

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345538</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-RALEIGH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2420 LAKE WHEELER ROAD</b> <b>RALEIGH, NC 27603</b>		
(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 000	INITIAL COMMENTS  The survey team entered the facility on 10/18/21 to conduct a complaint survey and exited on 10/22/21. Additional information was obtained on 10/25/21, 10/26/21, and 10/27/21. Therefore, the exit date was changed to 10/27/21. Five of the nine complaint allegations were substantiated. (Event 3IBT11).	F 000			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4)  §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:  §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.  §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.  §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Physician Assistant interviews, and Physician interviews, for one of one resident who sustained a right arm fracture of unknown origin, the facility failed to 1) interview multiple staff members who had cared for the resident within a short time frame of the fracture being identified and 2)	F 610	1. Resident # 1 was discharged on 10/4/2021.  2. A complete audit was conducted by the Social Worker and Social Work assistant of all residents with a BIMS score greater than 12 to see if they had an allegations of	11/24/21	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

11/12/2021

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 610	<p>Continued From page 1</p> <p>identify through incident report and record reviews that the resident had possibly sustained a similar injury to the left arm within the previous five weeks and incorporated interviews related to this within their right arm fracture investigation. The findings included:</p> <p>Resident # 1, who was 96 years of age, resided at the facility from 3/25/19 until her discharge on 10/1/21. The resident had diagnoses of dementia, hypertension, history of stroke with dysphagia, diabetes, chronic pain, muscle weakness, anemia, bradycardia, osteoporosis, contractures, and hyperlipidemia.</p> <p>Resident # 1's quarterly Minimum Data Set assessment, dated 7/23/21, coded the followed assessment. The resident was severely cognitively impaired; demonstrated behaviors such as hitting; required total staff assistance with her bed mobility, toileting, hygiene and bathing needs; required extensive assistance with eating; and had functional limitation in her range of motion.</p> <p>Resident # 1's care plan, updated on 7/28/21, included the information that Resident # 1 had a history of behaviors.</p> <p>Review of the resident's record revealed the resident had not sustained any falls since the date of 2/11/21 on which date she had a fall without any injury.</p> <p>On 8/31/21 at 7:08 PM Nurse # 1 documented she was asked to look at Resident #1's skin and observed she had a 5 X 5 (measurement scale not denoted) red non blanchable, non- raised area to her left arm. The nurse noted there was</p>	F 610	<p>abuse to report on 11/8/2021. One resident reported an allegation of neglect. The administrator submitted an Initial Allegation to the North Carolina Healthcare Personnel Registry on behalf of this resident.</p> <p>3.The Administrator and Director of Health Services reviewed 42CFR in the guidance to surveyors for further education on how to conduct a proper abuse investigation whereas investigations will be conducted by utilizing resident observations, identification of any injuries, location of incident, staff and resident observations. The facility will also conduct interviews with the alleged victim, representative, perpetrator, witnesses and other staff. A record review will be conducted as related to the investigation.</p> <p>4.The Administrator or designee will review all allegations of abuse prior to submittal to the state agency and will conduct a monthly audit of all investigations to ensure compliance. The findings will be presented during the monthly QAPI meeting for the next 3 months then quarterly thereafter.</p> <p>5.Date of compliance 11/24/21</p>		

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F 610	<p>Continued From page 2</p> <p>no indication of pain at the site. Nurse # 1 noted the resident's skin was thin and frail and she applied Geri sleeves to prevent bruising.</p> <p>On 9/1/21 at 5:00 AM Nurse # 8 documented Resident # 1 had a bruise from pressure leaning on the bed rail and there was red discoloration noted around her upper arm. The nurse noted the resident did have some non-verbal indicators of discomfort and she administered Tylenol.</p> <p>On 9/1/21 an X-ray of Resident # 1's left forearm was completed which showed the resident had moderate to severe osteoporosis. The radiologist further noted on one of the x-ray film views there was a thin sclerotic line on the ventral aspect of the radial head which was likely related to degenerative changes, "but a mildly impacted fracture of the radial head cannot be excluded." (The radial head is the portion of the arm bone where it meets the elbow).</p> <p>On 10/1/21 a review of records revealed Resident # 1 was sent to the hospital when the family chose to have intravenous fluids and labs done at the hospital rather than at the facility.</p> <p>At the time of the resident's hospitalization, the resident was identified to have sustained an injury to the area of her right elbow area also. Review of hospital notes revealed the following notation by the Emergency Department physician on 10/1/21. "She also seems to have a lot of discomfort when you move her right arm specifically at the elbow and shoulder, no obvious deformity and there was no reported fall but will need to be x-rayed to ensure no injury." Review of the hospital records revealed on 10/2/21 the physician noted Resident # 1's x-ray had shown a right radial head fracture</p>	F 610			

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F 610	<p>Continued From page 3 with a right elbow effusion.</p> <p>Review of progress notes prior to Resident # 1's transport to the hospital on 10/1/21 revealed the facility had not identified any injuries to the resident's right elbow.</p> <p>The facility Administrator provided documentation that they had investigated the right radial head fracture as an injury of unknown origin. Review of the facility's investigative file revealed the following. It was noted that on 10/4/21 the facility became aware the hospital had reported the right distal elbow fracture. There were four statements from staff regarding the incident; one of the three noted "I did not work with the resident." Six residents, who had resided on the hall on which Resident # 1 had resided, were interviewed regarding abuse.</p> <p>Review of the facility's investigative summary revealed in doing the investigation related to the right arm fracture, the facility did not note that the resident was identified to have a possible fracture on the opposite arm near the same area and which was identified on 9/1/21. The summary noted the facility had looked back through incident reports for two weeks. The summary read, "Facility interviews were conducted with staff working with the resident and no one noted any variance to care other than the resident was actively transitioning and was being kept comfortable. Resident cannot bear weight or reposition herself. Incident reports were reviewed for the last two weeks and there were no indications of any abuse. Resident interviews were also conducted and no one reported any other allegations of abuse. Resident has a history of moderate to severe osteoporosis so it is most</p>	F 610			

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F 610	<p>Continued From page 4</p> <p>likely that the fracture occurred during normal turning and repositioning." The report was signed as completed by the former DON (Director of Nursing).</p> <p>According to assignment sheets, Nurse # 5 had been assigned to care for Resident # 1 on 10/1/21. Nurse # 5 was interviewed on 10/25/21 at 12:09 PM and reported she did not usually care for Resident # 1, but had started working with her on the AM of 10/1/21. She gave the resident her medications and did not notice anything abnormal at the time for the resident. She switched assignments with Nurse # 9 when Nurse #9 reported to work. She had not been interviewed during the facility's investigation about Resident # 1's fracture and did not know how it might have occurred.</p> <p>Nurse # 9 was interviewed on 10/25/21 at 12:30 PM and reported the following. She had been off for awhile before returning to work on 10/1/21. She had cared for Resident # 1 up until her transport to the hospital on 10/1/21. She had never been interviewed during the facility's investigation about Resident # 1's fracture, and she was not aware it happened or how it could have occurred.</p> <p>Nurse # 6 had cared for Resident # 1 on the 7:00 PM to 7:00 AM shift beginning on 9/30/21. Nurse # 6 was interviewed on 10/21/21 at 12:00 PM and reported the following. Nurse # 6 stated she was unaware the resident was diagnosed with a fracture of her right arm and she was never asked about it during the facility's investigation. On the night prior to the resident's hospital transport the resident had not been doing well medically but she was unaware of any problems</p>	F 610			

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F 610	<p>Continued From page 5</p> <p>with the resident's arm or what could have caused the fracture.</p> <p>Nurse # 4 had cared for Resident # 1 on the 7:00 AM to 7:00 PM shift on 9/30/21. Nurse # 4 was interviewed on 10/21/21 1:15 PM and reported the following. She had not been aware the resident had a fracture and she was never interviewed about it during the facility's investigation. She did not recall anything happened to the resident's right arm, but she did recall the bruise to her left arm the previous month. The nurse stated the resident's body tended to move towards the siderails of the bed and the facility had padded them.</p> <p>Nurse # 7 had cared for Resident # 1 on the 7:00 PM to 7:00 AM shift beginning 9/29/21. Nurse # 7 was interviewed on 10/21/21 at 12:33 PM and reported she did not know the resident was identified to have a fracture to her right arm and had not been interviewed during the facility investigation. On her night shift, which began on 9/29/21, she had not noted anything wrong with the resident's right arm. She was aware she had a bruise to the left arm about a month previous and stated the resident tended to favor the left side and although she did not know of a particular incident, the resident could have hit it against the rail.</p> <p>Nurse # 2, who was the unit manager, was interviewed on 10/21/21 at 4:50 PM and reported the following. He had been notified Resident # 1 had been diagnosed with a right radial head fracture. He had not been interviewed during the facility's investigation. He did not know how the fracture had occurred but stated the resident tended to lean into the siderails of the bed.</p>	F 610			

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F 610	<p>Continued From page 6</p> <p>The former DON was interviewed on 10/21/21 at 10:12 AM and reported the following. While doing the investigation she had spoken to the nurse aides rather than the licensed nurses because the nurse aides were responsible for her direct care. They did not know of any abuse which could have occurred. The statements she had obtained were in the file. Some of the nurse aides had not gotten back with her. She had also reviewed the radiology reports. The family had been very involved with her care and at times had a sitter.</p> <p>The physician assistant (PA), who had routinely cared for Resident # 1, was interviewed on 10/19/21 at 11:00 AM and again on 10/21/21 at 10:50 AM. According to the PA the resident was very advanced in age and her dementia had progressed where she was not eating or drinking well. The family had some concerns about her left arm recently, and she had ordered diagnostic tests for the resident's left arm. She had discussed the results with the family, and comfort care was indicated for the resident; the family was agreeable to this. Prior to the right arm fracture being identified on 10/1/21 at the hospital, the resident had been transitioning (nearing death). The resident had no overt signs of problems in the right arm before she was transferred to the hospital.</p> <p>Resident # 1's physician was interviewed on 10/20/21 at 4:30 PM and reported the following. The resident was "clearly osteoporotic." The left arm x-ray did not show a definitive fracture and comfort measures had been appropriate when the possible fracture to the left arm had been identified. The right arm fracture was not displaced, and it could have happened with the</p>	F 610			

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F 610	Continued From page 7 resident's normal, routine care due to her osteoporosis.	F 610			
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)  §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and physician interview the facility failed to provide grooming and hygiene needs for one of one (Resident # 3) sampled resident reviewed for activities of daily living assistance. The findings included:  Resident # 3 was admitted to the facility on 9/11/18. The resident had a diagnosis of Seborrhea (a skin condition that causes scaly patches) and a history of head injury which had affected one of her eyes.  Resident # 3's minimum data set assessment, dated 7/16/21, coded the resident as needing total assistance from staff with her hygiene and bathing needs.  Resident # 3's care plan, updated on 7/13/21, revealed the resident required total assistance from staff with all of her activities of daily living. Staff on the care plan were directed to perform oral care each shift and as needed.  Review of current orders revealed Resident # 3 had an order for a specialized shampoo, Selenium Sulfide, to be used two times per week	F 677	1. Resident #3 was provided a shower and other ADL care to include oral care on 10/18/2021 by staff. Nursing assistants were educated by the DHS or Designee on 11/16/2021 on the use of Selenium Sulfide shampoo on resident #3 twice a week on shower days (Wednesday and Saturday)  2. A complete shower audit was conducted on all residents on 11/8/2021 by nursing personnel. A complete oral care audit will be conducted on all residents by 11/19/2021 to ensure proper oral care is being provided.  3. All nursing personnel were educated on the ADL Care Policy to include a current review of shower sheets, schedules and oral care on 11/12/2021 and 11/16/2021 by the DHS or Designee.  4. The DHS or designee will complete weekly monitoring audits to ensure all residents are showered and provided oral care. The ADL Monitoring Tool which includes oral care and showers will be	11/24/21	



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F 677	<p>Continued From page 8 on her shower days.</p> <p>Review of nursing notes revealed Resident # 3 was transferred to the hospital on 10/17/21 at 12:13 AM because her gastrostomy tube needed to be replaced.</p> <p>Resident # 3's responsible party (RP) was interviewed on 10/19/21 at 9:00 AM and reported the following. He was called by the hospital staff because Resident # 3 had appeared so unkempt when she arrived at the hospital on 10/17/21. When the RP arrived at the hospital, he found Resident # 3 to be dirty, have an odor, her hair full of "cradle cap," and her ears full of wax.</p> <p>A hospital social service note, dated 10/17/21 at 2:42 AM, included documentation that the social worker had met with the hospital nursing staff and the hospital physician caring for the resident. The social worker noted the following in her note. EMS (emergency medical services), who had transported the resident from the facility to the hospital, had reported the resident had matted hair and dirt in her eye. The hospital emergency department nurse had reported the resident had very dirty ears and hair. The emergency department physician had reported the resident had unclean ears, matted hair and poor oral hygiene.</p> <p>The hospital emergency department physician was interviewed on 10/27/21 at 9:50 AM via phone and corroborated the RP's interview and the social worker's note regarding the resident's lack of hygiene care. The physician stated on 10/17/21 the resident's hair was dirty and matted; she had a "little bit" of an odor that appeared to be coming from her mouth and had poor oral</p>	F 677	<p>brought to QAPI meeting each month for three months for review and updates then quarterly thereafter.</p> <p>5.Date of compliance 11/24/21</p>		

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F 677	<p>Continued From page 9</p> <p>care; her skin was flakey; and she needed better care around one of her eyes.</p> <p>Nurse # 4, who routinely cared for Resident # 3, was interviewed on 10/20/21 at 2 PM and reported the following. Resident # 3 tended to sweat a great deal. Her hair matted easily and the skin in her ears tended to get "crusty." Prior to 10/17/21 the Nurse Aides (NAs) should have been using the Selenium Sulfide shampoo on her shower days. Nurse # 4 reported that shower days for Resident # 3 were scheduled for Wednesdays and Saturdays on the 3:00-11:00 PM shift.</p> <p>Interview with the Administrator on 10/22/21 at 11:30 AM revealed 10/15/21 was the date the resident was last bathed prior to being transported to the hospital on 10/17/21.</p> <p>NA # 1 was interviewed on 10/22/21 at 12:04 PM and reported she had given Resident # 3 a bed bath on 10/15/21 but she did not use the physician ordered shampoo for the resident's hair. The NA reported she used a non-rinse body soap on her hair and took a towel and dried it. The NA did not think the resident had any special shampoo to use on her hair and reported once it is washed it still looked oily routinely. The NA reported she had washed the resident's eyes and ears during the bath.</p> <p>According to assignment sheets, NA # 2 had cared for Resident # 3 from 3:00 PM on 10/16/21 until she was transported to the hospital on 10/17/21. NA # 2 was interviewed on 10/20/21 at 12:00 PM and reported the following. She liked to bathe and care for all her residents, but on the 3:00-11:00 PM shift of 10/16/21 she had an entire</p>	F 677			

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F 677	Continued From page 10 hall of residents and helped out on another hall. This meant she had 20 to 24 residents for whom to care. She had not had time to do anymore than reposition and provide incontinent care for Resident # 3. She saw Resident # 3's hair was "dandruff looking," one of her eyes had some drainage clustered around it, and she had facial hair. She tried to clean her eye the best she could before the resident was transported, and it had bothered her she had not been able to care for Resident # 3 more before she was transported.  Interview with the Administrator on 10/22/21 at 3:00 PM revealed she wanted all her residents well cared for and it bothered her greatly the staff had not been able to provide care for Resident # 3. According to the Administrator, the facility was experiencing staffing problems regardless of efforts to recruit and maintain staff.	F 677			
F 684 SS=E	Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner interviews, Physician Assistant interview, Physician interview, and pharmacy manager interview the facility failed to obtain laboratory values and intravenous/ subcutaneous	F 684	1. Resident #1 was discharged on 10/4/2021. Resident #8 was started on IV Vancomycin on 9/16/2021. A wound culture for resident #8 was obtained on 9/28/2021. Resident #8 continued on IV	11/24/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345538</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2021</b>
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F 684	<p>Continued From page 11</p> <p>fluids for a resident experiencing end of life changes (Resident #1); failed to obtain wound cultures and sensitivity prior to administration of antibiotics (Resident #8); and failed to obtain vancomycin troughs as ordered (Resident #8) for two of three residents reviewed for professional standards of care according to the care plan. The findings included:</p> <p>1. Resident # 1 resided at the facility from 3/25/19 until her discharge on 10/1/21. The resident had diagnoses of dementia, hypertension, history of stroke with dysphagia, diabetes, chronic pain, muscle weakness, anemia, bradycardia, osteoporosis, contractures, and hyperlipidemia.</p> <p>Resident # 1's quarterly Minimum Data Set assessment, dated 7/23/21, coded the followed assessment. The resident was severely cognitively impaired; demonstrated behaviors such as hitting; required total staff assistance with her bed mobility, toileting, hygiene and bathing needs; required extensive assistance with eating; and had functional limitation in her range of motion.</p> <p>Resident # 1's care plan, updated on 7/28/21, included the information that the resident was a DNR (Do Not Resuscitate) and directed staff to discuss advance directives with the resident's appointed health care representative. The care plan also indicated labs were to be obtained as ordered.</p> <p>On 8/6/21 Resident had an order for a BMP (basic metabolic panel).</p> <p>On 9/8/21 the RD noted in the progress notes that Resident # 1 had experienced a significant</p>	F 684	<p>Vancomycin until 10/7/2021 when the IV was changed to Meropenem.</p> <p>2.A complete lab audit was conducted on all resident labs by the DHS or designee on 11/19/2021</p> <p>3.Merridian Labs extended the service to 5 days a week for the facility. LabCorp was also made available for the facility to utilize for stat labs. All weekend labs will be handled as a stat lab through LabCorp. If a lab is not picked up or drawn the DHS or designee will be notified for further resolution with the lab at the management level to ensure labs are picked up in a timely manner. All licensed nurses were educated by the DHS or designee of the stat lab process for Labcorp on 11/16/2021 on their policies and procedures regarding inputting lab orders, pick up times, stat labs and contact information.</p> <p>4.The DHS or designee will complete daily monitoring of all ordered labs to ensure timely lab pick up and completion and will review in the clinical morning meeting. The daily lab monitoring will be presented to QAPI meeting monthly for the next 3 months and then quarterly thereafter to ensure ongoing compliance.</p> <p>5.Date of compliance 11/24/21</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

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F 684	<p>Continued From page 12</p> <p>weight loss, nursing staff indicated the resident was sleeping most of the day, and the resident would refuse meals at times even though encouraged to eat.</p> <p>On 9/19/21 a social services progress note revealed the social worker had spoken to the resident's RP (responsible party) and the RP acknowledged she felt Resident # 1 was coming to the end of her life.</p> <p>On 9/21/21 the first BMP since the order of 8/6/21 was completed. The results, dated 9/21/21 at 7:25 PM, showed the resident's sodium was 160 and her BUN (blood urea nitrogen) was 71. Normal sodium levels were noted to be between 136-144 and normal BUN levels were noted to be between 5-25.</p> <p>On 9/22/21 at 11:51 AM Physician Assistant # 2 entered an order for one liter of D5W (Dextrose 5% in water solution) intravenous fluid to be infused at 50 ml (milliliters)/ hour. On 9/22/21 at 11:51 AM Physician Assistant # 2 also entered an order to repeat Resident # 1's BMP on the morning of 9/24/21.</p> <p>On 9/22/21 there was a notation made on the MAR (medication administration record) that the one liter of D5W, which had been ordered on 9/22/21, was not administered "due to condition."</p> <p>On 9/23/21 at 10:37 AM Nurse #2, who was the manager for Resident # 1's unit, entered an order from PA # 2 for one liter of D5W intravenous fluid to be infused at 50 ml (milliliters)/ hour.</p> <p>On 9/23/21 at 10:40 AM Nurse # 2 entered a progress note with the following documentation.</p>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 13</p> <p>He had contacted the pharmacy because the facility did not have D5W and it was not in their back up supply of intravenous fluids. He had consulted with the physician who did not want to change to an alternative fluid. The order for the D5W was refaxed to the pharmacy.</p> <p>According to Resident # 1's September 2021 MAR, the first liter of D5W was signed off as administered at 5:00 PM on 9/23/21 via way of hypodermoclysis (by instilling the fluid subcutaneous).</p> <p>On 9/23/21 Resident # 1 had a BMP completed which showed a sodium of 161 and a BUN of 117. There was no corresponding order for this lab.</p> <p>On 9/24/21 at 3:49 AM an order was created by PA # 3 and verified by Nurse # 3 for D5W at 100 ml/hour to be given continuously either by the IV (intravenous) or SQ (subcutaneous) route.</p> <p>There were no fluids signed off on the MAR as administered on 9/24/21.</p> <p>There were no repeat labs on 9/24/21 as per the order which had been dated 9/22/21.</p> <p>According to progress notes, on 9/24/21 the resident's RP requested hospice evaluate the resident for services.</p> <p>On 9/25/21 at 4:00 PM there was an order given by Resident # 1's physician and verified via Nurse # 4 for Normal saline to be administered SQ at 100 ml/hour. According to Resident # 1's September MAR this was infused beginning 9/25/21 and continued to be infused on 9/26/21.</p>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 14</p> <p>On 9/27/21 at 10:40 AM Nurse # 3 noted the fluids were "not administered." Under comments she noted, "D5W." The MAR continued to reflect the following regarding the normal saline order. 9/27/21 at 8:04 PM "not administered-on hold" 9/28/21 at 10:57 AM "not administered-on hold" 9/28/21 at 8:46 PM "not administered- on hold" 9/29/21 at 8:59 AM "not administered- on hold" 9/29/21 at 8:35 PM "not administered- on hold" 9/30/21 at 8:12 PM "not administered: discontinued"</p> <p>Following the BMP of 9/23/21, there was not another repeat BMP on the resident's record between the dates of 9/24/21 and 9/30/21.</p> <p>Review of progress notes by PA # 1, dated 10/1/21 at 2:18 PM, revealed the following information. Resident # 1 appeared to be "transitioning" (approaching death). The hospice company, which the family had requested, had evaluated Resident # 1 and felt she was not in need of transfer to their hospice facility. The PA noted she talked to the resident's family and their biggest concern was the facility had not been able to provide labs or intravenous fluids in the past week. The PA documented the labs were out of her control, but she would again order fluids for the resident.</p> <p>On 10/1/21 at 3:00 PM Nurse # 2 documented Resident # 1's family called EMS (emergency medical services) to transport the resident to the hospital.</p> <p>Review of hospital records for Resident # 1's hospitalization of 10/1/21 revealed labs were</p>	F 684			

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F 684	<p>Continued From page 15</p> <p>done and intravenous fluids were given. Following hospital care, the resident was transferred home with hospice services.</p> <p>Resident # 1's RP was interviewed on 10/20/21 at 10 AM and reported the following. The facility kept saying they could not get blood work done for the resident and although she knew the resident was doing poorly, she did want her to have labs and fluids. Since the facility could not provide these services, the family had the resident transferred to the hospital.</p> <p>Nurse # 2 was interviewed on 10/19/21 at 12:45 PM and reported the following. The pharmacy supplies the facility with fluids. The facility does have some fluids that are kept at the facility but D5W is not one of them. Although the order was written on 9/22/21 for the D5W, the D5W still had not been delivered from the pharmacy on 9/23/21. Therefore, he called the pharmacy and the pharmacy said they could not see the IV fluid order in their system and therefore had not sent the D5W the day before. Therefore, Nurse # 2 reentered the same order on 9/23/21 which had been entered on 9/22/21 so the pharmacy would send the fluids. He had contacted one of the providers, but the provider wanted the resident to have the originally ordered D5W. During a follow up interview with Nurse # 2 on 10/22/21 at 12:50 PM, Nurse # 2 reported labs were a problem in the facility. Sometimes the lab company did not show up to do the labs and getting results could be problematic as well. Also, the lab company did not do any week-end labs and this prolonged getting results also.</p> <p>Nurse # 3 was interviewed on 10/19/21 at 3:15 PM and reported the following. After the order for</p>	F 684			



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 16</p> <p>D5W was given on 9/22/21, Resident # 1 only received one liter of D5W because the pharmacy did not send anymore and there was none in the facility's back up supply. The order for D5W on 9/24/21 was never given. Nurse # 3 stated Nurse # 4 had called and spoken to the physician on 9/25/21 and an order was given for the normal saline. The resident gotten one liter of normal saline and then no more following that before she was transferred to the hospital on 10/1/21. After the resident had received one liter of normal saline, she (Nurse # 3) had talked to PA # 1 who wanted to get labs and then decide which fluids to give the resident. The labs were never done between the dates of 9/24/21 to 9/30/21. Nurse # 2 reported the facility had a problem with getting labs. Two of the dates that were not done (9/24/21 and 9/25/21) were the week-end dates of Saturday and Sunday, and Nurse # 3 reported the facility's lab company did not draw labs on the weekend. On other days, the nurses would enter the orders but sometimes the lab company would come in, not draw the lab, and not tell the nurse they had not drawn it. At other times, the lab company did not show up to draw labs at all. At times there were agency nurses working and they did not have access to enter lab orders or look at them. According to Nurse # 3, all these things could have contributed to the labs not being done for Resident # 1.</p> <p>Nurse # 4 was interviewed on 10/20/21 at 2:00 PM and reported the following. She recalled that on 9/25/21 there was no D5W to give the resident and she had called the physician who ordered the saline instead. At the time of 9/25/21, Nurse # 4 only recalled that there was lactated ringers and normal saline in the facility's supply to be given.</p>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 17</p> <p>Nurse #9 was interviewed on 10/25/21 at 12:30 PM and reported the following. She had worked with Resident #1 on the day she went to the hospital. She did not recall anything being said in nursing shift report that Resident # 1 needed labs. Nurse # 9 reported she was an agency nurse and therefore she did not have access to the lab company's system to see results or to order labs, and the way the facility did labs "could get confusing." On her shift of 10/1/21, the family had been present and were upset that the resident's labs and fluids had not been done. The unit manager talked with the family but they decided to call transport and have the resident sent to the hospital.</p> <p>PA # 1 was interviewed on 10/19/21 at 11:00 AM and reported the following. She normally cared for Resident # 1 and the resident had been declining due to her age and dementia. Comfort care and supportive care measures were appropriate near the end of her life. The RP knew Resident # 1 was not well and was nearing death, and the RP wanted labs and fluids as part of the resident's care in addition to comfort measures. She (PA #1) had been off work from 9/22/21 to 9/25/21 when the other medical providers were leaving orders for the resident's care. She returned on 9/27/21 and found there were no recent labs to determine the best fluid replacement. She told the nurses the labs needed to be done. (They had been ordered for 9/24/21 but had not been completed). She continued to wait for the labs but the facility had problems getting labs. The PA stated just that week she had been told by a staff member that a lab technician had come to draw labs and left within 15 minutes without doing any blood draws at all.</p>	F 684			

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F 684	<p>Continued From page 18</p> <p>Resident # 1's physician was interviewed on 10/20/21 at 4:30 PM and reported the following. Resident # 1's abnormal labs were "markers" that her bodily functions were ceasing. Although the hospital did hydrate the resident with fluids, it did not change the resident's outcome. The resident was sent home with hospice services following the intravenous fluids and care rendered at the hospital. It had been acceptable to administer the fluids the resident had received while at the facility via way of the subcutaneous route rather than via the intravenous route.</p> <p>2. Resident #8 had cumulative diagnoses one of which included non-pressure chronic ulcers to the right and left lower legs.</p> <p>The most recent quarterly minimum data set assessment dated 9/30/2021 coded Resident #8 as having moderately impaired cognition with no behaviors or rejection of care. Resident #8 was coded as receiving intravenous medications.</p> <p>The care plan for Resident #8 dated 11/12/2021 had a problem area which stated, "[Resident #8] has a right lower leg venous ulcers and left lower leg venous ulcer (resolved) is at risk for further impaired skin integrity relative to history of skin impairment; Peripheral Vascular disease, venous insufficiency; and occasional incontinence. Noncompliant with treatments and removes. 4/29/2021 - cellulitis (resolved) 6/28/2021 -rash abdominal folds, groin, buttocks (resolved) 7/22/2021 - cellulitis (resolved) 8/26/2021 - cellulitis left lower extremity." Some of the interventions included intravenous (IV) antibiotics as ordered for cellulitis, observe IV access site for redness, swelling, pain, follow protocol for IV, and administer medications as ordered and monitor for adverse reactions or worsening in infections.</p>	F 684			

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F 684	<p>Continued From page 19</p> <p>A. Documentation on a wound care follow-up progress note written by Wound Nurse Practitioner (NP #1) dated 9/2/2021 revealed Resident #8 was seen for follow up for wound care for her right lower leg. The Documentation in part stated, "A wound culture and sensitivity has been ordered for more narrow antibiotic coverage. Will follow up in one week."</p> <p>A nursing note dated 9/3/2021 at 5:18 PM written by Nurse #3 indicated Resident #8 was on antibiotics for lower leg cellulitis and afebrile. The note also indicated a wound culture was going to be taken by the Wound Care nurse (Nurse #1).</p> <p>Nurse #3 was interviewed on 10/22/2021 at 8:32 AM. Nurse #3 stated there was a process to get a wound culture sent to the laboratory. Nurse #3 stated the Wound Care nurse (Nurse #1) called the laboratory on 9/3/2021 to request the specific swabs needed from the laboratory to do the wound culture. Nurse #3 stated she was unsure when the actual swabs/culture kits arrived from the laboratory to do the wound culture for Resident #8.</p> <p>An interview was conducted with Nurse #1 on 10/21/2021 at 4:04 PM. Nurse #1 stated she was given the treatment orders or changes by the Wound Care nurse practitioner (NP #2) and she then transcribed the orders into the electronic medical record. Nurse #1 stated she ordered the culture kits from the laboratory contract service on 9/3/2021 but was unable to get the supplies to do the wound culture for Resident #8 until 9/27/2021.</p> <p>An interview was conducted with NP #2 on</p>	F 684			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 684	<p>Continued From page 20</p> <p>10/21/2021 at 4:23 PM. The NP #2 confirmed the facility was awaiting the laboratory services to bring culture kits because the facility did not have any on hand on 9/3/2021. The NP #2 explained the facility did not usually keep the culture kits on hand due to the culture kits having expiration dates and a specified time frame for which they needed to be used. The NP #2 further explained Resident #8 had a chronic cellulitis of her lower legs so without the ability to do a culture and sensitivity, the resident was put on Vancomycin, a broad spectrum antibiotic until the laboratory was able to get the culture kits to the facility. The NP #2 indicated the facility NP (NP #1) had to intervene contacting the laboratory to help the facility obtain the culture kits. The NP #2 stated the cellulitis of Resident #8 improved somewhat with the Vancomycin treatment but once the culture was able to be taken, Resident #8 was put on the antibiotic Meropenem, for which the bacterial infection was more sensitive to and had improved coverage.</p> <p>A physician's order for a wound culture and sensitivity for the right lower leg of Resident #8 was written on 9/27/2021.</p> <p>Documentation in the nursing progress notes dated 9/27/2021 at 4:06 PM revealed the wound culture of the right lower extremity of Resident #8 was collected and put in the refrigerator for the laboratory service to pick up.</p> <p>The wound culture and sensitivity report dated 9/27/2021 was signed as reviewed by NP #1 on 10/7/2021. The wound culture and sensitivity report for Resident #8 noted the infection growth was sensitive to the antibiotic Meropenem.</p>	F 684			

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F 684	<p>Continued From page 21</p> <p>A physician's order was written on 10/7/2021 for the antibiotic Meropenem 250mg (milligrams)/50ml (milliliters) twice a day for 7 days was to be administered intravenously for 7 days from 10/7/2021 to 10/14/2021 to Resident #8.</p> <p>An interview was conducted with the facility Nurse Consultant on 10/22/2021 at 10:45 AM. The Nurse Consultant indicated the previous Director of Nursing never brought any problems with the laboratory services to her attention.</p> <p>B. A physician's order for Vancomycin 1.25g (grams) to be administered intravenously every 12 hours was initiated on 9/16/2021 for Resident #8.</p> <p>Review of the medication administration record revealed Resident #8 was not administered the Vancomycin as ordered on 9/16/2021 at 9:00 PM and discontinued on 9/17/2021 at 1:45 PM.</p> <p>A nursing note dated 9/17/2021 at 5:46 PM stated, "Resident has current abt (antibiotic) order on hold due to placement of PICC (peripherally inserted central catheter) line. X-ray states that technician would arrive to facility by AM."</p> <p>Nursing notes for Resident #8 dated 9/17/2021 at 8:48 AM, 2:09 PM, and 4:26 PM revealed the triple lumen PICC line was placed and the physician assistant was notified.</p> <p>A physician's order for Vancomycin 1.25 grams to be administered intravenously as a reconstituted solution 1250 mg with normal saline 250 milliliters every 12 hours was initiated on 9/17/2021 at 9:00 AM for Resident #8.</p>	F 684			

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F 684	<p>Continued From page 22</p> <p>Documentation on the MAR (medication administration record) revealed Resident #8 received the Vancomycin as ordered beginning with the first dose at 9:00 PM on 9/17/2021 through 9:00 AM on 9/22/2021.</p> <p>On 9/21/2021 a physician's order for Resident #8 was written for a Vancomycin Trough to be drawn 30 minutes before administration at 6:30 PM.</p> <p>Review of laboratory results for Resident #8 dated 9/21/2021 revealed the Vancomycin, Trough results were high at 35.0 ug/ml (micrograms per milliliter) with the reference range being 15.0 to 20.0 ug/ml.</p> <p>Documentation in the nursing notes for Resident #8 dated 9/22/2021 at 2:18 PM written by Nurse #2, the day shift supervisor, stated, "Writer received call from Pruitt Pharmacy to hold ABT/Vanco (antibiotic Vancomycin) until trough can be collected 9/23/2021 along with serum creatine level. PA (physician assistant) made aware. Will continue to monitor."</p> <p>On 9/23/2021 a physician's order was written for a complete metabolic panel and a vancomycin trough on the 7:00 AM to 7:00 PM shift for Resident #8.</p> <p>Review of laboratory results for Resident #8 dated 9/23/2021 revealed the Vancomycin, Trough results were High at 36.0 ug/ml with the reference range being 15.0 to 20.0 ug/ml.</p> <p>Documentation in a wound note dated 9/24/2021 at 7:56 AM written by Nurse #1, the wound care nurse, stated in part, "Order for IV ABT to be</p>	F 684			

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F 684	<p>Continued From page 23</p> <p>extended x 3 more doses pharmacy notified, informed the resident of new order."</p> <p>Documentation in a nursing note dated 9/24/2021 at 2:54 PM written by Nurse #3, revealed in part, "IV ABT order re-activated for x3 more dosages to start tonight. Pharmacy called to confirm in these hours and to request stop date to be placed on order."</p> <p>Documentation in an additional nursing progress note dated Friday, 9/24/2021 at 7:04 PM written by Nurse #3 stated, "Pharmacy called back requesting another Vanc (Vancomycin) trough, which cannot be performed until Monday early AM. [Laboratory name] labs do not draw on weekends and per DHS (Director of Health Services) to order STAT (immediately). [Laboratory name] states do not provide our area with STAT draws or STAT pickups. This writer explained the PICC and stated that this writer could draw if they would pick up. [Laboratory name] stated they do not pick up for our area."</p> <p>Nurse #3 was interviewed on 10/22/2021 at 8:32 AM. Nurse #3 stated the pharmacy requested a Vancomycin trough on 9/24/2021 but the laboratory does not do anything STAT. Nurse #3 stated there was a delay in getting the lab results because the laboratory the facility had a contract with had a lot of trouble getting laboratory results done and couldn't provide services on the weekend, so all laboratory tests ordered for Friday had to wait until Monday.</p> <p>Documentation in a nursing progress note dated 9/25/2021 at 9:25 AM revealed, "Call placed to on-call NP for Premier to clarify if Vanc was being held, stated to call pharmacist as they make that</p>	F 684			



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F 684	<p>Continued From page 24</p> <p>call. Call placed to pharmacist [Name] stated to hold Vancomycin due to high trough on 9/23, redraw Vanc level on Monday. Floor nurse updated, Nurse Supervisor updated."</p> <p>A physician's order dated 9/27/2021 requested another Vancomycin trough level for Resident #8.</p> <p>Documentation in a nursing progress note dated Monday, 9/27/2021 at 4:06 PM written by Nurse #3 revealed the Vancomycin Trough was not drawn that day.</p> <p>Documentation in a nursing progress note dated 9/28/2021 at 10:06 AM written by Nurse #2 stated, "Vancomycin Trough collected on 9/28/2021, contacted pharmacy for instruction on how to proceed with administration of medication. Pharmacy informed writer to hold medication until results of labs before administering medication. MD aware at current time."</p> <p>Nurse #2 was interviewed on 10/21/2021 at 3:30 PM. Nurse #2 stated Vancomycin troughs ordered for Resident #8 were completed as ordered until the order that was made on Friday, 9/24/2021. Nurse #2 stated he was aware the pharmacy needed the Vancomycin trough level in order to correctly dose the remaining doses of Vancomycin ordered for Resident #8. Nurse #2 confirmed the facility laboratory could not provide laboratory services on the weekend, to include Friday. Nurse #2 stated he did not know why the Vancomycin trough was not obtained on Monday, 9/27/2021. Nurse #2 stated that after the Vancomycin trough results were obtained, he worked with the pharmacy to obtain correct orders for Resident #8 so she could receive the final Vancomycin doses as ordered.</p>	F 684			

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F 684	<p>Continued From page 25</p> <p>Review of a laboratory report dated 9/28/2021 revealed the random Vancomycin trough level for Resident #8 was 14.0 ug/ml with the reference range of trough at 5-10 ug/ml and peak at 20-40 ug/ml.</p> <p>On 9/28/2021 a physician's order for Vancomycin 1.25 gm reconstituted solution to be administered intravenously once a day.</p> <p>This order was documented on the MAR as administered on 9/28/2021 and discontinued on 9/28/2021.</p> <p>On 9/29/2021 a physician's order for Vancomycin 1,000 mg to be administered as a reconstituted solution to be mixed with 250 milliliters of Normal Saline over 90 minutes. This order was to be discontinued on 10/4/2021.</p> <p>This order was documented on the MAR as administered from 9/29/2021 until discontinuation on 10/4/2021.</p> <p>An interview was conducted with the pharmacy manager on 10/22/2021 at 12:45 PM. The pharmacy manager stated the pharmacy sent several requests to the facility for a Vancomycin trough to be drawn for Resident #8 on 9/18/2021, 9/21/2021, 9/22/2021, and 9/23/2021. The pharmacy manager stated the first results back were on 9/21/2021 as High at 35 ug/ml and the Vancomycin was put on hold for Resident #8. The pharmacy manager stated the next Vancomycin trough results came back on 9/24/2021 as still high at 36 ug/ml, so the Vancomycin remained on hold for the resident. The pharmacy manager revealed he was notified on 9/24/2021 a</p>	F 684			

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F 684	Continued From page 26 Vancomycin trough could not be drawn on the weekend so the pharmacy had to wait to determine the correct dosage of Vancomycin for the resident until another Vancomycin trough could be obtained. The pharmacy manger revealed ideally the pharmacy needed the Vancomycin trough levels every 24 hours in order to restart the Vancomycin but in the case of Resident #8 it worked out. The pharmacy manager explained that resident #8 was able to have the Vancomycin restarted on 9/28/2021 and since it had been so long since her last dose of Vancomycin, Resident #8 no longer needed another Vancomycin trough to be taken.  An interview was conducted with the facility Nurse Consultant on 10/22/2021 at 10:45 AM. The Nurse Consultant indicated the previous Director of Nursing never brought any problems with the laboratory services to her attention. The Nurse Consultant was unsure if the contract with the laboratory company included the provision of services on the weekend/after hours. She was unsure why anyone would make such a contract, but with Covid-19 possibly staffing has created a consistent problem with the services the laboratory company can provide.	F 684			
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)  §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and  §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		11/24/21	

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F 689	<p>Continued From page 27</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, for one (Resident # 1) of three sampled residents who sustained accidents, the facility failed to reassess alternative measures for siderails when the resident developed a bruise and was noted by staff to lean into the siderails and at times be combative. The findings included:</p> <p>Resident # 1 resided at the facility from 3/25/19 until her discharge on 10/1/21. The resident had diagnoses of dementia, hypertension, history of stroke with dysphagia, diabetes, chronic pain, muscle weakness, anemia, bradycardia, osteoporosis, contractures, and hyperlipidemia.</p> <p>Resident # 1's quarterly Minimum Data Set assessment, dated 7/23/21, coded the followed assessment. The resident was severely cognitively impaired; demonstrated behaviors such as hitting; required total staff assistance with her bed mobility, toileting, hygiene and bathing needs; required extensive assistance with eating; and had functional limitation in her range of motion.</p> <p>Resident # 1's care plan, updated on 7/28/21, included the information that Resident # 1 had a history of behaviors.</p> <p>Review of the resident's record revealed the resident had not sustained any falls since the date of 2/11/21 on which date she had a fall without any injury.</p> <p>On 8/31/21 at 7:08 PM Nurse # 1 documented she was asked to look at Resident #1's skin and observed she had a 5 X 5 (the type of</p>	F 689	<p>1. Resident #1 was discharged on 10/4/2021.</p> <p>2. An audit will be completed by 11/24/2021 on all resident side rails to determine side rail necessity and placement. The licensed nurses will complete a side rail assessment on each resident by 11/24/2021 determine necessity and use.</p> <p>3. All licensed nurses were educated on timely completion of quarterly observations of siderails. The MDS Coordinator was educated on ensuring nurses completion side rail assessments quarterly according to policy to ensure an accurate MDS completion and resident safety.</p> <p>4. The DHS or designee will monitor side rail assessments and their timely completion weekly for the next 12 weeks and review the results in QAPI to ensure ongoing compliance.</p> <p>5. Date of compliance 11/24/21</p>		

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F 689	<p>Continued From page 28</p> <p>measurement scale was not documented) red non blanchable, non- raised area to her left arm. The nurse noted there was no indication of pain at the site. Nurse # 1 noted the resident's skin was thin and frail and she applied Geri sleeves to prevent bruising.</p> <p>On 9/1/21 at 5:00 AM Nurse # 8 documented Resident # 1 had a bruise from pressure leaning on the bed rail and there was red discoloration noted around her upper arm. The nurse noted the resident did have some non-verbal indicators of discomfort and she administered Tylenol.</p> <p>Efforts were made to interview Nurse # 8 via phone on 10/21/21 at 11:05 AM and again on 10/27/21 at 10:45 AM. The nurse could not be reached and was not currently working at the facility.</p> <p>Nurse Aide (NA) # 5 had cared for Resident # 1 on the 3:00-11:00 PM shift of 8/31/21. NA # 5 was interviewed on 10/20/21 at 12:30 PM and reported the following. Resident # 1 could move her arms some, and at times she could hit or try to bite because she was confused.</p> <p>Nurse # 1 was interviewed on 10/21/21 at 11:50 AM and reported the following. She recalled assessing the bruise when it was first identified on 8/31/21 and stated the resident did not seem to have pain with it. The resident tended to lean to the left and kept a doll curled in her arm. The nurse felt the bruise could have come from some type of sustained pressure to the area.</p> <p>The care plan nurse was interviewed on 10/21/21 at 11:40 and reported the following regarding the side rails being used for the resident. Prior to</p>	F 689			

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F 689	<p>Continued From page 29</p> <p>8/31/21, Resident # 1 used to be more active and the rails were used for positioning. Resident # 1 had previously used them to help pull herself over in the bed. The resident had declined some and would lean in the bed towards the sides, and the side rails helped define the boundaries of the bed for her. The care plan nurse was not aware of alternative measures for the side rails after the bruise was identified on Resident # 1's arm.</p> <p>Nurse # 4, who routinely had cared for Resident # 1, was interviewed on 10/21/21 at 1:15 PM and reported the following. Resident # 1 could not turn herself but she could move her body towards the rails. If it had not been for the rails, Nurse # 4 felt the resident would have been on the floor. The nurse was not aware of alternatives to the side rails which had been attempted following the bruise.</p> <p>Nurse # 3, who had routinely cared for Resident # 1, was interviewed on 10/22/21 at 9 AM and reported the following. The resident had been placed on an air flow mattress in August 2021 when she developed a pressure sore. The staff would often find her against the side rails. She tended to rest in a fetal position and if the staff assisted the resident to sit up on her back in the bed, then she would move her head to one side. The momentum of her head movement would then pull her body towards the rail although she could not turn herself. The staff members were frequently readjusted her away from the rails.</p> <p>The previous DON (Director of Nursing) was interviewed on 10/21/21 at 10:12 AM and reported the following. After Resident # 1 had sustained the bruise on 8/31/21, she had reviewed the incident and looked at the resident's</p>	F 689			

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F 689	Continued From page 30 arm. The DON stated the resident's body had tended to shift towards the siderails and the resident then tended to rest against the siderail. One of the interventions had been to pad the siderails.  The nurse consultant was interviewed on 10/22/21 at 10:45 AM and reported the following. The previous DON had not spoken to her about the resident tending to rest against the rails or that she had developed a bruise on her upper arm. According to the consultant, the overall picture of the resident should have been evaluated and an assessment of the side rails been completed. It would have been her recommendation to the former DON to try bolsters for positioning if the resident tended to lie against the rails, but she had not been aware there had been an issue. The bolsters could have been obtained within a week. During a follow up interview with the Nurse Consultant, the Nurse Consultant reported Resident # 1's side rails had not been evaluated since February 2020. At that time, the resident had been more alert, responsive, and had used them for positioning.	F 689			
F 690 SS=E	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	F 690		11/24/21	

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F 690	<p>Continued From page 31</p> <p>comprehensive assessment, the facility must ensure that-</p> <p>(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;</p> <p>(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; and</p> <p>(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.</p> <p>§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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on resident interview, record review, staff interview, Nurse Consultant, and Physician Assistant interview the facility failed to assure urine cultures were done for two (Resident # 5 and #9) of two sampled residents reviewed for diagnosis and treatment of urinary tract infections. The findings included:</p> <p>Resident # 5 was admitted to the facility on 5/18/21 with chronic respiratory failure.</p> <p>The resident's quarterly minimum data set assessment, dated 9/8/21, coded Resident # 5 as</p>	F 690	<p>1. Resident #5 was started on Macrobid prophylactically on 11/1-11/8/2021. Nursing notes dated 11/3/2021 state that no complaints of pain or discomfort was noted. Resident #9 was started prophylactically on Macrobid on 11/1-11/8/2021.</p> <p>2. A complete lab audit will be conducted by the DHS or designees on all resident labs by 11/24/2021.</p> <p>3. Merridian Labs extended the service to</p>		



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F 690	<p>Continued From page 32</p> <p>having cognitive impairment, needing assistance with her toileting, and as incontinent of bladder and bowel all the time.</p> <p>Review of Resident # 5's care plan revealed on 6/15/21 the facility had updated the resident's care plan to reflect she was at risk for recurrent (UTI) urinary tract infections. Some of the interventions included to monitor the resident's labs, monitor for burning or painful urination, notify the physician of abnormalities, and provide peri care after each incontinent episode. This problem remained active on Resident # 5's current care plan.</p> <p>Review of physician orders revealed on Thursday, 8/26/21, an order was given for Resident # 5 to have a urinalysis with urine culture.</p> <p>On Friday, 8/27/21, at 7:51 PM a nurse documented the facility's lab had not collected the urine sample that day and a new order was placed in the system for "Sunday night so lab will collect on Monday morning."</p> <p>On Wednesday, 9/1/21, at 6:56 AM a nurse documented Resident # 5's urine was collected by the lab.</p> <p>Resident # 5's 9/1/21 urinalysis results showed the resident had 2+ blood and 4+ bacteria in the urine. The culture report was dated 9/3/21 at 8:27 AM and revealed the resident had &gt; 100,000 colonies of the bacteria Klebsiella pneumoniae. (This indicated the resident had a urinary tract infection). The culture result showed the specimen had been obtained by an in and out catheterization method. The culture report was initiated by Physician Assistant # 1 on 9/8/21.</p>	F 690	<p>5 days a week for the facility. LabCorp was also made available for the facility to utilize for stat labs. All weekend urine specimens will be handled as a stat lab through LabCorp. If a lab is not picked up or drawn the DHS or designee will be notified for further resolution with the lab at the management level to ensure labs are picked up in a timely manner. All licensed nurses were educated by the DHS or designee of the stat lab process for LabCorp on 11/16/2021 on their policies and procedures regarding inputting lab orders, pick up times, stat labs and contact information.</p> <p>4.The DHS or designee will complete daily monitoring of all ordered labs to ensure timely lab pick up and completion and will review in the clinical morning meeting. The daily lab monitoring will be presented to QAPI meeting monthly for the next 3 months to ensure ongoing compliance.</p> <p>5.Date of compliance 11/24/21</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

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F 690	<p>Continued From page 33</p> <p>Review of physician orders revealed on 9/8/21 Resident # 5 was ordered to receive the antibiotic Cefdinir 300 milligrams twice per day.</p> <p>Resident # 5 was interviewed on 10/20/21 at 3:00 PM and reported recently the lab had lost her urine specimen and it took several days to get any results and treatment for urinary burning she had been experiencing.</p> <p>Nurse #10 was interviewed on 10/21/21 at 3 PM and reported the following. She was caring for Resident # 5 the current day of 10/21/21. She recalled there had been a problem with the lab getting Resident # 5's urine specimen in September. She knew there had been a problem with the lab picking the specimen up. Nurse # 5 stated she thought the facility had to obtain the urine specimen three times before they could get a result. Nurse # 5 stated she could not access the facility's lab system to see the results and what had happened because she had not been given access to the facility's electronic lab system to view lab results.</p> <p>Nurse # 2, who was the manager of Resident # 5's unit, was interviewed on 10/21/21 at 3:00 PM and again on 10/22/21 at 12:50 PM. Nurse # 2 reported the following. The facility staff had in and out catheterized Resident # 5 three times in order to get the specimen ordered on 8/26/21. There had been an ongoing problem with the lab. At times the lab would not pick up urine specimens which were refrigerated, and therefore urine specimens had to be disposed of and a new one obtained after a certain timeframe. The lab also did not provide any lab services on the weekend, and therefore if a lab was ordered on Friday, then</p>	F 690			

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F 690	<p>Continued From page 34</p> <p>it was placed in the system to be obtained or picked up on the following Monday morning. He had talked to the lab company about Resident #5's urine specimens and the lab would say there were things wrong with the paperwork, but he had assured that everything was in order in regards to labeling and obtaining the urine. In talking to the lab company, the lab had indicated they were having staffing problems, they were not local, and they could not return to get specimens if the specimens were not picked up in the morning. There also had been a problem with getting the results. Sometimes the results would print out in different areas of the facility and at times only partial results would be sent rather than a complete culture result. As soon as he was able to get a result, he would get it to the Physician Assistant. At the time of 8/26/21, Resident # 5 was having some dysuria but she also was having burning from her hemorrhoids. It had been difficult to assess if all the resident's burning was from her urinary tract infection.</p> <p>Physician Assistant # 1 was interviewed on 10/19/21 at 11:00 AM and again on 10/22/21 at 9:50 AM and reported the following. Labs were a problem at the facility. The staff were having trouble getting labs done and results sent back to them. The first time she saw Resident # 5's urine culture result was on 9/8/2. At the time Resident # 5 was experiencing some dysuria which was causing some minor discomfort to her. She is routinely in the facility and the staff do communicate to her about the missing labs. On the AM of 10/19/21 (one of the mornings of the PA's interview), the PA stated the staff had informed her when she came to make rounds that the lab employee had arrived in the facility that AM, stayed there for 15 minutes while talking</p>	F 690			

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F 690	<p>Continued From page 35</p> <p>on the phone, then informed the staff she did not have time, and left without doing any labs at all that day. The PA stated, "You're just grateful for when you do get the labs."</p> <p>2. Resident #9 was admitted to the facility on 10/27/2020 with cumulative diagnoses some of which included acute kidney failure, retention of urine, encephalopathy, acute cystitis without hematuria, and history of urinary tract infections.</p> <p>The most recent quarterly minimum data set assessment dated 8/3/2021 coded Resident #9 as moderately cognitively impaired and always incontinent of bowel and bladder. Resident #9 was coded as having a urinary tract infection within the last 30 days of the assessment and for receiving intravenous medications.</p> <p>The care plan for Resident #9, dated as last reviewed on 8/3/2021, had a problem area for a risk for recurrent urinary tract infections relative to recurrent urinary tract infections. Some of the interventions included monitoring labs as ordered.</p> <p>Review of a physician assistant (PA) progress note dated 5/18/2021 revealed Resident #9 was reporting some burning with urination and was concerned she might have another urinary tract infection. The PA indicated in the progress note she ordered a repeat urinalysis.</p> <p>Review of the physician orders revealed an order dated 5/18/2021 for a urinalysis with urine culture for dysuria.</p> <p>Documentation in the nursing progress notes dated 5/19/2021 at 5:12 AM revealed Resident #9 refused the in and out catheterization for the urinalysis to be collected.</p>	F 690			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 690	<p>Continued From page 36</p> <p>Review of a PA progress note written by PA #1, dated 5/27/2021 revealed Resident #9 denied refusing the urinalysis and a repeat urinalysis was ordered on 5/27/2021.</p> <p>Review of the physician orders revealed an order dated, Thursday, 5/27/2021 for another urinalysis to be obtained with catherization.</p> <p>A nursing note dated 5/31/2021 at 7:12 PM stated, "UA (urinalysis) collected this evening, urine was cloudy."</p> <p>There was no corresponding laboratory result for the urinalysis collected on 5/31/2021.</p> <p>Documentation in a PA progress note written by PA #1 dated 6/1/2021 stated, "F/U (Follow up) of inhouse urine dipstick. (lab closed 5/28/2021-6/1/2021 opens 6/2/2021). Pt (patient) confused." Under the plan portion of the note the PA indicated a positive urinalysis and the antibiotic Cefdinir was to be ordered for 7 days.</p> <p>Documentation in the physician's orders revealed an order dated 6/1/2021 and discontinued on 6/8/2021 for a Cefdinir 300 mg (milligram) capsule to be administered twice a day by mouth to Resident #9.</p> <p>Review of a PA progress note written by PA #1 dated 6/22/2021 revealed under the interval history Resident #9 was concerned she had another urinary tract infection. Under the plan portion of the note it was indicated a repeat uranalysis with culture and sensitively would be ordered.</p>	F 690			

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F 690	<p>Continued From page 37</p> <p>Review of physician orders dated 6/22/2021 revealed Resident #9 had an order for a urinalysis with culture and sensitivity.</p> <p>Documentation in a nursing progress note dated 6/23/2021 at 2:26 AM stated, "UA collected per orders at [10:26 PM] on 6/22/2021 via straight [catherization], resident tolerated well. Very small amount of thick creamy white, blood tinged urine drained. Sample placed in refrigerator for lab [pick up]."</p> <p>There was no corresponding UA culture and sensitivity result for Resident #9 dated 6/22/2021.</p> <p>Documentation in the physician orders revealed an order dated 6/23/2021 for another urinalysis culture and sensitivity via a catherization.</p> <p>Review of a nursing note on 6/24/2021 at 2:55 PM revealed a urinalysis was collected that morning from Resident #9 and put in the refrigerator for the laboratory service to collect.</p> <p>Documentation in a nursing note by Nurse #2, dated Thursday, 6/24/2021 at 1:39 PM stated, "Writer contacted via phone from [Laboratory Name] labs related to [Resident #9] U/A (urinalysis) collecting writer informed that lab wouldn't be collected at current time due to sample leakage. Order to be replaced and labs to be recollected for collection."</p> <p>Review of the laboratory report dated 6/24/2021 revealed the urinalysis for Resident #9 was "not received."</p> <p>Review of the laboratory report dated 6/25/2021 revealed the urinalysis for Resident #9 indicated</p>	F 690			

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F 690	<p>Continued From page 38 probable contamination.</p> <p>Documentation in a nursing progress note dated 6/26/2021 at 6:45 AM stated in part, "Pt (patient) is alert and verbal about needs to staff. Pt c/o (complains of) severe abdominal pain and burning when she urinates. Narrator checked labs, no U/A results [were in] [Laboratory name] still awaiting results. Pt U/A was collected on 6/24/21. MD was notified. Per MD order to give Pt Cefdinir 300 mg bid (twice a day) starting 06/26/21 PA and results are in."</p> <p>Documentation in the physician orders dated Monday, 6/28/2021 revealed an order for a urinalysis with urine culture. The special instructions stated, "Please collect urine sample via straight catheterization for lab pickup on 6/29/21. Last sample collected via clean catch was contaminated."</p> <p>Review of the physician orders revealed an order for Cefdinir 300 mg to be administered by mouth every twelve hours to Resident #9 from 6/28/2021 to 6/30/2021.</p> <p>Documentation in a PA progress note dated 6/28/2021 stated, "Patient seen for follow up to urine results. Discussed that unfortunately her urine sample is contaminated, however given her ongoing dysuria, an antibiotic was started by the on-call MD over the past weekend. She reports improvement in her symptoms, stating it doesn't burn as much and her bladder doesn't hurt when she sits upright." In the plan portion of the PA progress note the documentation stated in part, "Dysuria - UACS (urinalysis culture and sensitivity) contaminated. Given patients ongoing sx (symptoms), empiric treatment was initiated</p>	F 690			

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F 690	<p>Continued From page 39</p> <p>over the weekend. Will continue for a few more days. She has noticed an improvement in her dysuria since starting the antibiotic."</p> <p>Review of the physician orders dated 6/29/2021 revealed an order for a urinalysis for Resident #9 with the special instructions to collect the urine sample via straight catheter for lab pick up on 6/30/21 because. "The last sample collected via clean catch was contaminated."</p> <p>Nursing notes dated 6/29/2021 indicated Resident #9 continued receiving the antibiotic for the urinary tract infection with no signs or symptoms of an adverse reaction with no reports of painful urination.</p> <p>Nursing notes dated 6/30/2021 at 7:04 PM revealed, "Pt is on ABT Cefdinir 300 mg q (every) 12hrs (hours) for UTI (urinary tract infection). Fluids and meals offered. Pt continues to complain of UTI irritation and burning. Will pass on report."</p> <p>Review of the laboratory report for the urinalysis collected on 6/30/2021 and reported on 7/2/2021 revealed the sample was contaminated.</p> <p>Documentation in a PA progress note written by PA #1 dated 7/6/2021 revealed under the plan portion of the note, "UACS contaminated again, will treat with 1 x dose Fosfomycin."</p> <p>Review of a physician order dated 7/6/2021 revealed Resident #9 was ordered to receive Monurol (Fosfomycin tromethamine) 3 grams by mouth one time.</p> <p>Documentation in a nursing note dated 9/29/2021</p>	F 690			



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F 690	<p>Continued From page 40</p> <p>indicated Resident #9 was acting confused and a new order for a urinalysis culture and sensitivity was entered.</p> <p>Review of the physician's orders revealed an order dated 9/29/2021 was initiated for a urinalysis culture and sensitivity for Resident #9.</p> <p>Review of the MAR revealed Resident #9 had a culture and sensitivity documented as completed on 9/29/2021.</p> <p>There was no corresponding laboratory report in the medical record for the 9/29/2021 urine sample taken from Resident #9.</p> <p>Review of the physician's orders revealed an order dated Friday, 10/1/2021 for another urinalysis culture and sensitivity for Resident #9.</p> <p>Documentation on the MAR for 10/1/2021 revealed the urine sample was not completed and Nurse #5 commented the order date had changed.</p> <p>Nurse #5 was interviewed on 10/26/2021 at 8:55 AM. Nurse #5 stated the order on 10/1/2021 was written on a Friday. Nurse #5 was told by the Director of Nursing the laboratory service did not pick up any laboratory samples at the facility on the weekend. Nurse #5 indicated all weekend laboratory orders had to be changed to Monday.</p> <p>Review of the physician's orders revealed an order dated 10/3/2021 for another urinalysis culture and sensitivity for Resident #9.</p> <p>Documentation on the MAR (medication administration record) and the nursing progress</p>	F 690			

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F 690	<p>Continued From page 41</p> <p>notes revealed on 10/3/2021 Resident #9 refused the urinalysis.</p> <p>Documentation in a PA progress note written by PA #1 dated 10/14/2021 stated in the interval history, "debility f/u (follow-up): Pt states she is not giving us another urine specimen anytime soon because she has given several and doesn't know what happens to them at the lab."</p> <p>An interview was conducted with Resident #9 on 10/20/2021 at 3:30 PM. Resident #9 reported the following. Before residing at the facility, she had a severe urinary tract infection which caused her to become very confused. Therefore, getting urine specimen results were important to her because she knows the infection can get in her blood stream. The resident reported there had been trouble getting urine specimen results at the facility because her urine specimens get lost and the lab doesn't do labs on the weekends. Also, the resident reported that if the urine specimens are not in the refrigerator at a certain time, the lab will not come back and get them. Because they couldn't get lab results, sometimes they had just put her on an antibiotic. The resident stated she thought being on an antibiotic without a urine specimen result was "quackery." The resident also reported that she knew one facility staff member had reported she (Resident #9), had refused one time when that was not the case. The resident stated the nurse had arrived to do a urine specimen during the early AM hours and she (Resident #9) had tried to explain to the nurse that there was very little time before the lab would pick up specimens and she didn't think the nurse had time. The resident reported the method the nurses used to obtain her specimens was to either place her on a bedpan and let the urine drip</p>	F 690			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345538</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>PRUITTHEALTH-RALEIGH</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2420 LAKE WHEELER ROAD</b> <b>RALEIGH, NC 27603</b>		
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F 690	<p>Continued From page 42</p> <p>into a cup (because she was incontinent) or in and out catheterize her. Resident #9 knew that if the specimen was not in the refrigerator then the lab would not come back and get it. Therefore, the nurse documented she refused for the culture to be taken.</p> <p>An interview was conducted with the Day shift nursing supervisor (Nurse #2) on 10/21/21 at 3:00 PM and again on 10/22/21 at 12:50 PM. Nurse # 2 reported the following. There had been an ongoing problem with the lab. At times the lab would not pick up urine specimens which were refrigerated, and therefore urine specimens had to be disposed of and a new one obtained after a certain timeframe. The lab also did not provide any lab services on the weekend, and therefore if a lab was ordered on Friday, then it was placed in the system to be obtained or picked up on the following Monday morning. In talking to the lab company, the lab had indicated they were having staffing problems, they were not local, and they could not return to get specimens if the specimens were not picked up in the morning. There also had been a problem with getting the results. Sometimes the results would print out in different areas of the facility and at times only partial results would be sent rather than a complete culture result. As soon as he was able to get a result, he would get it to the Physician Assistant.</p> <p>An interview was conducted with PA #1 on 10/22/2021. PA #1 reported the following. The facility has had a lot of problems with the laboratory company. Resident #9 sometimes refused to be catharized so a urinalysis can be completed, but in her defense the laboratory company often did lose the urine sample, or it</p>	F 690			

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F 690	Continued From page 43 was contaminated in route to the lab. PA #1 did not understand how a urine sample could get lost on the way to the laboratory, but it frequently happened. PA #1 stated in the past Resident #9 had to be put on an antibiotic empirically due to the laboratory losing the results or contamination of the results. PA #1 did not know what happened to the UA culture from 9/30/2021 for Resident #9 and she thought it was just lost. Resident #9 was not put on anything empirically after the 9/30/2021 UA results were lost, because she did not have any symptoms to warrant the use of an antibiotic at that time.  An interview was conducted with the facility Nurse Consultant on 10/22/2021 at 10:45 AM. The Nurse Consultant indicated the previous Director of Nursing never brought any problems with the laboratory services to her attention. The Nurse Consultant was unsure if the contract with the laboratory company included the provision of services on the weekend/after hours. She was unsure why anyone would make such a contract, but with Covid-19 possibly staffing has created a consistent problem with the services the laboratory company can provide.	F 690			
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2)  §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		11/24/21	

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F 725	<p>Continued From page 44</p> <p>diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).</p> <p>§483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>(i) Except when waived under paragraph (e) of this section, licensed nurses; and</p> <p>(ii) Other nursing personnel, including but not limited to nurse aides.</p> <p>§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, family interview, and physician interview the facility failed to provide sufficient staff to provide for the hygiene needs for one (Resident # 3) of one sampled resident reviewed for assistance with activities of daily living. The findings included: This tag is cross referred to:</p> <p>F677: Based on record review, staff interview, and physician interview the facility failed to provide grooming and hygiene needs for one of one (Resident # 3) sampled resident reviewed for activities of daily living assistance.</p> <p>On 10/21/21 at 1:20 PM the facility scheduler was interviewed and reported the following information. The facility tries to schedule 2 NAs for the 3:00 to 11:00 PM shift on the hall on which Resident # 3 resides. NA # 2 was the only NA for</p>	F 725	<p>1.Census at time of survey on 10/18/2021 was 95 and the nursing PPD was 2.476. The number of aides on 400 hall where resident number 3 resided on 10/16/2021 was one instead of two due to staffing challenges. The nursing PPD on 10/16/2021 was 2.245 and the census was 95. We currently utilize Maxim Staffing agency to provide nurses and CNAs for any vacancies that we may have. We utilize LPNS and admin nursing staff to assist nursing assistants when needed and other department managers help as need with job duties they can do within their scope. We are actively recruiting for CNAs and Nurses by placing ads on indeed and updating them weekly, Pruitt Website, flyers at local college campuses and working with the</p>		

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F 725	<p>Continued From page 45</p> <p>that entire hall on the 3:00-11:00 PM shift on 10/16/21 and therefore they were working short of what they wanted to staff. Currently they were having staffing problems but they were trying to recruit staff. Currently the facility had the following open/unfilled positions: Dayshift-16 full time nurse aide positions; 3 part time nurse aide positions Evening shift- 8 full time nurse aide positions; 5 part time nurse aide positions; and 2 PRN (As needed) Night Shift-9 full time positions and 1 part time position Weekend 12 hours shifts-five positions</p> <p>The scheduler reported bonuses were being offered for Nurse Aides to work. The scheduler would try to get staff to work double shifts if needed to cover staffing needs. They utilized agency staff also, and the agency staff were initially arranged to work for the facility through corporate. Recently some of the agency contracts had expired and the agency had been contacted to ask them to supply more staff for the facility, but the agency was having trouble finding staff also.</p> <p>Interview with the Administrator on 10/22/21 at 3:00 PM revealed she wanted all her residents well cared for and it bothered her greatly the staff had not been able to provide care for Resident # 3. According to the Administrator, the facility was experiencing staffing problems regardless of facility efforts such as offering increased pay and bonuses.</p>	F 725	<p>community colleges. We also hire PCAs and send them to area schools for their CNA Training. We are offering \$5000 sign on bonuses for CNAs and \$7000 sign on bonuses for Nurses. We have also provided incentives in the form of extra shift bonuses when we are staffing challenged. We are always transparent with families and our residents on our staffing challenges but ensure them that our main concern is meeting the needs of our residents.</p> <p>2.Audit of showers will be done by DHS and or designee on a daily basis times 1 week, then 3x week for 2 weeks then weekly.</p> <p>3.Resident #3 was provided a shower and other ADL care on 10/18/2021 by the CNA. Nursing assistants will be educated by the DHS or Designee on 11/16/2021 on the use of Selenium Sulfide shampoo on resident #3 twice a week on shower days (Wednesday and Saturday) Nursing assistants will be in-serviced on the importance of making sure bed bath or showers are done routinely and documentation is complete. Facility admin nursing staff has looked at assignments and made changes were needed. When an aide is unable to provide showers or beds bath the nurse on the until will be notified of the issue immediately for resolution. The nurse will assign showers and or bed baths to other aides in the facility to ensure all residents who are scheduled to get a shower or bed bath is bathed. Each resident will have shower</p>		

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F 725	Continued From page 46	F 725	<p>sheets with assigned days and type of bath that will be completed by the CNA. The charge nurse will review all shower sheets at the end of their shift to ensure all showers/and or baths are given. The shower sheets will be kept in a notebook at the nurses station and will be uploaded monthly into MatrixCare.</p> <p>4.Finding of the audits will be take to the QAPI Committee Meeting by DHS/Admin monthly times 3 then quarterly times 3 months.</p> <p>5.Date of compliance 11/24/21</p>		
F 755 SS=D	<p>Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)</p> <p>§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>§483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-</p> <p>§483.45(b)(1) Provides consultation on all</p>	F 755		11/24/21	

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F 755	<p>Continued From page 47</p> <p>aspects of the provision of pharmacy services in the facility.</p> <p>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and</p> <p>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and physician assistant interview the facility failed to assure intravenous fluids were available from their pharmacy for one (Resident # 1) of three sampled residents who had either fluids or antibiotics ordered via an intravenous/subcutaneous route. The findings included:</p> <p>Record review revealed Resident # 1 resided at the facility from 3/25/19 until her discharge on 10/1/21. The resident had a diagnosis of dementia.</p> <p>Resident # 1's quarterly Minimum Data Set assessment, dated 7/23/21, coded the resident as severely cognitively impaired.</p> <p>On 9/22/21 at 11:51 AM Physician Assistant # 2 entered an order for one liter of D5W (Dextrose 5% in water solution) intravenous fluid to be infused at 50 ml (milliliters)/ hour.</p> <p>On 9/22/21 there was a notation made on the MAR (medication administration record) that the one liter of D5W, which had been ordered on</p>	F 755	<p>1.Resident #1 was discharged on 10/4/2021.</p> <p>2.A complete audit of all IV orders was conducted from 10/26-11/24/2021 ensure IV fluids were available and delivered timely.</p> <p>3.Pharmacy Tech came to the facility on 10/26/2021 to re-evaluate cubex inventory. DFW was added as well as other standard IV fluids which will remain in the cubex for emergency use going forward. All nurses were educated by the Pharmacy Consultant on 11/12/2021 on how to enter IV orders into Matrix to ensure timely and accurate receipt of IV fluids from the Pharmacy. They were also educated on the proper way to sign out meds from the cubex and reorder from the pharmacy. Nurses were also educated on the proper mixing of antibiotics and IV fluids.</p> <p>4.All IV orders will be monitored daily by DHS or designee to ensure proper</p>		



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F 755	<p>Continued From page 48</p> <p>9/22/21, was not administered "due to condition."</p> <p>On 9/23/21 at 10:37 AM Nurse #2, who was the manager for Resident # 1's unit, entered an order from PA # 2 for one liter of D5W intravenous fluid to be infused at 50 ml (milliliters)/ hour.</p> <p>On 9/23/21 at 10:40 AM Nurse # 2 entered a progress note with the following documentation. He had contacted the pharmacy because the facility did not have D5W and it was not in their back up supply of intravenous fluids. He had consulted with the physician who did not want to change to an alternative fluid. The order for the D5W was refaxed to the pharmacy.</p> <p>According to facility supply records, the facility did not keep D5W supplied in the facility and any bags which were administered to Resident # 1 would have been delivered from the pharmacy. According to pharmacy records, one 1000 ml (milliliter) bag of D5W was sent to the facility on 9/23/21. Following this date, no further bags of D5W were sent from the pharmacy for Resident # 1 for the rest of September 2021.</p> <p>According to Resident # 1's September 2021 MAR the liter of D5W, which was delivered by the pharmacy on 9/23/21, was signed off as administered at 5:00 PM on 9/23/21 via way of hypodermoclysis (by instilling the fluid subcutaneous).</p> <p>On 9/24/21 at 3:49 AM an order was created by PA # 3 and verified by Nurse # 3 for D5W at 100 ml/hour to be given continuously either by the IV (intravenous) or SQ (subcutaneous) route.</p> <p>This 9/24/21 order was placed on the MAR to</p>	F 755	<p>implementation and order accuracy. The results will be brought to the QAPI committee for the next 3 months to ensure on-going compliance.</p> <p>5.Date of compliance 11/24/21</p>		

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F 755	<p>Continued From page 49</p> <p>start on the date of 9/24/21. There was no indication on the MAR that this 9/24/21 order was initiated on 9/24/21.</p> <p>On 9/25/21 Nurse # 4 initialed by the 9/24/21 order of D5W at 100 ml/ hour on the 7:00 AM to 7:00 PM shift by placing her initials by the order during the timeframe marked "7:00 AM-7:00 PM."</p> <p>On 9/25/21 at 4:00 PM there was an order given by Resident # 1's physician and verified via Nurse # 4 for Normal saline to be administered SQ at 100 ml/hour. According to Resident # 1's September MAR this was initialed by Nurse # 4 as administered on 9/25/21 during the timeframe of "days." This was the same day Nurse # 4 had noted the D5W was infusing on "7A-7-PM."</p> <p>Nurse # 2 was interviewed on 10/19/21 at 12:45 PM and reported the following. The pharmacy supplies the facility with fluids. The facility does have some fluids that are kept at the facility but D5W is not one of them. Although the order was written on 9/22/21 for the D5W, the D5W still had not been delivered from the pharmacy on 9/23/21. Therefore, he called the pharmacy and the pharmacy said they could not see the IV fluid order in their system and therefore had not sent the D5W the day before. Therefore, Nurse # 2 reentered the same order on 9/23/21 which had been entered on 9/22/21 so the pharmacy would send the fluids. Nurse # 2 thought the problem was due to how the orders were being entered into the electronic system which in turn did not enable the pharmacy to see the fluid orders.</p> <p>Nurse # 3, who had routinely cared for Resident #1, was interviewed on 10/19/21 at 3:15 PM and reported the following. After the order for D5W</p>	F 755			

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F 755	Continued From page 50 was given on 9/22/21, Resident # 1 only received one liter of D5W because the pharmacy did not send anymore and there was none in the facility's back up supply. The order for D5W on 9/24/21 was never given and she had not received any D5W on 9/25/21.  Nurse # 4 was interviewed on 10/20/21 at 2:00 PM and reported the following. She recalled that on 9/25/21 there was no D5W to give the resident and she had called the physician who ordered the saline instead. She administered the normal saline and did not administer the D5W she had signed for on the MAR on the date of 9/25/21. Nurse # 4 recalled there had only been lactated ringers and normal saline in the facility's supply.  PA # 1 was interviewed on 10/19/21 at 11:00 AM and reported the following. She normally cared for Resident # 1 and the resident had been declining due to her age and dementia. The fluid orders were part of comfort care and supportive care measures near the end of her life.	F 755			
F 835 SS=E	Administration CFR(s): 483.70  §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner interviews, Physician Assistant interview, Physician interview, and Pharmacy Manager interview the facility failed to have	F 835	1.Resident #1 was discharged on 10/4/2021. Resident # 8 had a wound culture completed on 9/28/2021 and the Vancomycin was discontinued and a new	11/24/21	

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F 835	<p>Continued From page 51</p> <p>effective processes and systems in place for laboratory services to include supplies, laboratory reports, and intravenous fluids.</p> <p>Findings included:</p> <p>A. Cross refer to F684: Based on record review, staff interviews, Nurse Practitioner interviews, Physician Assistant interview, Physician interview, and pharmacy manager interview the facility failed to obtain laboratory values and intravenous/subcutaneous fluids for a resident experiencing end of life changes (Resident #1); failed to obtain wound cultures and sensitivity prior to administration of antibiotics (Resident #8); and failed to obtain vancomycin troughs as ordered (Resident #8) for two of three residents reviewed for professional standards of care according to the care plan.</p> <p>B. Cross refer to F690: Based on resident interview, record review, staff interview, and physician assistant interview the facility failed to assure urine cultures were completed for two (Resident # 5 and #9) of two sampled residents reviewed for diagnosis and treatment of urinary tract infections.</p> <p>Interviews with the Administrator on 10/19/21 at 12:20 PM and again on 10/20/21 at 9:10 AM revealed the following information. She was aware the facility had a problem with their contracted lab company and they were starting to work on audits and finding a lab company to replace the one they had. They just had not finalized fixing the problem but had been making efforts. It had been very difficult in the last months dealing with multiple issues. Staffing issues had been one of the issues. In recent</p>	F 835	<p>antibiotic Meropenem was started.</p> <p>2.A complete audit of all vancomycin orders was conducted by the DHS on 11/24/2021 to ensure all lab orders for Vancomycin troughs were completed timely and carried out appropriately. A complete lab audit was conducted on all resident labs by the DHS or designee on 11/24/2021 to include wound and urine cultures. The administrator will attend additional in-person training on Quality Assurance utilizing Abaqis Quality Assurance Software on 11/17/2021 to ensure all quality assurance processes are being followed at the facility. All department managers will conduct monthly quality assurance audits generated by a resident sample to ensure the systems in the facility are functioning according to state and federal guidelines. Issues identified will be addressed by the Quality Assurance Committee and Plans of Correction will be put into place accordingly.</p> <p>3.Meridian Labs extended the service to 5 days a week for the facility. LabCorp was also made available for the facility to utilize for stat labs. All licensed nurses were educated by the DHS or designee of the stat lab process for LabCorp on 11/16/2021 on their policies and procedures regarding inputting lab orders, pick up times, stat labs and contact information.</p> <p>4.The DHS or designee will complete daily monitoring of all ordered labs to ensure</p>		

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F 835	Continued From page 52 weeks her Director of Nursing just quit one day without any notice. This entailed having a corporate employee come in and try to pick up as an interim DON where the previous DON had left off. The previous DON would not return the Administrator's phone calls for any questions the Administrator might have. The previous DON had also not made her aware there had been any issues with obtaining intravenous fluids from the pharmacy or she would have worked on resolving that. According to the Administrator, she had been an Administrator for over twenty years, had a long history of assuring facilities ran well, and knew how to fix problems. It had been challenging in the last months because of the unprecedented pandemic times which had increased work loads and created problems with staff.	F 835	timely lab pick up and completion and will review in the clinical morning meeting. The daily lab monitoring will be presented to QAPI meeting monthly for the next 3 months to ensure ongoing compliance.  5.Date of compliance 11/24/21		
F 842 SS=E	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;	F 842		11/24/21	

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F 842	<p>Continued From page 53</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§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-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(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.</p> <p>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(i)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(i)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p> <p>(iii) The comprehensive plan of care and services</p>	F 842			

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F 842	<p>Continued From page 54</p> <p>provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, staff interview, and Nurse Consultant interview the facility failed to accurately document the administration of narcotic medication (Resident #10 and #12) and intravenous fluid administration (Resident #1) for three of four residents reviewed for accurate documentation on the medication administration record.</p> <p>Findings included:</p> <p>1. Resident #10 was admitted to the facility on 6/1/2021 with cumulative diagnoses some of which included Alzheimer's disease, gout, and left shoulder pain.</p> <p>The most recent quarterly minimum data set assessment dated 9/3/2021 coded Resident #10 as having short- and long-term memory problems, receiving scheduled pain medications, and receiving opioids seven days of the assessment period.</p> <p>Resident #10 had a current physician's order, originally initiated on 6/24/2021, for Hydrocodone-Acetaminophen- Schedule II 325 mg (milligrams) administered as one tablet twice a day.</p>	F 842	<p>1. Resident #1 was discharged on 10/4/2021. Resident #10 and Resident #12's EMR was reviewed to ensure that nurses were signing out under their own individual log on.</p> <p>2. A security audit will be performed on 11/19/2021 to ensure all nurses are documenting under their assigned log in and that narcotic sheets are being signed with MAR documentation.</p> <p>3. Nurse # 6 was released from her agency contract 10/14/2021. Nurse #2 was educated on the Matrix Security policy by the DHS on 11/9/2021. All nurses were educated on the Matrix Security policy, narcotic documentation, ordering medications and placing IV orders on 11/12/2021 by the Pharmacy Consultant. The DHS or designee will review all IV orders during morning meeting to ensure proper order entry and timely administration. All IV documentation will be reviewed daily by the DHS or designee to ensure continued proper administration.</p> <p>4. Narcotic Sheet will be monitored twice a</p>		

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F 842	<p>Continued From page 55</p> <p>Review of the medication administration record for October 2021 for Resident #10 revealed Resident #10 was documented as receiving the Hydrocodone-Acetaminophen tablet as ordered on 10/6/2021 at 8:00 PM administered by Nurse #4 and 10/11/2021 at 8:00 PM administered by Nurse #2.</p> <p>Review of the Controlled Drug Record initiated on 9/22/2021 for the Hydrocodone-Acetaminophen for Resident #10 revealed the medication was not signed out on 10/6/2021 at 8:00 PM or on 10/11/2021 at 8:00 PM.</p> <p>Review of the nursing schedule for 10/6-7/2021 and 10/10-11/2021 revealed Nurse #6 was assigned the hallway for which Resident #10 resided for the 7:00 PM to 7:00 AM shift.</p> <p>Nurse #6 was interviewed on 10/22/2021 at 2:45 PM. Nurse #6 revealed she was not always able to log into the electronic medical record system when she was working at the facility and she would use the log in information of another nurse who working on the shift prior to her. Nurse #6 stated Resident #10 spits out her medication and she was not going to pull the narcotic medication out of the drawer for her to just spit it out. Nurse #6 stated if she gave the pain medication to Resident #10 then she would have signed out the narcotic on the Controlled Drug Record. Nurse #6 also stated if she did not sign out the medication on the Controlled Drug record then she did not give the medication to Resident #10. Nurse #6 also offered that Resident #10 did not give any indication she was in pain when the pain medication was not given.</p> <p>Nurse #4 was interviewed on 10/25/2021 at 8:59</p>	F 842	<p>week for a month and then weekly x 4 weeks then monthly thereafter. All documentation related to residents on IVs will be monitored twice a week for a month and then weekly x 4 weeks then monthly thereafter. Results will be brought to the QAPI meeting for on-going compliance.</p> <p>5.Date of compliance 11/24/21</p>		



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F 842	<p>Continued From page 56</p> <p>AM. Nurse #4 stated she was aware once or twice Nurse #6 was using her login information to document administration of medications.</p> <p>Nurse #2 was interviewed on 10/22/2021 at 1:15 PM. Nurse #2 reported the following. On 10/11/21 he gave Nurse # 6 his login to the facility system so that she could give and document medications. Nurse # 2 validated that on the shift of 10/12/21 he did not give all the medications where his signature appeared. Nurse # 6 had administered the medications from 7:00 PM to 7:00 AM, and his initials appeared because she was using Nurse # 2's login.</p> <p>An interview was conducted with the facility nurse consultant on 10/22/2021 at 3:00 PM. The facility nurse consultant acknowledged the nurses needed to accurately document what medications have been administered and have been refused. The facility nurse consultant acknowledged the nurses also should have access to the electronic medical record so they can use their own name for documentation.</p> <p>2. Resident #12 was admitted to the facility on 8/28/2020 with cumulative diagnoses some of which included dementia and pain in right knee.</p> <p>The most recent annual minimum data set assessment dated 9/8/2021 coded Resident #12 as having short- and long-term memory problems, receiving scheduled pain medications, and receiving opioids seven days of the assessment period.</p> <p>Resident #12 had a current physician's order initiated on 6/15/2021 for Morphine Concentrate - Schedule II solution 100 mg(milligrams)/5 ml</p>	F 842			

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F 842	<p>Continued From page 57</p> <p>(milliliters) to be administered orally every four hours.</p> <p>Documentation on the medication administration record for October 2021 for Resident #12 revealed she received the following doses of scheduled Morphine as ordered: on 10/6/2021 at 10:00 PM by Nurse #4; 10/7/2021 at 2:00 AM by Nurse #4; 10/7/2021 at 6:00 AM by Nurse #4; 10/10/2021 at 2:00 AM by Nurse #4; 10/10/2021 6:00 AM by Nurse #4; 10/11/2021 at 10:00 PM by Nurse #2; 10/12/2021 at 2:00 AM by Nurse #2; and 10/12/2021 at 6:00 AM by Nurse #2.</p> <p>Review of the Controlled Drug Record initiated on 10/4/2021 for the scheduled Morphine for Resident #12 revealed the medication was not signed out on 10/6/2021 at 10:00 PM; 10/7/2021 at 2:00 AM; 10/7/2021 at 6:00 AM; 10/10/2021 at 2:00 AM; 10/10/2021 6:00 AM; 10/11/2021 at 10:00 PM; 10/12/2021 at 2:00 AM; and 10/12/2021 at 6:00 AM.</p> <p>Review of the nursing schedule for 10/6-7/2021, 10/9-10/2021, and 10/11-12/2021 revealed Nurse #6 was assigned the hallway for which Resident #12 resided for the 7:00 PM to 7:00 AM shift.</p> <p>Nurse # Nurse #6 was interviewed on 10/22/2021 at 2:45 PM. Nurse #6 revealed she was not always able to log into the electronic medical record system when she was working at the facility and she would use the log in information of another nurse who working on the shift prior to her. Nurse #6 stated Resident #12 refused to take her medications and was combative. Nurse #6 stated she was not going to pull the medications for Resident #12 and fight about it with her. Nurse #6 stated if she gave the pain</p>	F 842			

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F 842	<p>Continued From page 58</p> <p>medication to Resident #12 then she would have signed out the narcotic on the Controlled Drug Record. Nurse #6 also stated if she did not sign out the medication on the Controlled Drug record then she did not give the medication to Resident #12. Nurse #6 also offered that Resident #12 did not give any indication she was in pain when the pain medication was not given.</p> <p>Nurse #4 was interviewed on 10/25/2021 at 8:59 AM. Nurse #4 stated she was aware once or twice Nurse #6 was using her login information to document administration of medications.</p> <p>Nurse #2 was interviewed on 10/22/2021 at 1:15 PM. Nurse #2 reported the following. On 10/11/21 he gave Nurse # 6 his login to the facility system so that she could give and document medications. Nurse # 2 validated that on the shift of 10/12/21 he did not give all the medications where his signature appeared. Nurse # 6 had administered the medications from 7:00 PM to 7:00 AM, and his initials appeared because she was using Nurse # 2's login.</p> <p>An interview was conducted with the facility nurse consultant on 10/22/2021 at 3:00 PM. The facility nurse consultant acknowledged the nurses needed to accurately document what medications have been administered and have been refused. The facility nurse consultant acknowledged the nurses also should have access to the electronic medical record so they can use their own name for documentation.</p> <p>3. Record review revealed Resident # 1 resided at the facility from 3/25/19 until her discharge on 10/1/21. The resident had a diagnosis of dementia.</p>	F 842			

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F 842	<p>Continued From page 59</p> <p>On 9/24/21 at 3:49 AM an order was created by PA # 3 and verified by Nurse # 3 for D5W at 100 ml/hour to be given continuously either by the IV (intravenous) or SQ (subcutaneous) route.</p> <p>This 9/24/21 order was placed on the MAR to start on the date of 9/24/21. There was no indication on the MAR that this 9/24/21 order was initiated on 9/24/21.</p> <p>On 9/25/21 Nurse # 4 initialed by the 9/24/21 order of D5W at 100 ml/ hour on the 7:00 AM to 7:00 PM shift by placing her initials by the order during the timeframe marked "7:00 AM-7:00 PM." It did not note if the fluids were given by IV or SQ route.</p> <p>On 9/25/21 at 4:00 PM there was an order given by Resident # 1's physician and verified via Nurse # 4 for Normal saline to be administered SQ at 100 ml/hour. According to Resident # 1's September MAR this was initialed by Nurse # 4 as administered on 9/25/21 during the timeframe of "days." This was the same day Nurse # 4 had noted the D5W was infusing on "7A-7-PM."</p> <p>Nurse # 4 was interviewed on 10/20/21 at 2:00 PM and reported the following. She recalled that on 9/25/21 there was no D5W to give the resident and she had called the physician who ordered the saline instead. She administered the normal saline and did not administer the D5W she had signed for on the MAR on the date of 9/25/21.</p> <p>Resident # 1's record was reviewed with the facility's Nurse Consultant on 10/19/21 at 1:00 PM. According to the Nurse Consultant Resident # 1's record should have accurately reflected the time fluids were initiated and the route they were</p>	F 842			

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F 842	Continued From page 60 given.	F 842			