failed to ensure a significant medication (Lantus insulin) was administered on 12/26/20 for Resident #5. Diagnosis for Resident #5 included but not limited to Type II Diabetes. Resident #5's Minimum Data Set (MDS - an assessment protocol) a quarterly assessment with an Assessment Reference Date of 07/09/21 coded Resident #5's Brief Interview for Mental Status (BIMS) scored a 15 out of a possible score of 15 indicating no cognitive impairment. Resident #5's person-centered care plan with a revision date 12/41/19 documented resident is an insulin dependent diabetic. The goal: will remain adequate glucose levels and experience no	F 760		

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signs/symptoms (s/s) of hypo/hyperglycemia episodes. One intervention/approaches to manage goal included: please give me medication as ordered.

During the review of Resident #5's Order Summary Report for December 2020 revealed the following medication order: Insulin Glargine Solution - inject 40 units subcutaneously at bedtime for Type II Diabetes starting on 10/19/20.

Further review of the December 2020 MAR, revealed evidenced there were no initials by the nurse; indicating the mentioned medication above was not administered on 12/26/20 at 9:00 p.m.

On 08/19/21 at approximately 9:10 a.m., an interview was conducted with the Director of Nursing (DON.) The DON reviewed the MAR for December 2020. After she reviewed the MAR, the DON stated "I was not here in December 2020, but I expect for the nurses to administer all medication as ordered by the physician."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/19/21 at approximately 3:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled: Medication Administration - date implemented (11/01/20.) Medications are administered by license nurses or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.

F760

1. Medication Lantus insulin failed to be administered to Resident #5 on 12.26.20. Medication Dose was administered on 12/27/20. Resident #5 was monitored to ensure no signs/symptoms of hypo/hyperglycemia episodes. Resident #1 was administered incorrect IV antibiotic Cefazolin on 7/21/21. Correct IV antibiotic Zosyn was administered on 7/22/21. Diphenhyramine HCl Tablet (Benedrayl) was also administered by mouth on 7/22/21. Resident #1 was monitored for adverse signs and symptoms, and no adverse reaction was observed.
2. All residents have the potential to be affected from this deficient practice.
3. Education was provided to all licensed nursing staff on medication administration to include the five rights of medication administration.
4. DON or designee will conduct med pass observation on five residents 3X per week x 4 weeks to verify correct medications are being administered. Results of audits will be reported monthly to the QAPI Committee. The QAPi committee is responsible for the on-going monitoring for compliance
5. DOC 10/3/21

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Complaint deficiency

2. Facility staff failed to ensure Resident #1 was free from a significant medication error and administered the incorrect intravenous (IV) antibiotic to Resident #1 on 7/21/21.

Resident #1 was admitted to the facility on 7/10/21 and readmitted on 7/26/21 with diagnoses that included but were not limited to unspecified open wound to the right foot, complete traumatic amputation of one right lesser toe, acute osteomyelitis (infection) of the right ankle and foot, type two diabetes mellitus, quadraplegia, and deep vein thrombosis of the lower extremities. Resident #1's most recent Minimum Data Set (MDS) assessment was an admission assessment with an assessment reference date (ARD) of 7/10/21. Resident #1 was coded as being intact in cognitive function scoring 15 out of possible 15 on the Brief Interview for Mental Status Exam (BIMS). Resident #1 was coded in Section N (Medications) as receiving antibiotics (ABT). Resident #1 was coded in Section O (Special Treatments and Programs) as receiving intravenous (IV) medications.

Review of Resident #1's July 2021 POS (Physician Order Summary) documented the following orders:

1) "Zosyn (1) (antibiotic) 3-0.375 grams (GM). Use 3.375 gram intravenously every 6 hours for infection for 150 administrations." This order was discontinued on 8/12/21.

Review of Resident #1's clinical record revealed

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the following nursing note dated 7/21/21: "Upon entering resident room to give his PM (night) ABT (antibiotics) IV (Intravenous), this nurse noticed a used bag for (Name of another resident) hanging on (Name of Resident #1's) pole empty. This nurse asked him (resident) His name and called DON (Director of Nursing) & on-call (Name of physician group) Long Term Care left message, Minutes later a nurse for NP (Nurse Practitioner) (Name of NP) gave a V/O (verbal order): to continue his regular scheduled ABT (IV) prescribed and monitor him for adverse reactions of : rash itching, hives and notify ASPA (sic) if any concern, full assessment given, neuro wnl (within normal limits), lungs CTA (Clear to Auscultate), vs (vital signs) : 131/71, 94, 18, 97.1,98% RA (Room Air), denies any pain/ discomfort issues."

Review of a medication error incident report dated 7/21/21 documented the following: "Upon entering resident room too (sic) give PM ABT IV, noticed a used bag for (Name of other resident): Cefazolin (2) hanging on (Name of Resident #1) 's IV pole empty."

A note dated 7/22/21 at 4:15 a.m. documented in part, the following: "Staff has QHRS (hour) monitored him for any adverse reactions, he has verbally stated, "No, I feel fine." I will let yall (sic) know if anything changes. VS (vital signs) wnl , lungs CTA, skin dry & intact w/o (without) any rashed, irritation noted."

The next noted dated 7/22/21 at 4:20 a.m. documented in part, the following: "Resident made aware, shown his ABT IV bag , denies any discomfort/pain, no adverse reactions noted, skin w/o any rashes/ irritation."

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Further review of Resident #1's clinical record revealed an order dated 7/22/21 that documented the following: "DiphenhydrAMINE HCl Capsule (3) 25 MG (Benedrayl) Give 1 capsule by mouth every 8 hours as needed for allergies for 7 Days."

Review of Resident #1's clinical record revealed that Benedrayl was administered on 7/22/21 at 10:29 p.m. The following was documented: "rash from med (medication) error."

There was no other instances where Benedrayl had to be administered.

On 8/18/21 at 11:22 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #3, the nurse who saw that the wrong antibiotic had been administered to Resident #1 on 7/21/21. LPN #3 stated that she worked the 7 p.m. to 7 a.m. shift. LPN #3 stated that she had walked into the resident's room to give Resident #1 his night dose of his antibiotic and noticed an empty bag still hanging on the IV pole. LPN #3 stated that she noticed that IV bag had a different resident name on it and then she realized that Resident #1 had been administered the wrong antibiotic. LPN #3 stated that Cefazolin rather than Zosyn was hanging from the IV pole. LPN #3 stated that she confirmed with the resident that he had been administered the antibiotic bag that had been hanging on the pole. LPN #3 stated that she had made the resident aware that he had received Cefazolin rather than Zosyn. LPN #3 stated that Resident #1 had told her that he was allergic to Keflex, which was in the same family antibiotic family as Cefazolin. LPN #3 stated that she called the on call physician and DON (Director of Nursing) immediately. LPN #3 stated

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that the physician gave an order to continue to his current antibiotic schedule and to monitor Resident #1 for any adverse reactions. LPN #3 stated that she assessed the resident and then continued monitoring every hour for the remainder of her shift. LPN #3 stated that Resident #1 did not have any type of reactions for her on the night shift. When asked who the nurse was who administered the antibiotic, LPN #3 stated it was the nurse who worked 7 a to 7 p shift, but that she couldn't remember her name as she was an agency nurse.

Further review of Resident #1's clinical record revealed he had allergies to Keflex (antibiotic) (4).

On 8/18/21 at 11:27 a.m., an interview was attempted with the nurse who administered the wrong antibiotic. She could not be reached for an interview.

On 8/18/21 at 12:25 p.m., an interview was attempted with the nurse had ordered Benedrayl for Resident #1. She could not be reached for an interview.

On 8/18/21 at 12:30 p.m., an interview was conducted with OSM (Other Staff Member) #7, the Pharmacist. When asked if giving one dose of the wrong intravenous antibiotic could lead to significant reactions, OSM #7 stated that any error with antibiotics could be significant depending on allergies or any comorbidities the resident has. When asked if a resident is allergic to Keflex if that automatically means they will have a reaction to Cefazolin, OSM #7 stated that even though Keflex and Cefazolin were part of the same antibiotic family, the Cephaloporins, they were different generations of the antibiotic.

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OSM #7 stated that a person maybe allergic to a first generation Cephalosporin but not a second generation.

On 8/19/21 at 2:49 p.m., Administrative Staff Member (ASM) #1, the Administrator, ASM #2, the DON (Director of Nursing), ASM #3, the Regional Director of Clinical Services, and ASM #5, the corporate nurse were made aware of the above concerns. When asked if any education or in services were provided regarding the above medication error, ASM #2 stated that she did not as the agency nurse never came back to the facility to work another shift. When asked if in services were done for all other nursing staff regarding preventing medication errors, ASM #2 stated that she did not do in services with other nursing staff.

Facility policy titled, "Medication Error" documents in part, the following: "It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors...Significant medication error means one which causes the resident discomfort or jeopardizes his/her health and safety...To prevent medication errors and ensure safe medication administration, nurses should verify the following information:
a. Right medication, dose, route, and time of administration;
b. Right resident and right documentation."

No further information was presented prior to exit.

(1) Zosyn- also known as Tazocin® piperacillin/tazobactam is an intravenously

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administered antibiotic. This information was obtained from The National Institutes of Health. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2504059/.

(2) Cefazolin is a beta-lactam antibiotic and first-generation cephalosporin with bactericidal activity. This information was obtained from the National Institutes of Health. https://pubchem.ncbi.nlm.nih.gov/compound/cefazolin.

(3) Benedrayl temporarily relieves these symptoms due to hay fever or other upper respiratory allergies: runny nose itchy, watery eyes, sneezing, itching of the nose or throat and temporarily relieves these symptoms due to the common cold: runny nose and sneezing. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=af5053d8-ba02-4cdf-877f-8c1e368dafe0.

(4) Keflex Capsules (Cephalexin, USP) is a semisynthetic cephalosporin antibiotic intended for oral administration. This information was obtained from The National Institutes of Health. https://dailymed.nlm.nih.gov/dailymed/fda/fdaDrugXsl.cfm?setid=68fba58a-7748-4581-8432-f5286c46d90a.

COMPLAINT DEFICIENCY