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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated complaint survey was conducted 8/24/21 through 8/26/21. Four complaints were investigated during survey: VA00052783: Substantiated with deficiency; VA00049782: substantiated with a deficiency; VA00049688: substantiated with a deficiency; VA00048483: Unsubstantiated, with no deficiency. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 80 certified bed facility was 73 at the time of the survey. The survey sample consisted of 4 current resident reviews (Residents #1 through #4) and 4 closed record reviews (Residents #5 through #8).	F 000		
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		

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

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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 staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician and or resident's representative of missed laboratory services for 2 residents, a new antibiotic order for levaquin for 1 resident and missed pain medication doses with a new prescription needed for 1 resident, for 4 out of 8 residents (Resident #5, Resident #6,

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Resident #8 and Resident #1) in the survey sample.

The findings included:

1. The facility staff failed to notify the physician and resident representative of missed blood work ordered on 08/04/21 for Vitamin B12 for Resident #5. Resident #5 was originally admitted the nursing facility on 09/30/20. Diagnosis for Resident #5 included but not limited to Iron Deficiency Anemia. The most recent Minimum Data Set (MDS) was an quarterly assessment with an Assessment Reference Date (ARD) of 04/17/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 11 out of a possible score of 15, which indicated moderate cognitive impairment for daily decision-making. Resident #5 was coded total dependence of one with dressing, toilet use, personal hygiene and bathing, extensive assistance of one with bed mobility, transfer and eating for Activities of Daily Living (ADL.)

Review of the psychotherapy note written by (name of physician) on 08/04/21 included but not limited to the following information: "Resident #5 has been uncharacteristically quiet for the last two weeks, none of the usual hollering. She's compliant and sleepy, lies in bed unresponsive until touched and then she watches." Further review of clinical notes request the following recommendation; ask the attending physician to consider obtaining blood work for Vitamin B12.

During the review of Resident #5's clinical record on 08/26/21 did not reveal lab results for Vitamin B12. On the same day, the Director of Nursing (DON) stated she reviewed Resident #5's clinical

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record and was not able to locate Vitamin B12 blood work. The DON stated, "The blood work was never done." The DON said she expect for the nurses to notify the physician and resident representative of missed Vitamin B12 level for Resident #5.

A phone interview was conducted with the Nurse Practitioner (NP) on 08/26/21 at approximately 2:35 p.m. She said, the facility never informed her of the psychotherapist recommendation for Vitamin B12 blood work. When asked, what you're looking for with Vitamin B12 blood work, she replied, "A low or high Vitamin B12 can affect the resident's mental status as well as showing if the resident is anemic and may require some type of iron supplement or even a blood transfusion."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/26/21 at approximately 2:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

2. The facility staff failed to notify the physician and resident representative of missed laboratory services ordered on 05/04/20 for UA/C&S for Resident #6. Resident #6 was originally admitted the nursing facility on 01/01/20. Diagnosis for Resident #6 included but not limited to Alzheimer's disease. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 05/25/21 coded the resident on the Brief Interview for Mental Status (BIMS) with short and long-term memory problems and cognitive skills severely

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impaired-never/rarely made decisions. Resident #6 was coded total dependence of one with dressing, toilet use, personal hygiene and bathing, extensive assistance of two with transfer and extensive assistance of one with bed mobility and eating for Activities of Daily Living (ADL.)

The care plan with a revision date of 06/08/20 identified Resident #6 with incontinence of bladder. One of the interventions/approaches the staff would use to accomplish this goal is monitor for signs and symptoms of UTI.

Review of Resident #6's clinical note written by Registered Nurse (RN) #1 on 05/04/21 included the following: Resident #6 noted with a low grade temperature. The Nurse Practitioner (NP) #1 made aware with a new order to obtain urine for Urine Analysis (U&A) and Culture and Sensitivity (C&S.)

Review of Resident #6's Lab Administration Report for May 2020 revealed the following order: UA, C&S - one time for fever. During the review of Resident #6's clinical record on 08/26/21 did not reveal lab results for UA/C&S. Further review of the May 2020 Lab Administration Record (LAR), revealed evidenced of two blank spaces on 05/04/20 and 05/05/20 for UA, C&S, indicating the mentioned urine specimen was not obtained as ordered.

An interview was conducted with the DON on 08/25/21 at approximately 4:03 p.m. After the DON reviewed Resident #6's clinical record for the urine culture results that was ordered on 05/04/20, she replied, "Apparently, it was not done." The DON said she expect for the nurses to notify the physician and resident representative

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of the missed labs for UA, C&S for Resident #6.

A phone call was placed to RN #1 on 08/26/21 at approximately 1:06 p.m. RN #1 wrote the order to obtain the lab work for the UA/C&S on 05/04/21. A message was left, the RN never called back.

The facility policy titled Notification of Changes - revision date 11/01/20.
Policy: 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 authority, resident's representative when there is a change requiring notification. Circumstances that require a need to alter treatment. This may include: New treatments.

Definitions:

1. Vitamin B12 measures how much of the vitamin is in your blood. It can help diagnosis a specific type of anemia and other problems (https://www.webmd.com/a-to-z-guides/vitamin-b12-test.)

2. Iron Deficiency Anemia is a common type of anemia that occurs if you do not have enough iron in your body (https://www.nhlbi.nih.gov/health-topics/iron-deficiency-anemia.)

2. Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-cultur

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e.)

3. Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture.)

4. Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html.)
3. Resident #8 was admitted to the facility on 11/7/12 with diagnoses to include but not limited to Chronic Obstructive Pulmonary Disease, Atrial Fibrillation and Congestive Heart Failure. Resident #8 expired in the facility on 8/19/21.

Resident #8's most recent comprehensive Minimum Data Set (MDS) was a significant change/5 day with an Assessment Reference Date (ARD) of 12/12/21. Resident #8's Brief Interview for Mental Status (BIMS) was coded as 00 with short and long term memory deficits indicating the resident was severely cognitively impaired and incapable of daily decision making.

Resident #8's Progress Notes were reviewed and are documented in part, as follows:

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8/3/2021 16:15 Orders - General Note Text:
Levaquin Tablet 500 MG.
Give 1 tablet by mouth one time a day for

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infection-PNA(pneumonia) for 7 Days.

Resident #8's Physician Orders dated 8/3/21 were reviewed and are documented in part, as follows:

Order Summary: Levaquin Tablet 500 MG (milligrams) Give 1 tablet by mouth one time a day for infection-PNA (pneumonia) x 7 days.
Order Date: 8/3/21
Start Date: 8/3/21

Resident #8's Medication Administration Record for August 2021 was reviewed and is documented in part, as follows:

Levaquin Tablet 500 MG (milligrams) Give 1 tablet by mouth one time a day for infection-PNA (pneumonia) x 7 days.
Medication was signed off as being administered on 8/3/21 at 21:00 (9 P.M.)

There was no Progress Note indicating Resident #8's Responsible Party was notified of the new order obtained for the antibiotic levaquin on or after 8/3/21.

The facility submitted a Facility Reported Incident (FRI) with the State Agency on 8/9/21 after a meeting with Resident #8's daughter. Resident #8's daughter informed the facility that she had not been made aware that her mother had been started on Levaquin. The facility's 5 day FRI investigation was reviewed and is documented in part, as follows:

Findings: Based on the investigation a deficient practice was found in the notification of family members regarding new medications.

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On 8/25/21 a phone interview was conducted with Registered Nurse (RN) #2. RN #2 was asked if he obtained Resident #8's new order for levaquin on 8/3/21 and if notified the residents daughter of the new order. RN #2 stated, "Yes, the Nurse Practitioner came in to see the her (Resident #8) that day and she wrote a new order to start her on levaquin. I can't remember if I called the daughter, if I did I would have documented it in the progress notes."

On 8/26/21 at 10:00 A.M. an interview was conducted with the Director of Nursing (DON). The DON was asked if Resident #8's daughter was notified of the physician order for levaquin on 8/3/21. The DON stated, "I couldn't find any documentation that she was notified. We all know if it isn't documented it didn't happen. The nurse should have called her (Resident #8's) daughter and let her know of new order and document it in the clinical record. She (Resident #8) is not her own responsible party."

The facility policy titled "Medication Orders" implemented 11/1/2020 was reviewed and is documented in part, as follows:

4. Documentation of Medication Orders:
h. Notify resident's sponsor/family of new medication order.

On 8/26/21 at 1:28 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

4. The facility staff failed to notify the attending

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physician that Resident #1's was in need of a new prescription for her Fentanyl Patch after the last available patch was applied on 7/2/21 which resulted in the resident missing 3 doses equaling 9 days without constant pain management coverage. Resident #1 was originally admitted to the facility on 8/22/14 and readmitted on 8/5/21 with diagnoses to include but not limited to Rheumatoid Arthritis, Peripheral Vascular Disease, Status Post Left Leg above the Knee Amputation and Phantom Limb Syndrome with Pain.

Resident #1's most recent Minimum Data Set (MDS) Assessment was a Scheduled 5 Day with an Assessment Reference Date (ARD) of 8/9/21. Resident #1's Brief Interview for Mental Status (BIMS) was code a 13 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under J0300 Pain Presence, Resident #1 was coded as a 1 (Yes) for having has pain or hurting at any time in the last 5 days. Under J0400 Pain Frequency, Resident #1 was coded as a 3 (Occasionally) for how much time have you experienced pain or hurting over the last 5 days. Under J0600 Pain Intensity, Resident #1 was coded as a 2 (Moderate) for intensity of worst pain over the last 5 days.

Resident #1's Comprehensive Care Plan last revised 9/16/21 was reviewed and is documented in part, as follows:

Focus: The resident has chronic pain related to Rheumatoid Arthritis, previous pelvic fracture, restless leg syndrome and left above the knee amputation. Date Initiated: 5/21/18

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Interventions:
-Give pain medications per MD (Medical Doctor) order. Monitor for effectiveness and side effects.
Date Initiated: 5/21/18

On 8/24/21 at 12:26 P.M. this surveyor received a call from the Ombudsman regarding Resident #1. The Ombudsman stated he had received the fax notification that the team was in the facility and he wanted to update me on a complaint he had received. The Ombudsman stated, "I have been working on a complaint with the facility regarding (Name) Resident #1 who had missed 3 doses of her fentanyl pain patch in July 2021." Ombudsman thanked for the information and an investigation began.

Resident #1's Physician Orders were reviewed and are documented in part, as follows:

FentaNYL Patch 72 Hour 25 MCG/HR (micrograms per hour)
Apply 1 patch transdermally every 72 hours for pain and remove per schedule.
Ordered: 6/11/2021.
Fentanyl Transdermal 72 hour Patch: a medication used to help relieve severe ongoing pain. Fentanyl is a Schedule II opoid narcotic. Suddenly stopping this medication may cause withdrawal symptoms such as restlessness, mental/mood changes, trouble sleeping or thought of suicide. (http://www.webmd.com).

On 8/24/21 at 1:15 P.M. an interview was conducted with Resident #1 regarding her fentanyl patches and their availability. Resident #1 stated, "I haven't had any problem with not having my pain patches lately but last month I missed I think 3 doses.

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Resident #1's July 2021 Medication Administration Record (MAR) was reviewed and is documented in part, as follows:

FentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule.
Start date: 6/11/2021
Remove 0859; Apply 0900.

On 7/5/21, 7/8/21 and 7/11/21 the FentaNYL Patch 72 Hour 25 MCG/HR order was signed off with the Code 9. According to the Chart Codes/Follow Up Codes box on the MAR #9 = Other/See Nurses Note. The last dose of Fentanyl Resident #1 was administered according the July MAR was 7/2/21 and was not administered again until 7/14/21. All other entries for this medication had a check which indicates it was administered. Based on the MAR Resident #1 missed 3 doses of her fentanyl patch and went a total of 9 days with no patch in place.

Resident #1's Progress Notes were reviewed for 7/5/21, 7/8/21 and 7/11/21 and are documented in part, as follows:

7/5/2021 15:36 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
Awaiting refill.

7/8/2021 09:36 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
not on.

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7/8/2021 09:37 eMar - Medication Administration
Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
awaiting pharmacy.

7/11/2021 10:02 eMar - Medication Administration
Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
med enroute from pharmacy.

7/11/2021 10:03 eMar - Medication Administration
Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule.

On 8/25/21 at 1:56 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was asked to explain why she documented on 7/5/21 that Resident #1's fentanyl patch was not available and what she did to resolve the medication issue. LPN #2 stated, " I went to give her her fentanyl that morning and it wasn't there, she was out of the medication. So I called (Name) answering service for the oncall provider and asked them to send an escript (electronic script) to the pharmacy for the medication. I'm not sure if I left a message or they picked up. They were supposed to send it. I then left it alone and waited for it to come in." LPN #2 was asked what was facility procedure for obtaining narcotic refills for the residents. LPN #2 stated, "When I see that the resident has less than a seven day supply left I print off the script and leave it in the doctor's book so she can sign it. Then after it has been signed I fax the script to the pharmacy to be filled. We should never run

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out of narcotics."

On 8/24/21 at 3:30 P.M. a phone interview was conducted with LPN # 9, who was the oncall service receiving calls on 7/5/21 for providers from the facility. LPN #9 was asked if calls are logged and if so was there any calls from the facility on 7/5/21 to alert the provider that Resident #1 needed a new prescription for her fentanyl patch. LPN #9 stated, "All calls that come in Monday through Friday from 8 am to 5 pm are placed on the log for that day. Also all of our calls are recorded. There were no calls received from the facility on 7/5/21 about a fentanyl prescription that was needed for (Name) Resident #1"

Attempted to call LPN #8 on 8/25/21 at 3:20 P.M.; who charted Resident #1's fentanyl patch was not available on 7/8/21 for an interview but phone was disconnected.

Attempted to call and left a message for Registered Nurse (RN) #4 on 8/26/21 at 9:42 A.M., who charted Resident #1's fentanyl was enroute on 7/11/21, however call was never returned.

On 8/25/21at 3:00 P.M. an interview was conducted with the Nurse Practitioner regarding Resident #1's 3 missing doses and 9 days with her fentanyl Patch. The Nurse Practitioner was asked if she had been called by the facility from 7/5/21 upto 7/12/21 when she signed a new hard script for Resident #1's fentanyl patches making her aware that the resident was out. The Nurse Practitioner stated, "No, I did not receive a call. If I had been called I could have sent over an emergency script to the pharmacy to hold the

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resident for 3 days until I could get into the facility to write one. I'm in the building 3 to 4 days a week and the nurses usually print the narcotic orders that need to be refilled and place the order in my book and I sign it for them. I look at that book every day I come to the facility. It's usually the first thing I do."

On 8/25/21 at 4:15 P.M. a phone interview was conducted with the Medical Director regarding Resident #1 missing 3 doses of fentanyl which equaled 9 days without her ordered medication. The Medical Director stated, "I was not aware she had missed this many doses."

On 8/26/21 at 9:45 A.M. a phone interview was conducted with the Pharmacist #7 regarding Resident #1's Fentanyl Pain Patches. The Pharmacist stated, "We sent 10 patches to the facility and they arrived on 7/13/21. Before they were delivered on 7/13/21 around 1:00 A.M., the last time we sent the facility fentanyl patches for her was on 6/10/21 and 5 patches were sent then."

On 8/26/21 at 10:00 A.M. an interview was conducted with Director of Nursing regarding the above findings. The Director of Nursing stated, "We ran out of the hard script and it was documented that we were waiting for the order. She missed 9 days of the medication. There was a breakdown between the provider and the facility. She missed 3 doses of the fentanyl. We got a new medication script for the fentanyl on July 12 and sent it to the pharmacy." The Director of Nursing was asked if she had completed an investigation regarding how Resident #1' had missed 3 fentanyl medication doses and why there was no facility follow-up with

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F 580	Continued From page 15 the provider after 7/5/21. The Director of Nursing stated, "I did not do an investigation because I was just made aware of it last week but I can now see in Point Click Care daily when a resident has less that a six day supply of a narcotic available so I can make sure it is reordered in time." On 8/26/21 at 1:28 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared. COMPLAINT DEFICIENCY	F 580		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary;	F 690		

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and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on complaint investigation, staff interviews, clinical record review and facility documentation, the facility staff failed to provide the necessary care and services to prevent complications of a urinary tract infection for 1 of 8 residents (Resident #6) in the survey sample. The facility staff failed to recognize early signs and symptoms of sepsis to include altered mental status, decrease in intake and output, fever, pain and decreased blood pressure, as well as a failure to follow physician's STAT orders for urinalysis and culture and sensitivity that would have determined further treatment. The resident was discharged and admitted to the hospital on 06/03/20 with a diagnosis of sepsis with shock and Acute Renal Failure (ARF).

The findings included:

Resident #6 was originally admitted the nursing facility on 01/01/20. The resident was discharged to the local hospital on 06/03/20 and did not return to the nursing facility. Diagnosis for Resident #6 included but not limited to

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Alzheimer's disease. Resident #6's Minimum Data Set (MDS-an assessment protocol) a quarterly assessment with an Assessment Reference Date of 05/25/20 coded Resident #6 with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. The MDS coded Resident #6 total dependence of one with dressing, toilet use, personal hygiene and bathing, extensive assistance of two with transfer and extensive assistance of one with bed mobility for Activities of Daily Living care. Under section H - (Bladder and Bowel) was coded for always incontinent of bladder and bowel.

The care plan with a created date of 01/10/20 identified Resident #6 with bladder incontinence. The goal set for the resident by the staff was that the resident will remain free from skin breakdown due to incontinence and brief use. One of the interventions/approaches the staff would use to accomplish this goal is to monitor/document/report any signs/symptoms of a UTI.

Resident #6's nurse's note written on 05/04/20 at approximately 12:20 p.m., by the Unit Manager, Registered Nurse #1 (RN) indicated the Resident #6 had a "low grade" temperature but the actual temperature was not recorded. The nurse's notes indicated Nurse Practitioner (NP) #2 was made aware that resident had a fever with new orders written for urine culture and sensitivity, chest x-ray, Complete Blood Count (CBC) and Basic Metabolic Panel (BMP).

All of the physician ordered labs for 05/04/20 were obtained except for the urine culture with sensitivity. Review of the May 2020 Lab

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Administration Record (LAR), revealed two blank spaces on 05/04/20 and 05/05/20 that indicated the UA, C&S was not obtained, per the Director of Nursing (DON) acknowledgment during an interview on 08/24/20 at approximately 4:03 p.m. The lab results were not in the clinical chart and could not be located by the DON.

A phone call was placed License Practical Nurse (LPN) #7 on 08/26/21 at approximately 1:06 p.m. The LPN was assigned to provide care and services to Resident #6 on 05/04/20 (7a-7p shift). A message was left, the LPN never returned the call.

A phone interview was conducted with Resident #6's Representative on 08/25/21 at approximately 10:56 a.m. She stated she had contacted the facility on 05/20/20 (not sure of the exact time) and informed her nurse that Resident #6 was not acting or talking like herself. The Representative said the last time Resident #6 behavior was like this she had a bad UTI. She said the facility ignored me by not addressing my concerns related to the change that I witnessed with Resident #6. The resident's Representative said, Resident #6 was transferred to (name of hospital) on 06/03/20 but was then transferred her to a second hospital because they can provide immediate onsite dialysis if necessary for Renal Failure.

A nurse's note entered by LPN #7 on 05/20/20 (7a-7p) shift revealed the following concern voiced by Resident #6's Representative: "Resident #6 was not sounding like her normal self. The family member stated the last time this happen she had a UTI. The family is requesting for the NP to check resident for UTI." The UM

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and NP were notified on 05/20/20 at approximately 2:51 p.m. Resident #6's nurse note from 05/20/20 - 05/29/20 failed to provide evidence that Resident #6 was ever assessed for a UTI.

NP #2's progress note dated 05/29/20 revealed the following information; "Resident #6 is being seen today via telemedicine with the assistance of UM for decline in condition. Per nursing, Resident #6 has had a decrease in oral intake and sleeping more frequently." The NP wrote an order was for a STAT UA C&S for suspected UTI along with a STAT (immediate) CBC and BMP with any abnormal results called to the on-call team. The UA, C&S, BMP and CBC was written as a one-time order instead of a STAT order, which meant the UA C&S could have been obtained at any time. This was not keeping with the orders by NP #2.

Review of the May 2020 LAR, revealed evidenced of two blank spaces on 05/29/20 and 05/30/20 for UA, C&S which indicated the UA, C&S was not obtained, per the DON acknowledgment during an interview on 08/25/21 at approximately 3:45 p.m. The lab results were not in the clinical chart and could not be located by the DON.

An interview was conducted with the DON on 08/24/21 at approximately 4:30 p.m. The DON stated, "The order was given as a STAT order for a reason." The DON stated a STAT order is done within 2 hours. A standard order which a one-time order could be obtained at any time." It is the floor nurse's responsibility to make sure all labs are obtained as ordered by the physician. The DON stated all physician ordered labs are to

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be obtained and followed up with their results.

On 08/25/21 at approximately 2:36 p.m., a call was placed to LPN #5 who was assigned to provide care and services to Resident #6 on 05/29/20 (7p-7a) shift; she never returned the call.
This LPN documented in the resident's nurses note on 05/30/20 at 6:09 a.m., that she was not able obtain the UA, C&S as ordered due to resident discomfort. The progress note did not indicate the NP or physician was made aware the UA, C&S was not obtain due to the resident's discomfort.

On 08/25/21 at approximately 3:45 p.m., an interview was conducted with the DON and Corporate nurse. The DON stated she was not the DON during the time
Resident #6 resided in the facility. The DON stated due to Resident #6's pain and discomfort, she should have been sent out as an emergency to a higher level of care. The DON said, "She should have been sent out to acute care because obviously, Resident #6 needed more help than what was being offered here in the facility".

The nurse's notes on 06/02/20 at approximately 2:25 p.m., entered by LPN #6 included the following information: "Resident #6's meal consumption for breakfast was 0% with 30 ml of meal replacement shake and consumed less than 50% of lunch". On the same day at approximately 6:41 p.m., the nurse's note indicated the resident is not eating or drinking, and the NP #2 was notified via phone and informed of the resident's change in condition. Orders were given again, for a UA/C&S, CBC with diff and BMP. The nurse's note indicated the

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vital signs were but not limited to the following: (BP) 88/51 - (hypotension) and oxygen saturation level at 91% on oxygen at 2 liters via nasal/cannula (oxygen saturation levels 96%-100% is considered normal on room air) (https://www.ncbi.nlm.nih.gov). The on call NP was notified via phone of change in condition and waiting on a call back for further instruction.

On 06/03/20, a nurse's note entered at 1:08 a.m., included an order to send Resident #6 out for further testing. The nurse's note indicated Resident #6 was hospitalized due to scant urine. Resident #6 did not return to the nursing facility.

Review of Resident #6 clinical record revealed the nursing staff was able to collect UA, C&S that was ordered by the NP on 06/02/20, which the results were received by facility on 06/03/20 at 1:54 a.m. The urine culture included the following: greater than 100,000 colonies, more than 2 different organisms; please submit a new specimen but by the time the urine culture was received to the facility. Resident #6 had already been discharged and admitted to the hospital at the time of these results.

Review of the hospital records revealed Resident #6 presented in the Emergency Room (ER) on 06/03/20 as a transfer from the originated hospital's ER for further evaluation due to Altered Mental Status (AMS). On the evaluation work-up at (name of transferring hospital), the resident was diagnosed with Acute Renal Failure (ARF) with a blood creatinine above 19 (0.59-1.04 = normal range). A creatinine blood level measures of how well your kidneys as performing their job of filtering waste from your blood (www.mayoclinic.org). The resident's potassium

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level was 6.2 (H) (3.6 to 5.2 = normal range). High potassium levels (hyperkalemia) are apparent in the late stages of sepsis, these alterations can reach statistically significant levels in the shock period (https://pubmed.ncbi.nlm.nih.gov/7094219/). Upon arrival to the hospital, the ER records indicated Resident #6's body temperature was 94.6 F(*hypothermia - low body temperature), with a *Bair Hugger placed on the resident along with five warming blankets. The ER records indicated the resident was septic with shock requiring Intensive Care Unit (ICU) admission. Intravenous Fluids (IV), IV antibiotic (Zosyn and Vancomycin) was started as well as an urgent central line for possible dialysis. The laboratory data revealed sepsis due to a renal source as her urinalysis has too numerous to count (white cells.)

*Hypothermia is a medical emergency that occurs when your body loses heat faster than can produce heat, causing a dangerously low body temperature. Normal body temperature is around 98.6. Hypothermia occurs as your body temperature falls below 95 degrees Fahrenheit (https://www.mayoclinic.org).

*Bair hugger system is a temperature management system used in a hospital or survey center to maintain a patient's core body temperature (https://www.bairhugger.com).

On 08/26/21 at approximately 1:30 p.m., a pre-exit meeting was held with the Administrator, DON and Corporate, the Resident #6's issues was presented again. No additional information was forth coming.

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Definitions:

1. Urinary tract infection occurs when there is compromise of host defense mechanisms and a virulent microbe adheres, multiplies, and persists in a portion of the urinary tract. Most commonly, UTI is caused by bacteria, but fungi and viruses are possible. Urine culture and sensitivity are the gold standards for diagnosis of bacterial UTI (https://www.ncbi.nlm.nih.gov).

2. Sepsis is a serious medical condition. It's caused by an overwhelming immune response to infection. The body releases immune chemicals into the blood to combat the infection. Those chemicals trigger widespread inflammation, which leads to blood clots and leaky blood vessels. As a result, blood flow is impaired, and that deprives organs of nutrients and oxygen and leads to organ damage. In severe cases, one or more organs fail. In the worst cases, blood pressure drops, the heart weakens, and the patient spirals toward septic shock (https://www.nigms.nih.gov/education/Documents/Sepsis.pdf).

3. Severe sepsis symptoms may include but not limited to organ failure, such as kidney (renal dysfunction resulting in less urine) low platelet count and change in mental status, pain in the lower abdomen and blood in the urine. Systolic pressure is equal to or less than 100 millimeters of mercury (mmhg) and abnormal white blood cell count (either too high or too low). In some cases, sepsis may turn into septic shock, which is a drastic drop in blood pressure that can increase the risk of death. Signs of septic shock include but not limited to: needing medication to maintain systolic blood pressure equal to or greater than

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F 690	Continued From page 24 64 mmHG and high levels of lactic acid in your blood, which means your cells aren't using oxygen in the right way. To prevent urosepsis, get treated as soon as possible. The longer you delay treating UTI, the more likely to develop urosepsis, septic shock, renal failure and death (https://webmd.com). 4. Acute Renal Failure is the rapid (less than 2 days) loss of your kidneys' ability to remove waste and help balance fluids and electrolytes in your body (https://medlineplus.gov). 5. Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture). 6. Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-culture). Complaint deficiency	F 690		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		

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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 a complaint investigation, clinical record review, resident interview, staff interviews and facility document review the facility failed to ensure that 1 of 8 residents (Resident #1) in the survey sample was free from a significant medication error as evidenced by 3 missed doses of a fentanyl patch equaling a total of 9 days with no pain patch in place.

The findings included:

Resident #1 was originally admitted to the facility on 8/22/14 and readmitted on 8/5/21 with diagnoses to include but not limited to Rheumatoid Arthritis, Peripheral Vascular Disease, Status Post Left Leg above the Knee Amputation and Phantom Limb Syndrome with Pain.

Resident #1's most recent Minimum Data Set (MDS) Assessment was a Scheduled 5 Day with an Assessment Reference Date (ARD) of 8/9/21. Resident #1's Brief Interview for Mental Status (BIMS) was code a 13 out of a possible 15 indicating the resident was cognitively intact and capable of daily decision making. Under J0300 Pain Presence, Resident #1 was coded as a 1 (Yes) for having has pain or hurting at any time in the last 5 days. Under J0400 Pain Frequency, Resident #1 was coded as a 3 (Occasionally) for how much time have you experienced pain or hurting over the last 5 days. Under J0600 Pain Intensity, Resident #1 was coded as a 2 (Moderate) for intensity of worst pain over the last

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5 days.

Resident #1's Comprehensive Care Plan last revised 9/16/21 was reviewed and is documented in part, as follows:

Focus: The resident has chronic pain related to Rheumatoid Arthritis, previous pelvic fracture, restless leg syndrome and left above the knee amputation. Date Initiated: 5/21/18

Interventions:
-Give pain medications per MD (Medical Doctor) order. Monitor for effectiveness and side effects. Date Initiated: 5/21/18

On 8/24/21 at 12:26 P.M. this surveyor received a call from the Ombudsman regarding Resident #1. The Ombudsman stated he had received the fax notification that the team was in the facility and he wanted to update me on a complaint he had received. The Ombudsman stated, "I have been working on a complaint with the facility regarding (Name) Resident #1 who had missed 3 doses of her fentanyl pain patch in July 2021." Ombudsman thanked for the information and an investigation began.

Resident #1's Physician Orders were reviewed and are documented in part, as follows:

FentaNYL Patch 72 Hour 25 MCG/HR (micrograms per hour)
Apply 1 patch transdermally every 72 hours for pain and remove per schedule.
Ordered: 6/11/2021.
Fentanly Transdermal 72 hour Patch: a medication used to help relieve severe ongoing pain. Fentanyl is a Schedule II opoid narcotic.

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Suddenly stopping this medication may cause withdrawal symptoms such as restlessness, mental/mood changes, trouble sleeping or thought of suicide. (http://www.webmd.com).

On 8/24/21 at 1:15 P.M. an interview was conducted with Resident #1 regarding her fentanyl patches and their availability. Resident #1 stated, "I haven't had any problem with not having my pain patches lately but last month I missed I think 3 doses. They did give me my other pain medicine while they were waiting for the patches to come in." Resident #1 was observed with her current fentanyl patch on her right arm.

Resident #1's July 2021 Medication Administration Record (MAR) was reviewed and is documented in part, as follows:

Hydrocodone-Acetaminophen Tablet 5-325 MG(milligrams) Give 1 tablet by mouth every 8 hours as needed for pain.
Start date: 6/9/2021
From July 5, 2021 through July 13. 2021 Resident #1 received 7 doses of the as needed Hydrocodone with documented effective pain relief for each dose administered on the medication administration record.

Hydrocodone-Acetaminophen: A combination drug used to relieve moderate to severe pain, It contains an opoid pain reliever (hydrocodone) and a non-opoid pain reliever (acetaminophen). Hydrocodone is a Schedule II opoid narcotic. (http://www.webmd.com).

Resident #1's July 2021 Medication Administration Record (MAR) was reviewed and

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is documented in part, as follows:

FentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule.
Start date: 6/11/2021
Remove 0859; Apply 0900.

On 7/5/21, 7/8/21 and 7/11/21 the FentaNYL Patch 72 Hour 25 MCG/HR order was signed off with the Code 9. According to the Chart Codes/Follow Up Codes box on the MAR #9 = Other/See Nurses Note. The last dose of Fentanyl Resident #1 was administered according the July MAR was 7/2/21 and was not administered again until 7/14/21. All other entries for this medication had a check which indicates it was administered. Based on the MAR Resident #1 missed 3 doses of her fentanyl patch and went a total of 9 days with no patch in place.

Resident #1's Progress Notes were reviewed for 7/5/21, 7/8/21 and 7/11/21 and are documented in part, as follows:

7/5/2021 15:36 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
Awaiting refill.

7/8/2021 09:36 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR
Apply 1 patch transdermally every 72 hours for pain and remove per schedule
not on.

7/8/2021 09:37 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR

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Apply 1 patch transdermally every 72 hours for pain and remove per schedule
awaiting pharmacy.

7/11/2021 10:02 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule
med enroute from pharmacy.

7/11/2021 10:03 eMar - Medication Administration Note: fentaNYL Patch 72 Hour 25 MCG/HR Apply 1 patch transdermally every 72 hours for pain and remove per schedule.

On 8/25/21 at 1:56 P.M. an interview was conducted with Licensed Practical Nurse (LPN) #2. LPN #2 was asked to explain why she documented on 7/5/21 that Resident #1's fentanyl patch was not available and what she did to resolve the medication issue. LPN #2 stated, " I went to give her her fentanyl that morning and it wasn't there, she was out of the medication. So I called (Name) answering service for the oncall provider and asked them to send an escript (electronic script) to the pharmacy for the medication. I'm not sure if I left a message or they picked up. They were supposed to send it. I then left it alone and waited for it to come in." LPN #2 was asked what was facility procedure for obtaining narcotic refills for the residents. LPN #2 stated, "When I see that the resident has less than a seven day supply left I print off the script and leave it in the doctor's book so she can sign it. Then after it has been signed I fax the script to the pharmacy to be filled. We should never run out of narcotics."

On 8/24/21 at 3:30 P.M. a phone interview was

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conducted with LPN # 9, who was the oncall service receiving calls on 7/5/21 for providers from the facility. LPN #9 was asked if calls are logged and if so was there any calls from the facility on 7/5/21 to alert the provider that Resident #1 needed a new prescription for her fentanyl patch. LPN #9 stated, "All calls that come in Monday through Friday from 8 am to 5 pm are placed on the log for that day. Also all of our calls are recorded. There were no calls received from the facility on 7/5/21 about a fentanyl prescription that was needed for (Name) Resident #1"

Attempted to call LPN #8 on 8/25/21 at 3:20 P.M.; who charted Resident #1's fentanyl patch was not available on 7/8/21 for an interview but phone was disconnected.

Attempted to call and left a message for Registered Nurse (RN) #4 on 8/26/21 at 9:42 A.M., who charted Resident #1's fentanyl was enroute on 7/11/21, however call was never returned.

On 8/25/21at 3:00 P.M. an interview was conducted with the Nurse Practitioner regarding Resident #1's 3 missing doses and 9 days with her fentanyl Patch. The Nurse Practitioner was asked if she had been called by the facility from 7/5/21 to 7/12/21 when she signed a new hard script for Resident #1's fentanyl patches making her aware that the resident was out. The Nurse Practitioner stated, "No, I did not receive a call. If I had been called I could have sent over an emergency script to the pharmacy to hold the resident for 3 days until I could get into the facility to write one. I'm in the building 3 to 4 days a week and the nurses usually print the narcotic

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orders that need to be refilled and place the order in my book and I sign it for them. I look at that book every day I come to the facility. It's usually the first thing I do."

Physician hard written prescriptions for Resident #1's Fentanyl 25 mcg/hr Patch were observed in the medical record dated 6/9/21 for 5 patches to be dispensed. The next prescription was not written until 7/12/21 for 10 patches to be dispensed. According to the Pharmacy Medication Packing Slips the medication arrived at the facility on 7/13/21.

On 8/25/21 at 4:15 P.M. a phone interview was conducted with the Medical Director regarding Resident #1 missing 3 doses of fentanyl which equaled 9 days without her ordered medication. The Medical Director was asked if fentanyl was considered a significant medication. The Medical Director stated, "I was not aware she had missed this many doses. It is a significant medication and it is also a medication error."

On 8/26/21 at 9:45 A.M. a phone interview was conducted with the Pharmacist #7 regarding Resident #1's Fentanyl Pain Patches. The Pharmacist stated, "We sent 10 patches to the facility and they arrived on 7/13/21. Before they were delivered on 7/13/21 around 1:00 A.M., the last time we sent the facility fentanyl patches for her was on 6/10/21 and 5 patches were sent then. The Pharmacist was asked if missing 3 doses and 9 days of a fentanyl patch wound be considered a significant medication error. The Pharmacist stated, "Yes it is a significant medication because it is a steady dosage of medication for her pain. When there is pain in the body it can cause an increased heart rate,

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increase the blood pressure and cause increased anxiety. Pain can have multiple effects that can negatively affect the body."

On 8/26/21 at 10:00 A.M. an interview was conducted with Director of Nursing regarding the above findings. The Director of Nursing stated, "We ran out of the hard script and it was documented that we were waiting for the order. She missed 9 days of the medication. There was a breakdown between the provider and the facility. She missed 3 doses of the fentanyl. We got a new medication script for the fentanyl on July 12 and sent it to the pharmacy." The Director of Nursing was asked why Resident #1 was not administered the fentanyl patch until 7/14/21 at 9:00 A.M. when the medication was available in the facility on 7/13/21 according to the pharmacy medication packing slip. The Director of Nursing stated, "I have no clue as to why it was not given until the 14th. All I know is that I was told we were waiting on the hard script from the physician." The Director of Nursing was asked if she had completed an investigation regarding how Resident #1' had missed fentanyl medication doses and why there was no facility follow-up with the provider after 7/5/21. The Director of Nursing stated, "I did not do an investigation because I was just made aware of it last week but I can now see in Point Click Care daily when a resident has less that a six day supply of a narcotic available so I can make sure it is reordered in time."

On 8/26/21 at 1:28 P.M. a pre-exit debriefing was conducted with the Administrator, the Director of Nursing and the Regional Director of Operations, where the above information was shared. Prior to exit no further information was shared.

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F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and the facility's policy, the facility staff failed to follow physician orders for laboratory services for 2 out of 8 residents (Resident #5 and Resident #6) in the survey sample. The findings included: 1. The facility staff failed to obtain Resident #5's blood work ordered on 08/04/21 for Vitamin B12. Resident #5 was originally admitted the nursing facility on 09/30/20. Diagnosis for Resident #5 included but not limited to Iron Deficiency Anemia. The most recent Minimum Data Set (MDS) was an quarterly assessment with an Assessment Reference Date (ARD) of 04/17/21 coded the resident on the Brief Interview for Mental Status (BIMS) with a score of 11 out of a possible score of 15, which indicated moderate cognitive impairment for daily decision-making. Resident #5 was coded total dependence of one with dressing, toilet use, personal hygiene and bathing, extensive assistance of one with bed	F 770		

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mobility, transfer and eating for Activities of Daily Living (ADL.)

Review of the psychotherapy note written by (name of physician) on 08/04/21 included but not limited to the following information: "Resident #5 has been uncharacteristically quiet for the last two weeks, none of the usual hollering. She's compliant and sleepy, lies in bed unresponsive until touched and then she watches." Further review of clinical notes request the following recommendation; ask the attending physician to consider obtaining blood work for Vitamin B12.

During the review of Resident #5's clinical record on 08/26/21 did not reveal lab results for Vitamin B12. On the same day, the Director of Nursing (DON) stated she reviewed Resident #5's clinical record and was not able to locate Vitamin B12 blood work. The DON stated, "The blood work was never done, I expect for the nurses to notify the physician/ NP of the psychotherapist recommendations, they should have obtain the lab work for the Vitamin B12.

A phone interview was conducted with the Nurse Practitioner (NP) on 08/26/21 at approximately 2:35 p.m. She said, the facility never informed her of the psychotherapist recommendation for Vitamin B12 blood work. When asked, what you're looking for with Vitamin B12 blood work, she replied, "A low or high Vitamin B12 can affect the resident's mental status as well as showing if the resident is anemic and may require some type of iron supplement or even a blood transfusion."

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

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on 08/26/21 at approximately 2:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

2. The facility staff failed to obtain lab work for UA/C&S ordered on 05/04/20. Resident #6 was originally admitted the nursing facility on 01/01/20. Diagnosis for Resident #6 included but not limited to Alzheimer's disease. The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 05/25/21 coded the resident on the Brief Interview for Mental Status (BIMS) with short and long-term memory problems and cognitive skills severely impaired-never/rarely made decisions. Resident #6 was coded total dependence of one with dressing, toilet use, personal hygiene and bathing, extensive assistance of two with transfer and extensive assistance of one with bed mobility and eating for Activities of Daily Living (ADL.)

The care plan with a revision date of 06/08/20 identified Resident #6 with incontinence of bladder. One of the interventions/approaches the staff would use to accomplish this goal is monitor for signs and symptoms of UTI.

Review of Resident #6's clinical note written by Registered Nurse (RN) #1 on 05/04/21 included the following: Resident #6 noted with a low grade temperature. The Nurse Practitioner (NP) #1 made aware with a new order to obtain urine for Urine Analysis (U&A) and Culture and Sensitivity (C&S.)

Review of Resident #6's Lab Administration Report for May 2020 revealed the following order:

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UA, C&S - one time for fever. During the review of Resident #6's clinical record on 08/26/21 did not reveal lab results for UA/C&S. Further review of the May 2020 Lab Administration Record (LAR), revealed evidenced of two blank spaces on 05/04/20 and 05/05/20 for UA, C&S, indicating the mentioned urine specimen was not obtained as ordered.

An interview was conducted with the DON on 08/25/21 at approximately 4:03 p.m. After the DON reviewed Resident #6's clinical record for the urine culture results that was ordered on 05/04/20, she replied, "Apparently, it was not done." The DON stated, "The expectation is that the nurses are to obtain labs as ordered by the physician/NP."

A phone call was placed to RN #1 on 08/26/21 at approximately 1:06 p.m. RN #1 wrote the order to obtain the lab work for the UA/C&S on 05/04/21. A message was left, the RN never called back.

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/26/21 at approximately 2:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

The facility's policy titled: Laboratory Services and Reporting with a revision date of 10/28/20. Policy: The facility must provide or obtain laboratory services when ordered by the physician, physician assistant, nurse practitioner, or clinical specialist in accordance with state law.

Policy explanation and compliance guidelines:

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The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the timeliness of the services.

Definitions:

1. Vitamin B12 measures how much of the vitamin is in your blood. It can help diagnosis a specific type of anemia and other problems (https://www.webmd.com/a-to-z-guides/vitamin-b12-test.)

2. Iron Deficiency Anemia is a common type of anemia that occurs if you do not have enough iron in your body (https://www.nhlbi.nih.gov/health-topics/iron-deficiency-anemia.)

2. Urine Analysis (UA) is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder. This means it does not contain any bacteria or other organisms (such as fungi) but bacteria can enter the urethra and cause a UTI (http://www.webmd.com/a-to-z-guides/urine-culture.)

3. Culture and Sensitivity (C&S) is sample of urine is added to a substance that promotes the growth of germs. If no germs grow, the culture is negative. If germs grow, the culture is positive. The type of germ may be identified using a microscope or chemical tests. Sometimes other tests are done to find the right medicine for treating the infection. This is called sensitivity testing (http://www.webmd.com/a-to-z-guides/urine-cultur

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495296	A. BUILDING _____ B. WING _____	C 08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT COURTLAND	23020 MAIN STREET COURTLAND, VA 23837

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 38 e.) 4. Urinary Tract Infection (UTI) is an infection involving any part of the urinary system, including urethra, bladder, ureters, and kidney (http://www.cdc.gov/HAI/ca_uti/uti.html.)	F 770		
F 842 SS=D	Complaint deficiency Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law;	F 842		

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F 842	Continued From page 39	F 842		

(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility

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F 842	Continued From page 40	F 842		

documentation review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 8 residents (Resident #7) in the survey sample.

The findings included:

Resident #7 was admitted to the nursing facility on 02/25/20 and discharged on 03/05/20. Diagnosis for Resident #7 included but not limited to Heart Failure and End Stage Renal Disease (ESRD.) Resident #7's Minimum Data Set (MDS - an assessment protocol) a comprehensive assessment with an Assessment Reference Date (ARD) of 03/02/20 coded Resident #7's Brief Interview for Mental Status (BIMS) scored a 8 out of a possible score of 15 indicating moderate cognitive impairment. The MDS coded Resident #7 total assistance of two with bed mobility, dressing, toilet use and personal hygiene, total dependence of one with bathing and extensive assistance of one with eating for Activities of Daily Living (ADL) care. In addition, under section H - (Bladder and Bowel) was coded for always incontinent of bladder and bowel.

The surveyor was unable to locate Resident #7's clinical record in the facilities software program Point Click Care (PCC.) An interview was conducted with the Administrator on 08/24/21 at approximately 11:50 a.m. The Administrator searched for Resident #7 clinical information in PCC but could not validate if Resident #7 was ever a resident at the facility because her clinical record was not present. The Administrator said (name of previous nursing home) was acquired by (name of new owner) on 04/01/20. He stated, "I'll reach out to cooperate support for assistance with this matter."

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F 842	Continued From page 41	F 842		

On 08/25/21 at approximately 1:37 p.m., an interview was conducted with the Administrator. He said, the new company acquired the facility on 04/01/20, after Resident #7 was discharged from the facility, returned not anticipated. Resident #7's records were not transferred over to (name of new facility). The Administrator said the original contract should have an Agreement for the facility to maintain access to Resident #7's clinical record. The Agreement was requested by the surveyor.

On 08/26/21 at approximately 11:50 a.m., the Administrator provided a letter that read in part: This letter serve as an explanation of the inability to procure the records requested on Resident #7 of the facility during the previous owner. (Name of current owner) acquired this property from (name of previous owner) on 04/01/20. Resident #7 was a closed record and her record and not transferred to (name of current facility.) Our Cooperate leadership team attempted to reach out to the (previous owner) and now the (previous owner) has been sold entirely. The Administrator was asked if he was able to locate the Agreement between the previous owner and with the new ownership, the Administrator replied, "No, we were not able to locate the Agreement."

A pre-exit conference was conducted with the Administrator, Director of Nursing and Cooperate on 08/26/21 at approximately 2:30 p.m. The Administration team were informed of the above findings; no further information was provided prior to exit.

Complaint deficiency