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| E 000 | Initial Comments<br><br>An unannounced onsite Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 12/19/22 through 12/20/22. The facility was in compliance with E0024 of 42 CFR Part 483.73, Requirements for Long-Term Care Facilities. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>An unannounced Medicare/Medicaid abbreviated standard survey and COVID-19 Focused Infection Control survey were conducted on 12/19/2022 through 12/20/2022. One complaint was investigated during the survey. Complaint VA00056427 was substantiated with deficiencies cited as past non-compliance. The facility was in substantial compliance with 42 CFR Part 483 Federal Long Term Care requirements.<br><br>The census in this ninety certified bed facility was seventy-nine at the time of the survey. The survey sample consisted of two current resident reviews and one closed record review. | F 000 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>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.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility | F 684 | Past noncompliance: no plan of | |

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

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| F 684 | Continued From page 1<br>document review, clinical record review and complaint investigation, the facility staff failed to administer medications as ordered by the physician for one of three residents in the survey sample. Resident #2's intravenous medications were not administered at frequencies designated by physician's order.<br><br>The findings include:<br><br>Resident #2 was admitted to the facility with diagnoses that included status post cholecystectomy with suspected intra-abdominal abscess, reflux esophagitis, anorexia, hypertension, protein-calorie malnutrition and depression. The minimum data set (MDS) dated 7/21/22 assessed Resident #2 as cognitively intact.<br><br>Resident #2's closed clinical record documented the resident was admitted to the facility with a central venous catheter in the right upper chest for the administration of intravenous antibiotics. The record documented physician orders for the following antibiotic medications dated 7/19/22: Ceftazidime-Avibactam (Avycaz) solution reconstituted - give 2.5 grams intravenously every shift until 7/26/22 for treatment of infection and Vancomycin HCl solution - give 1 gram intravenously every 18 hours for treatment of infection.<br><br>Resident #2's medication administration record (MAR) report dated 7/21/22 documented the first dose of Avycaz scheduled for 7/19/22 at 11:00 p.m. was administered over three hours later at 2:11 a.m. Another dose of Resident #2's Avycaz scheduled for 7/21/22 at 12:00 a.m. was administered over three hours later at 3:10 a.m. | F 684 | correction required. | |

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A nursing note dated 7/20/22 documented the Avycaz was late due to the resident's late arrival at the facility on the evening of 7/19/22. There was no documentation regarding the late administration of Avycaz scheduled for 7/21/22 at 12:00 a.m.

Resident #2's MAR documented a dose of Vancomycin was administered as ordered on 7/20/22 at 10:18 a.m. The next dose of Vancomycin scheduled for 7/21/22 at 4:00 a.m. was not administered. A nursing note dated 7/21/22 at 10:08 a.m. documented the 7/21/22 dose of Vancomycin was not administered when scheduled. A new order was entered to administer the dose "now." The resident was transferred to the hospital per resident request prior to the administration of the 7/21/22 dose of Vancomycin.

The facility's policy titled Medication Administration Times (revised 1/1/22) documented, "...Facility should commence medication administration within sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration..."

On 12/19/22 at 2:15 p.m., the registered nurse (RN #2) assistant director of nursing (ADON) was interviewed about Resident #2's late antibiotic administration. RN #2 stated the resident and family reported concerns about the late antibiotic administration. RN #2 stated the late dose of Vancomycin on 7/21/22 was because the nurse put the wrong lock on the medication refrigerator and was unable to access the medicines. RN #2 stated maintenance cut the lock on 7/21/22 after

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8:00 a.m. RN #2 stated an order was obtained to administer the medication late but the resident wanted to be discharged and did not want the dose administered.

On 12/19/22 at 4:30 p.m., the regional director of clinical services (RN #1) and the ADON (RN #2) were interviewed about Resident #2's late medications. RN #1 stated the Avycaz was ordered once per shift (three times per day) and the first dose was administered on 7/20/22 at 2:00 a.m. RN #1 stated the next dose should have been given "around 10:00 a.m." and was not administered until after 4:00 p.m. RN #1 stated the resident was in the facility for a total of 38 hours and received four doses of the Avycaz but the doses were not timely and not administered each shift as ordered. RN #1 stated nurses should have adjusted the scheduled administration times after the first dose was late to provide timely administration at the required frequency/intervals. RN #1 stated the Vancomycin dose scheduled on 7/21/22 at 4:00 a.m. was missed because the nurse put a wrong lock on the medication refrigerator and was unable to access the medication. RN #2 stated the resident was offered the Vancomycin dose later that morning after the lock was removed but the resident did not want the medication administered and requested to return to the hospital. RN #1 stated the nurse should have immediately contacted the provider and nursing administration about the late medications and incident with the refrigerator so interventions to get the medicine could have been initiated sooner.

On 12/19/22 at 10:45 p.m., the licensed practical nurse (LPN #1) caring for Resident #2 on 7/21/22

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was interviewed. LPN #1 stated she unlocked the refrigerator to get Resident #2's Vancomycin scheduled for the early morning dose on 7/21/22. LPN #1 stated she got distracted with another issue and placed a lock back on the refrigerator. LPN #1 stated, "I put the wrong lock on the refrigerator." LPN #1 stated there were several extra locks in a drawer and she placed the wrong lock back on the refrigerator. LPN #1 stated when she went back to get the Vancomycin, she was unable to open the refrigerator and unable to find a key for the lock. LPN #1 stated she notified the director of nursing and administrator when the day shift came in and maintenance cut the lock from the refrigerator later in the morning. LPN #1 stated the Vancomycin was not administered as scheduled during the early morning on 7/21/22 due to the locked refrigerator issue.

On 12/20/22 at 8:20 a.m., the regional director of clinical services (RN #1) was interviewed again about Resident #2's antibiotics. RN #1 stated medications were expected to be administered within 60 minutes of the assigned times as required in their policy. RN #1 stated the director of nursing and administrator initiated a quality assessment and performance improvement plan regarding Resident #2's late/missed medications. RN #1 presented a correction plan initiated on 7/21/22 regarding Resident #2's late antibiotic medication administration.

The correction plan dated 7/21/22 documented nursing "failed to follow physician orders and/or notify MD [physician] and NSG [nursing] admin [administration] of unavailable med [medication] - this was d/t [due to] it being locked in fridge with the wrong lock and no key was available...Nursing staff did not follow

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policy/guidance r/t [related to] medication administration...Licensed nurses needed to be re-educated on IV [intravenous] medication administration and admission process/times of medications based on last dose given and how to enter those orders..." The plan to address Resident #2's late and inconsistent antibiotic administration times included the following:

1. Verbal consultation with charge nurse that failed to notify MD and administration of unavailable medication, needed supplies and immediate maintenance need. Education provided to licensed nurses on following physician orders and specifically about notifying physician of late medications, unavailable medications and/or lack of intravenous supplies.

2. The electronic health record dashboard was reviewed daily (Monday through Friday) for medications not administered and follow up initiated on any identified issues.

3. Education provided to all licensed nurses regarding when and who to notify when a medication was unavailable and/or not administered timely. IV infusion education and handouts provided regarding IV administration sets and infusion of medications. IV infusion competencies/skills completed that included management of midlines/central lines and medication administration. Admission process updated to include times of ordered medications based on arrival time to facility versus when do and how to accurately enter those orders. A checklist titled Management of Midlines and Central Vascular Access Devices (2021) was documented for use with staff competencies.

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| F 684 | Continued From page 6<br>4. Random medication pass observations with licensed nurses were conducted two times per week for 8 weeks to ensure nurses were able to identify if medications were late, if physician was notified if not available and prompt notification to nursing administration of any issues and/or delays with medication administration.<br><br>Date of compliance was 9/30/22.<br><br>Review of the correction plan documented staff education, competency checks and monitoring as listed.<br><br>Resident #3 was added to the current survey sample and was reviewed regarding care/services related to a central venous catheter. Resident #3's central line and IV medication administration were observed with no deficiencies identified. Nurses were able to access the medication refrigerator with no extra locks observed.<br><br>These findings were reviewed with the administrator, ADON and regional director of clinical services on 12/20/22 at 8:45 a.m. The director of nursing was on leave and not available during the survey.<br><br>This was a complaint deficiency cited as past non-compliance. | F 684 | | |
| F 694 SS=D | Parenteral/IV Fluids<br>CFR(s): 483.25(h)<br><br>§ 483.25(h) Parenteral Fluids.<br>Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the | F 694 | | |

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| F 694 | Continued From page 7<br>comprehensive person-centered care plan, and the resident's goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview, facility document review, clinical record review and complaint investigation, the facility staff failed to provide sterile caps for use with a central venous catheter. Resident #2's central venous catheter was observed by a staff member without a protective cap in place over the access hub.<br><br>The findings include:<br><br>Resident #2 was admitted to the facility with diagnoses that included status post cholecystectomy with suspected intra-abdominal abscess, reflux esophagitis, anorexia, hypertension, protein-calorie malnutrition and depression. The minimum data set (MDS) dated 7/21/22 assessed Resident #2 as cognitively intact.<br><br>Resident #2's closed clinical record documented the resident was admitted to the facility with a central venous catheter in the right upper chest for the administration of intravenous antibiotics. The record documented physician orders for the following antibiotic medications dated 7/19/22: Ceftazidime-Avibactam (Avycaz) solution reconstituted - give 2.5 grams intravenously every shift until 7/26/22 for treatment of infection and Vancomycin HCl solution - give 1 gram intravenously every 18 hours for treatment of infection.<br><br>On 12/19/22 at 2:15 p.m., the registered nurse (RN #2) assistant director of nursing (ADON) was interviewed about the complaint allegation that no | F 694 | Past noncompliance: no plan of correction required. | |

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cap was placed on Resident #2's central line port at some point during the resident's stay. RN #2 stated the facility had no supply of green caps to cover the hub access upon Resident #2's admission. RN #2 stated pharmacy usually sent the green caps when the intravenous medications were ordered. RN #2 stated Resident #2 was admitted on the evening of 7/19/22 and there were no green caps for the line access in the facility. RN #2 stated the caps were not delivered until 7/21/22 and nurses had not immediately informed administration that the caps were unavailable. RN #2 stated the access hubs on the central line catheters were supposed to have a green cap for protection of the line access against contamination. RN #2 stated after removal to administer medications and/or flushes, a new green cap was supposed to be placed on the hub. RN #2 stated the resident reported that nurses put a dressing over the access hub instead of a sterile cap.

On 12/19/22 at 4:30 p.m., the regional director of clinical services (RN #1) was interviewed about no caps available for Resident #2's central line hub. RN #1 stated there were no caps available in the facility for the hub when Resident #2 was admitted. RN #1 stated the caps were available on 7/21/22. RN #1 stated nurses had not reported to nursing administration that the central line caps were unavailable.

On 12/19/22 at 10:45 p.m., the licensed practical nurse (LPN #1) caring for Resident #2 on 7/21/22 was interviewed. LPN #1 stated Resident #2 had a central line with one access port. LPN #1 stated when she reported to work on the evening of 7/20/22 the hub did not have a green cap but was covered with a Tegaderm dressing. LPN #1

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| F 694 | Continued From page 9 | F 694 | | |

stated, "We did not have any caps." LPN #1 stated she thought a day shift nurse had placed the Tegaderm dressing over the port. LPN #1 stated caps were available on 7/21/22 and she replaced the Tegaderm dressing with a sterile green cap during her shift. LPN #1 described Tegaderm as a sterile, transparent dressing usually used over the central line access site but not the hub.

On 12/20/22 at 8:20 a.m., the RN #1 was interviewed again about the unavailable caps for Resident #2's central line. RN #1 stated a quality improvement and performance improvement plan was completed regarding the unavailable central line caps and failure of nurses to notify administration about the unavailable caps. RN #1 presented a correction plan initiated on 7/21/22 regarding Resident #2's unavailable central line caps.

The correction plan dated 7/21/22 documented, "Nursing staff failed to notify administration of unavailable supplies...Nursing staff did not follow policy/guidance r/t [related to] medication administration and infection control practices..." The plan to address the unavailable central line caps included the following:

1. Verbal consultation with charge nurses that failed to notify MD and administration of unavailable/needed supplies. Education provided to licensed nurses on following physician orders and specifically about immediately notifying nursing administration of unavailable/needed intravenous supplies.

2. In-service education was provided to all licensed nurses regarding infection control prior

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to and during intravenous (IV) medication administration. Education included when and who to notify if medications and/or supplies were not available. IV infusion education/handouts were provided that addressed IV administration sets, infusion of medications and sterile end caps.

3. IV infusion competencies/skills completed for licensed nurses in management of midlines/central lines and medication administration and when/who to notify if supplies unavailable. A checklist titled Management of Midlines and Central Vascular Access Devices (2021) was documented for use with staff competencies.

4. Random medication pass observations with licensed nurses were conducted two times per week for 8 weeks to ensure nurses were able to identify if medications were late, if physicians were notified if not available and prompt notification to nursing administration of any issues and/or delays with medication administration or unavailable supplies.

Date of compliance was 9/30/22.

Review of the correction plan documented staff education, competency checks and monitoring as listed.

During the current survey, Resident #3 was included in the survey sample for review of care/services related to a central venous catheter. On 12/19/22 at 4:10 p.m., accompanied by LPN #2, Resident #3's central line site was observed. The central line was positioned on the resident's right upper chest and was covered with

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a transparent dressing dated as changed on 12/18/22 with a nurse's initials noted. The line had two access ports with both hubs covered with a green cap. There was no redness, drainage, swelling, signs of infection and/or complication at the access site. There was a supply of sterile green caps available in the unit's storage room. The record documented a physician's order to change the central line site transparent dressing once every 7 days in addition to orders regarding flushing/care of the central catheter.

On 12/20/22 at 8:00 a.m., LPN #3 was observed administering the intravenous medication Avycaz to Resident #3 via the central line. Green caps were in place on both hubs of the central line access at the time of this observation. LPN #3 followed appropriate infection control practices during the flushing then start-up of the intravenous medication. LPN #3 applied a sterile green cap to the access hub after flushing the central line with sterile normal saline. The IV medication was administered as ordered. LPN #3 stated green caps had been available for use with the port and she was not aware of any unavailable IV supplies.

There were no identified deficiencies during the current survey regarding IV medication administration or the availability of supplies for a central line.

These findings were reviewed with the administrator, ADON and regional director of clinical services on 12/20/22 at 8:45 a.m. The director of nursing was on leave and not available during the survey.

This was a complaint deficiency cited as past

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| F 694 | Continued From page 12<br>non-compliance. | F 694 | | |