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	345172	A. BUILDING _____ B. WING _____	C 02/08/2021

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F 000	INITIAL COMMENTS A complaint survey was conducted on 2-8-21. Event ID # FOTO11 Past-noncompliance was identified at: CFR 483.12 at tag F600 at a scope and severity J The tag F600 constituted Substandard Quality of Care. A partial extended survey was conducted. 1 of 1 complaint allegations were substantiated.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility neglected to (1) administer intravenous (IV) antibiotics to treat a stage IV sacral pressure sore for 12 days. This occurred for 1 of 3 residents (Resident #1)	F 600	Past noncompliance: no plan of correction required.	2/23/21

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

Electronically Signed | 02/26/2021

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reviewed for intravenous therapy. This caused Resident #1 to be readmitted to the hospital with sepsis and bacteremia resulting in a second surgery for a bone biopsy and debridement of the sacral wound. Resident #1 passed away while in the hospital.

Findings included:

Review of the hospital discharge summary dated 11-7-20 revealed Resident #1's pressure ulcer measured 11 centimeters long, 13 centimeters wide, 3.5 centimeters deep with 3 centimeters of undermining. The wound bed tissue had 90% granulation with a moderate amount of serosanguinous drainage. Resident #1 was to receive Ertapenem (antibiotic) 1 gram intravenously daily with a stop date of 11-24-20 to treat a stage IV sacral pressure sore.

Resident #1 was readmitted to the facility on 11-7-20 with multiple diagnoses that included pressure ulcer of the sacral region stage 4, sepsis, and severe protein calorie malnutrition.

The facility's physician order dated 11-7-20 revealed Resident #1 was to receive Ertapenem (antibiotic) 1 gram intravenously via Peripherally Inserted Central Catheter (PICC) line daily with a stop date of 11-12-20.

Resident #1's care plan in place on 11-7-20 (originally dated 10-29-20) revealed a goal that the resident would not have any complications related to her Intravenous (IV) therapy. The interventions for the goal were in part; flush IV per policy, inspect site for signs and symptoms of inflammation each shift, monitor catheter with each dressing change to check for migration,

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monitor for allergic reaction to the medication. Resident #1's care plan also had a goal that her wound would have evidence of healing as evidenced by decrease in size, absence of erythema and drainage. The interventions for the goal were in part; assist resident in turning and repositioning, observe skin condition daily and provide wound treatment as ordered.

Resident #1's Treatment Administration Record (TAR) for the month of November 2020 revealed the resident received wound care treatments that started 11-8-20 and continued through 11-24-20. There was no documentation of the size or condition of the wound.

Review of Resident #1's Medication Administration Record (MAR) for the month of November 2020 revealed the resident had received Ertapenem (antibiotic) 1 gram intravenously daily from 11-7-20 to 11-12-20. The MAR reflected the resident did not receive the antibiotic from 11-13-20 to 11-24-20.

The admitting nurse (Nurse #1) was interviewed on 1-26-21 at 1:05pm. Nurse #1 discussed reviewing the discharge medications from the hospital for Resident #1. She stated she had not reviewed the hospital discharge summary where Resident #1's intravenous antibiotic stop date was located and said when she verified the medication with the on-call physician she requested a stop date for the intravenous antibiotic and was given a date of 11-12-20. The nurse commented that the on-call physician requested the nurse practitioner or the facility physician review the intravenous antibiotic but she stated that was not completed because she did not know how to leave messages for the

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nurse practitioner or facility physician. Nurse #1 clarified she had not attempted to find out how to leave a message for the nurse practitioner or physician.

The 5-day Minimum Data Set (MDS) dated 11-13-20 revealed Resident #1 was moderately cognitively impaired and was coded for a stage 4 pressure ulcer and intravenous (IV) medication.

The wound care physician's documentation revealed the physician saw Resident #1 on 11-17-20. He documented Resident #1's stage IV pressure ulcer of the sacrum was approximately 56 days in duration and that there was moderate serous exudate present with 100% granulation tissue. He noted in his documentation that Resident #1 had not appeared to have any pain associated with the wound. He had documented the size of the wound as 9 centimeters long by 5.5 centimeters wide and 1.9 centimeters deep with no undermining and a surface area of 49.5 centimeters.

The facility's wound physician was interviewed by telephone on 2-2-21 at 10:07am. The wound physician stated he was not informed of the resident's return to the facility until 11-17-20 and was unaware the resident had received and should have been still receiving intravenous antibiotics on 11-17-20. He also stated he could not comment if Resident #1 missed 12 days of antibiotic could have deteriorated the wound.

An interview with the facility's nurse practitioner (NP) occurred by telephone on 2-1-21 at 9:39am. The NP acknowledged she had signed off on the order for the intravenous antibiotic stop date of 11-12-20. She said she had read Resident #1's

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hospital discharge summary but not in detail and assumed the stop date on 11-12-20 was correct. The NP discussed learning of the error after the resident had been discharged and the facility had begun their investigation. She stated it was at that time she read through Resident #1's discharge summary and realized the intravenous antibiotic should have been stopped on 11-24-20.

The Director of Nursing (DON) was interviewed on 1-26-21 at 12:29pm. The DON stated the facility investigated the reason Resident #1 had not received her intravenous antibiotic as ordered from the hospital and discovered there were errors in communication with the nurse practitioner and facility physician as well as the admitting nurse not reading through Resident #1's discharge summary for the accurate stop date. She also stated she had completed education on 11-25-20 with nursing staff on transcribing orders and reading resident hospital discharge summaries.

During a telephone interview with the Infectious Disease nurse practitioner (NP) on 2-1-20 at 11:26am, the NP discussed her follow up with Resident #1 on 11-24-20 was initiated by her due to the last date of the intravenous antibiotic was 11-24-20. She discussed Resident #1 had developed an infection in the bone of her sacrum and was septic. She stated the sacral wound appeared significantly worse then when the resident was discharged from the hospital on 11-7-20. She described the wound to have slough that was gray and no viable tissue covering the wound bed. The NP explained the resident had septicemia and bacteremia prior to the discharge on 11-7-20 but upon discharge the bacteremia had been cleared but the resident still required

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the intravenous antibiotic until 11-24-20 due to the sepsis and to prevent the bacteremia from returning. She attributed the deterioration of the wound and the resident being septic to not having the antibiotics for 12 days. The NP discussed sending the resident back to the hospital from her office on 11-24-20 where Resident #1 underwent surgery to debride the wound and perform a bone biopsy. She stated Resident #1 died on 12-2-20 with contributing factors of septicemia and untreated bacteremia.

Resident #1's admission hospital records dated 11-24-20 revealed an assessment of her sacral wound. The assessment documented Resident #1's wound as a stage IV sacrum pressure injury measuring 10 centimeters long, 9.5 centimeters wide, 4 centimeters deep with 4 centimeters undermining. The documentation described the wound bed tissue as 90% necrotic with yellow slough and 10% non-granulating tissue with exposed bone. The type and amount of drainage documented was moderate purulent drainage with a strong foul odor. The admission documentation revealed Resident #1 was started on intravenous antibiotics for sepsis.

Review of Resident #1's death certificate signed 12-2-20 revealed Primary cause of death was sepsis secondary to sacral decubitus ulcer.

The facility provided a plan of correction with a correction date of 11-30-20. The plan of correction included: F600.

1.On 11-24-20 at 2:30pm the facility had received a phone call from the hospitals emergency room manager questioning the facility about Resident #1 not receiving her IV antibiotic treatment.

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Immediately following the hospital emergency room managers call, the facility received a call from Resident #1's family member about neglectful care.
On 11-24-20 the facility completed an initial investigation report concerning the allegations of neglect and missed antibiotic IV therapy.
On 11-25-20 the facility had completed their investigation and concluded the resident had received the IV antibiotics as ordered and the allegation of neglect was unsubstantiated. The corrective action the facility provided included the resident was re-hospitalized and had surgery.

2. The facility conducted an ADHOC QAPI meeting on 11-24-20 and developed an action plan that consisted of the following 4 points.

a. "It was discovered upon admission to hospital for worsening wound that resident had missed antibiotic order from admission".

b. "All residents with orders for antibiotics on admission have potential to be effected. Nursing leadership audited 100% of new admissions for the last 30 days to ensure that orders for antibiotics were transcribed and delivered accordingly".

c. "Education provided to the licensed nurses on how to review discharge summaries from hospital and ensure orders transcribed correctly. All staff reeducated on neglect, to include not providing ordered medication is considered neglectful".

d. All new admission charts to be brought to the clinical morning meeting for nursing leadership to review discharge summary compared to orders in point click care to ensure orders carried out accordingly. Results of these audits will be brough before the Quality Assurance and Performance Improvement

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F 600	Continued From page 7 Committee responsible for ongoing compliance". The facility began education on 11-25-20 which covered neglect; "the failure of the center and its employees to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish and emotional distress. Missing medications or treatment is neglect". On 11-25-20 the facility completed audits of new admissions for the past 30 days. The Immediate Jeopardy plan of correction was validated on 2-8-20 and the corrections were implemented by 11-30-20 as the facility alleged. Validation was evidenced by staff interviews, record reviews, observation, facility training that included the facility's abuse and neglect policy and procedure, reading discharge summaries and discharge orders and, communication process with the facility physician and nurse practitioner. Observation of the units revealed communication books for the physician and nurse practitioner at each nursing station. Record review of three residents, who were on intravenous therapy, revealed all orders were in place and none of the residents had missed a dose of their medication.	F 600		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F 694		2/26/21

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F 694	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and physician interviews, the facility failed to provide care and maintenance to Resident #1's Peripherally Inserted Central Catheter (PICC) line which was used to deliver the resident's antibiotic treatment. This occurred for 1 of 3 residents (Resident #1) reviewed for intravenous therapy. Findings included: Resident #1 was readmitted to the facility on 11-7-20 with multiple diagnoses that included pressure ulcer of the sacral region stage 4, sepsis, and severe protein calorie malnutrition. Resident #1's active care plan dated 10-29-20 revealed a goal the resident would not have any complications related to her Intravenous (IV) therapy. The interventions for the goal were in part; flush IV per policy, inspect site for signs and symptoms of inflammation each shift, monitor catheter with each dressing change to check for migration, monitor for allergic reaction to the medication. The 5-day Minimum Data Set (MDS) dated 11-13-20 revealed Resident #1 was moderately cognitively impaired and was coded as having intravenous (IV) medication. Review of Resident #1's hospital discharge summary dated 11-7-20 revealed the resident had a Peripherally Inserted Central Catheter (PICC) line in her right upper extremity. The discharge summary did not have any orders for the care/maintenance of the residents PICC line.	F 694	F694 Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction is prepared and / or executed solely because it is required by both Federal and State laws. Resident #1 no longer resides at the facility, thus, no other corrective action can be completed for this resident. Any resident receiving intravenous (IV) therapy has the potential to be affected. An audit of all IV therapy orders for the last 30 days was completed by the Regional Resource Nurse on 2/24/21 and there were no active orders for IV therapy at this time. The licensed nurses were in-serviced by the Center Nurse Executive (CNE) or designee regarding the requirement for orders for the care and maintenance of venous access devices including orders that are specific for the medication to be administered, route, dose, and frequency, the dressing change frequency and dressing to be used, flush/locking including the flushing agent(s), the strength/concentration, the volume and the frequency. When the vascular access is a peripherally inserted central catheter (PICC) the order must also include	

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F 694	Continued From page 9 Review of the facility's physician orders dated from 11-7-20 to 11-24-20 revealed no physician orders for the care and maintenance of Resident #1's PICC line. The admitting nurse (Nurse #1) was interviewed on 1-26-21 at 1:05pm. Nurse #1 discussed Resident #1 had orders for the PICC line to be flushed during the resident's previous admission and believed the previous admission orders for the PICC line flushes would have been reinstated for Resident #1's readmission on 11-7-20. She stated she had not discussed care/maintenance for the residents PICC line when she spoke with the physician. Review of Resident #1's Medication Administration Record and Treatment Administration Record from 11-7-20 to 11-12-20 revealed the resident received IV antibiotics and maintenance. Review of Resident #1's Medication Administration Record (MAR) and Treatment Administration Record (TAR) from 11-13-20 to 11-24-20 revealed Resident #1's IV antibiotics and maintenance had been stopped on 11-13-20 with no further documentation that care, and maintenance was provided to Resident #1's PICC line. Review of nursing documentation from 11-13-20 to 11-24-20 revealed no documentation of Resident #1's PICC line had been cared for or maintained. Nurse #2 was interviewed by telephone on 2-3-21 at 11:19am. Nurse #2 acknowledged she had worked with Resident #1 but could not remember	F 694	measurement of the length of the external catheter and obtaining upper arm circumference. Documentation of the central vascular access device tip location and the measurement of the length of the external catheter must be in the medical record prior to use. This in-service will be added to the orientation process of all licensed nurses. The education was completed on 2/26/2021. The physician orders will be reviewed in the daily clinical meeting for any orders for IV therapy. The orders will be audited by the clinical team to ensure all requirements for care and maintenance are included in the order. They will be corrected and the nurse that transcribed the order will be educated as needed. The IV therapy orders will audited 5X week for four weeks, then randomly thereafter. Results of those audits will be reported to QAPI committee monthly the CNE for three months and the quality monitoring schedule will be modified based on findings	

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if it was during Resident #1's prior admission or the resident's readmission on 11-7-20. She stated in order for the PICC line to be flushed, there had to be a physician order and then the nurse would document the care provided on the resident MAR. Nurse #2 explained she could not remember maintaining or caring for Resident #1's PICC line during the 11-7-20 admission.

An interview with Nurse #3 occurred by telephone on 2-3-21 at 11:25am. Nurse #3 stated she remembered Resident #1 and she had cared for the resident but could not remember if the resident had a PICC line. She stated she did not provide any maintenance or care to the PICC line when she was scheduled to work with Resident #1. Nurse #3 discussed needing a physician order to flush a PICC line and stated she did not remember any orders to flush Resident #1's PICC line.

The facility's medical director was interviewed by telephone on 2-1-20 at 9:46am. The physician stated he remembered Resident #1 and was aware she had a PICC line but was not able to answer why the resident did not have orders for the care and maintenance of the PICC line or why the PICC line was not removed when the resident had finished her IV therapy.

The Infectious Disease nurse practitioner (NP) was interviewed by telephone on 2-1-21 at 11:26am. The NP discussed Resident #1 had a PICC line located in her upper right extremity during Resident #1 follow up appointment on 11-24-20. The NP stated the PICC line was no longer viable due to the line clotting off. She explained a PICC line became clotted off when the line was no longer used daily and had not

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F 694	Continued From page 11 been maintained or cared for by flushing. The NP stated if the PICC line was not going to be used, the facility should have called to have the devise discontinued. During an interview with the Director of Nursing (DON) by telephone on 2-2-21 at 1:28pm, the DON acknowledged there were no orders for the PICC line to be maintained or cared for upon Resident #1's 11-7-20 readmission. She explained the lack of orders for the PICC line were a clerical error. She also stated she had not been aware the PICC line was not maintained and being aware of the resident's history of needing IV therapy, she stated she had not considered having the PICC line removed.	F 694		