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F 000	INITIAL COMMENTS The surveyor entered the facility to conduct a complaint investigation on 10/29/24 and exited on 10/31/24. Further information was obtained on 11/1/24 and 11/4/24. Therefore, the exit date was changed to 11/4/24. The following intakes were investigated. NC00221868, NC00222251, NC00222294, NC00222460, NC00223110. One of the thirteen allegations resulted in deficiency. Past-noncompliance was identified at: CFR 483.25 at tag F 689 at a scope and severity J The tag F 689 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/20/24 and was removed on 8/23/24. A partial extended survey was conducted.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.	F 583		

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

Electronically Signed | 11/08/2024

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F 583	Continued From page 1 §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff the facility failed to afford privacy when a Nurse Aide used a cell phone by video chat in the vicinity of an unclothed resident receiving a shower. This was for one (Resident # 5) of four sampled residents who were interviewed about care. The findings included: Resident # 5 was admitted to the facility on 11/2/23. The resident's diagnoses in part included depression and anxiety. Resident # 5's significant change Minimum Data Set assessment, dated 9/11/24, coded the resident as cognitively intact and totally	F 583	Past noncompliance: no plan of correction required.	

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dependent on staff for bathing and showering.

Resident # 5's care plan, dated 9/20/24, included information that the resident exhibited manipulative behaviors and had been known to make false statements regarding staff. One of the care plan interventions was to ensure two staff members were in the resident's room when providing care services. This intervention had been added to the care plan on 6/25/24 and remained part of the active care plan.

Resident # 5 was interviewed on 10/29/24 at 11:40 AM and again on 10/30/24 at 2:00 PM. Resident # 5 reported the following information. In recent weeks there had been an incident when NA # 3 had been using a cell phone in the shower room while she (Resident # 5) was being showered by NA # 2. At the time she (Resident # 5) was not clothed and was lying on a shower bed while NA # 2 showered her. There was a curtain pulled lengthwise down the long side of the shower bed which afforded privacy if anyone entered the shower room. At the bottom of the shower bed (near her feet), there was a gerichair recliner. During the first part of the shower, NA # 3 was outside of the privacy curtain. She (Resident # 5) could hear NA # 3 using her phone from the other side of the privacy curtain but the privacy curtain was protecting Resident # 5 from being viewed initially when NA # 3 was on the phone. While she was still being showered, NA # 3 came around the privacy curtain and took a seat in the gerichair at the foot of the shower bed while still talking on the phone. She (Resident # 5) lifted her neck and looked down towards the foot of the shower bed where NA # 3 was. NA # 3 had people on her phone and was face timing them while talking to them. The phone was

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angled so that it was pointed more at her (Resident # 5) than it was at NA # 3. She (Resident # 5) could see heads on the screen of the phone and felt that whoever was on the phone could see her naked on the shower chair. She yelled at NA # 3 to get out of the shower room, and she left.

A review of the facility's investigation into the incident revealed the incident date was 9/23/24.

The DON (Director of Nursing) and Unit Manager were interviewed on 10/29/24 at 1:00 PM and reported the following. On the date of the incident NA # 3 had been in the shower room as the care planned second staff member for Resident # 5 due to her false accusations. NA # 3 had reported the incident herself when Resident # 5 yelled at her. She had reported she received an emergency phone call about a sick child in her family and reported that was why she took the phone call. The DON reported NA # 3 should have momentarily stepped out of the shower room to afford privacy for Resident # 5, but NA # 3 reported she did not want to leave NA # 2 alone with the resident because that would have placed NA # 2 at risk of having false accusations made against her.

On 10/30/24 at 10:20 AM NA # 2 and the DON were accompanied to the shower room where NA # 2 demonstrated and reported the following information she had observed on the incident date. The privacy curtain was pulled down the long length of the shower bed. The other long length of the shower bed was against the wall. She (NA #2) was behind the privacy curtain with Resident # 5 standing at the side of the shower bed near the foot. The bottom privacy curtain was

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open, enabling her to maneuver around the long shower bed as she worked to shower the resident and shave the resident's legs. Privacy was still afforded with the bottom of the shower curtain open as long as no one came around to the foot of the bed. There was a gerichair near the foot of the shower bed approximately 2 to 3 feet away. It was not facing the shower bed. The left arm of the gerichair would have been towards the shower bed. While she (NA #2) was working to shave Resident # 5's legs, she had her back to the gerichair. She heard Resident # 5 yell at NA # 3. She turned around and saw that NA # 3 had come around the privacy curtain and sat in the gerichair. NA # 3 was not facing or looking at Resident # 5 while doing so. NA # 3 had a cell phone holding it in front of her and looking into the screen of the cell phone. She was talking to someone on the phone while holding it in front of her. She (NA # 2) had not noticed when NA # 3 had received a phone call or what she was doing prior to that because she was shaving Resident # 5's legs and was concentrated on that so as not to cut the resident. She never saw NA # 3 turn the phone towards Resident # 5. When the resident yelled, NA # 3 left.

An attempt was made to reach NA # 3 during the survey and she could not be reached for interview.

The DON and Administrator were interviewed on 10/30/24 at 5:00 PM. The Administrator reported Resident # 5 did have a history of falsely accusing staff members and that was why NA # 3 had been present. The DON reported NA # 3 was a very good Nurse Aide who had no other problems prior to the incident. Both of the administrative staff members felt the Nurse Aide

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had taken the call because of an emergency and did not intend to invade Resident # 5's privacy. They had taken corrective action and provided the following plan of correction.

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

On 9/23/2024 Resident # 5 was receiving a shower by two CNAs when one of them received a personal call from children via video chat and remained in the shower room during the call. The facility failed to provide privacy while the resident was being showered when a staff member used a cell phone in a patient care area.

The CNA no longer works in the facility. A trauma screen was performed on 9/24/24 by the Social Worker with no new trauma triggers identified.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

The Quality Assurance Committee (Regional Director of Clinical Services, Administrator, Therapy Manager, Director of Nursing, Assistant Director of Nursing, Medical Director, and Staff Development Coordinator) met on 9/25/2024 to review the findings and initiated a plan.

The Administrator reviewed care concerns for the last 30 days on 9/24/24. There were no other concerns regarding cell phone use in patient care areas.

3. Address what measures will be put into place or systemic changes made to ensure that the

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deficient practice will not recur;

The Administrator educated all staff on customer service as it relates to patient care and patient rights to include not using cell phones in resident care areas and privacy. This was completed on 9/26/2024. All newly hired employees will receive this education in orientation prior to assignment. No employee will be allowed to work until they have received this education.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

When the Quality Assurance Committee (Regional Director of Clinical Services, Administrator, Therapy Manager, Director of Nursing, Assistant Director of Nursing, Medical Director, and Staff Development Coordinator) met on 9/25/2024 to review the findings and initiated a plan, the Quality Assurance Committee also devised a monitoring plan.

The DON and nurse managers will ensure cell phones are not being used in resident care areas through rounding, once in the morning and once in the afternoon on every hallway. This will occur 5x/week x 2 weeks, 3x/week x 2 weeks and 2x/week and 4 weeks.

The results will be reported to the monthly QAPI committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis.

Compliance: 9/27/24

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F 583	Continued From page 7 The facility's plan of correction was validated by the following: Beginning on 10/29/24 at 9:54 AM a tour of the facility was conducted. Multiple residents were interviewed and did not report privacy issues. Staff were observed closing doors during care. There were no staff observed in resident care areas utilizing cell phones. During the interview, which was conducted with Resident # 5 on 10/29/24 at 11:40 AM the resident stated she had reported the 9/23/24 incident and since she had done so she had not experienced staff using their cell phones while providing care or in the vicinity of where care was provided to her. The facility provided documentation of inservice education and audits per the plan of correction. The facility's plan of correction date of 9/27/24 was validated on 10/30/24.	F 583		
F 689 SS=J	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. This REQUIREMENT is not met as evidenced by: Based on observation of a recorded video, record review and interviews with resident, staff,	F 689	Past noncompliance: no plan of correction required.	

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and a van transportation company, the facility failed to ensure a resident was safely transported to a physician's visit. The facility's contracted transportation company's Van Driver failed to ensure the lift platform was level with the van before rolling Resident # 7 out of the van. The resident fell backwards out of the transport van to a lift platform that was located on the ground approximately 3 feet below the level of the van. Review of the van company's recorded video of the incident revealed the resident could be heard crying and yelling loudly when she hit the ground. Failure to ensure safety when assisting residents onto mechanical van lifts has a high likelihood of resulting in serious resident harm. This was for one (Resident # 7) of three residents reviewed for accidents.

The findings included:

Resident # 7 was admitted to the facility on 8/29/21. The resident's diagnoses in part included a history of stroke.

Resident # 7's annual Minimum Data Assessment, dated 8/7/24, coded the resident as cognitively intact. The resident was coded to use a wheelchair, and as needing substantial to maximum assistance to wheel at least 150 feet.

Review of Resident # 7's nursing notes revealed an entry on 8/20/24 at 2:58 PM noting "It was reported that during transport from an appointment that the resident had a fall. Resident is being transported by EMS (emergency medical services) to the ER (emergency room) for evaluation."

A review of hospital records for the dates of

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8/20/24 and 8/21/24 revealed the following information. Resident # 7 was seen in the ER on 8/20/24 following the incident. The physician noted the resident "was in no acute distress" at the time of the physician's assessment. The physician noted the resident's speech was hard to understand. When she slowed down her speech was not slurred, and she was able to report she had landed on her back inside her wheelchair during a fall from a transport van. The caregiver (transport driver) landed on top of her. The physician further noted, "She denies any complaints at this time, no neck pain, no headache, nausea, vomiting, chest pain, reports legs are less painful than they were prior to arrival." A CT (computerized tomography) of her head and cervical spine were ordered and were negative for injury. The resident was discharged back to the facility from the ER on 8/21/24.

The resident was interviewed on 10/29/24 at 10:47 AM and again on 10/31/24 at 2:40 PM. The resident was observed to talk very fast making it difficult to discern every word. She clearly reported the following information. In August 2024 she had been transported to a doctor's appointment and the Van Driver pushed her out of the van onto the concrete. Before the incident, the Van Driver complained to her that she (the resident) was heavy. Then she fell out of the van. It hurt when she fell, and she had to go to the hospital.

An interview was conducted with the Administrator and NA# 1 on 10/31/24 at 3:15 PM. NA (Nurse Aide) # 1 reported and demonstrated the following. NA # 1 had ridden in the van with the contract company to Resident # 7's appointment. Once they arrived at the physician's

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appointment, she (NA # 1) went into the office to check the resident into the office. She (NA # 1) then came out the door and stood at the doorway while the Van Driver was unlocking and getting Resident # 7 out of the van. She could see the back of the van. The resident and the Van Driver both fell backwards out of the van, and they landed on the lift platform. The wheelchair flipped all the way upside down on top of the resident so that the bottom of the wheelchair seat was facing up in the air and the top of the wheelchair backrest was on the surface of the lift platform. The accident happened very quickly, and she thought the Van Driver had tripped some way and the lift platform was still up in the air when the resident fell backwards. The physician's office staff came to assist with the incident. 911 was called. She called and reported the incident to the facility. She had not observed anything about the Van Driver before the incident which would indicate the Van Driver was not a safe driver. The Administrator reported the facility had used the contracted van company many times and they had given safe and reliable services. The van company had reviewed the incident with her and reported that the Van Driver had not put the lift platform even with the van before rolling the resident out of the van. Instead, the Van Driver had lowered the lift platform all the way to the ground. The van company had reported to the Administrator that there were safety mechanisms in place at the rear of the van, and the Van Driver should have recognized when she met resistance getting the resident out of the van over one of them that there was a possible problem.

The Van Company's Director was interviewed on 10/31/24 at 4:53 PM and reported the following information. Their Van Driver had made a mistake

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and Resident # 7 had fallen out of the transport van. They were very sorry about the incident. They went to check the van at the time of the incident and found nothing mechanically wrong with the lift or the van which led to the incident. The lift was damaged due to the impact of the fall, and it was taken out of service for repair following the incident. She had worked closely with the facility Administrator to try to determine what had happened. There was a video recording from inside of the van which they had watched multiple times to determine what had happened. She and her husband owned the transportation company, and the Director put her husband on the phone call with the surveyor during the interview. Together they reported the following information. The video recorder was facing the rear of the van and therefore the video showed the incident from that angle only. From reviewing the video, they saw NA # 1 had ridden with the resident and the Van Driver. Once they arrived, NA # 1 left the van to go into the doctor's office, and the angle of the video did not pick NA # 1 up until after the incident occurred. After the fall, the video's angle picked up NA # 1 rushing to the back of the van. Upon arrival to the doctor's office, the Van Driver could be seen exiting the van, walking to the rear of the van and letting the lift platform down. The Van Driver then returned inside the van, unlocked the resident's wheelchair's security devices and rolled the resident backwards. While conducting their investigation, they had viewed other transport videos where there had been no incidents. From viewing and comparing the videos where transports were done correctly versus the video where Resident # 7 fell, they were able to see that when the lift platform was even with the van in a safe position to roll residents out, then safety

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arms on the lift would be visible in all the videos. In viewing the video of Resident # 7's transport, they saw when the Van Driver lowered the lift platform, the safety arms disappeared almost completely. Only a small portion could be seen. This indicated to them that the lift platform had been all the way to the ground instead of level with the back of the van when the resident was rolled backwards. In the video they saw the resident and the Van Driver fall out of the van towards the ground. They estimated that the drop was about 36 inches. They reported they would share the video with the surveyor and a statement from the Van Driver.

On 11/1/24 the van company's video was viewed, and the following was observed. Resident # 7 could be seen seated in the rear of the van in a wheelchair. The Van Driver was seated in front and NA # 1 was in the front passenger seat. They came to a stop. NA # 1 stepped out of the van and exited from sight. The video camera no longer was able to capture NA # 1 as she walked into the physician's office to check the resident in. The Van Driver exited the front of the van and opened the back doors of the van. A lift platform could be seen going down at the rear of the van. The arms of the lift faded away from sight as it lowered. There did not appear to be anything in the rear of the van where the lift platform should be. The Van Driver reentered the van and removed the security belts and ties that had kept the resident's wheelchair in place during the transport. She and the resident appeared to be talking. The resident was facing the front of the van and thereby her back was facing the rear of the van. Therefore, the resident could not see where she was headed as she was being rolled backwards in her wheelchair. The Van Driver

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backed the resident towards the rear of the van. When the Van Driver got to the rear, she appeared to have trouble getting the wheelchair to roll and appeared to be meeting resistance. She readjusted the wheelchair several times pulling it towards her and back again. Then with the last push backwards toward the open rear of the van, the resident fell backwards out of the van in her wheelchair. The Van Driver fell forward out of the van also with the resident. The resident could be heard yelling and crying loudly. After the fall, the resident was out of view from the camera angle. NA # 1 was seen coming into view of the video camera and asking what happened. A gentleman came from one side of the van and physician office staff members were seen coming from the other side to the rear of the van to offer assistance. The wheelchair could be seen lifted up and away. Someone was heard telling the resident they were calling EMS. Someone in the video was heard saying "she is on the ground." Once multiple people were attending to the resident, the Van Driver could be seen reentering the front seat of the van and making a phone call to someone. She was heard explaining the incident and stated to the person to whom she was talking that she (the Van Driver) was trying to get Resident # 7 on the lift and couldn't get her. The Van Driver commented, "She is so heavy." "I was trying to push a little harder. I couldn't rock her because she was so heavy." She then said she tried to rock again and push back again, and the resident fell out of the van and they both hit the ground.

The van company also provided a statement from the Van Driver which was in an email from the Van Driver to the Director of the van company on 8/22/24. The emailed statement read as typed,

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"On Tuesday August 20th I [name of van driver] had transported [Resident # 7] to her destination. Once we arrived I locked my breaks, got of my vehicle to go through the proper steps to remove {Resident #7} from the vehicle. The second step was to unfold the lifter and level it so that {Resident # 7} could be placed on the lifter so that I could bring her down to ground level. At the time I didn't realize that I dropped the lifter all the way to the ground instead of keeping it leveled up so that can roll her onto the lifter. Then proceed to unbuckle her restraints so that I could put her onto the lifter upon moving her, not realizing that the lift was ground level, I then proceeded to push her what I thought was on the lifter. Once I started pushing her wheelchair still not realizing that the lifter was down ground level I ended up falling on top of her all the way to the ground. In my mind, I had leveled the lifter but it evident that I didn't, and I fell on top of her going backwards, and we both hit the ground." The van driver ended her statement by saying she had not done anything intentionally to hurt anyone, it had been an unfortunate accident, and she had been properly trained.

Interview with the Administrator on 10/31/24 at 3:15 PM revealed the facility identified the incident as needing a plan of correction and they implemented one to ensure residents were safe. The Administrator provided the facility's plan of correction.

On 11/1/24 at 11:00 AM the Administrator was notified of immediate jeopardy. The facility's completed corrective action plan was as follows:

1. Address how corrective action will be accomplished for those residents found to have

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been affected by the deficient practice;

On 8/20/2024 resident #7 was being transported by a contracted company to an appointment. During the unloading process, the driver proceeded to lower lift pad to the ground and not level to the van bumper. When the driver proceeded to wheel resident #7 onto lift pad she tripped on safety mechanism and toppled onto resident. This force pushed resident #7 and chair out of the van resulting in a fall in which resident #7 landed on the lift gate landing.

On 8/20/2024 resident #7 was not moved until EMS arrived staff helped provide pillows and blankets for dignity until EMS arrived. EMS assisted lowering resident #7 to the ground on the lift gate. Resident #7 was transported to the hospital for further medical treatment.

The Driver was suspended on 8/20/2024. The lift gate was damaged during the incident and therefore the van was removed from service until repaired.

The driver was drug and alcohol tested on 8/20/2024 with no findings.

The driver was interviewed on 8/20/2024 by the contract transport company and maintained that a flap on the van used to keep patients in place failed to drop as expected therefore causing her to trip.

On 8/20/2024 the aide who went on transport provided a statement and recollection of the events. She stated she was checking resident #7 into her appointment at the office and was coming out at the time the incident occurred. She stated

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she saw the driver trip and move forward onto resident #7 at which time the wheelchair tipped backwards and the resident fell. The aide stated that the lift gate was up in the air and that EMS had to assist further lowering it to the ground.

On 8/21/2024 the transportation contract company owners came to the facility and brought the van that was part of the incident. The administrator, assistant administrator and owners discussed their findings. The owners stated the van was equipped with video camera that was on the dash and pointed toward the back. They reviewed the video footage however stated it was difficult to fully understand what was happening with the lift gate due to resident #7 and her chair being in the center. They stated they also reviewed footage of her earlier transportations for the day and noticed that the sides of the lift gate were not in visible sight as they had been on her earlier transports for the day. The owners maintain that those flaps only stay up if the lift gate is not level. The driver had received certification upon hire on safety as it relates to ensuring the lift gate is even with the van bumper prior to unrestraining a patient and proceeding with unloading.

The owners had implemented a remediation plan of their own after reviewing the tapes starting 8/21/2024. All transports that have a single driver must call dispatch prior to removing the patient from the van to confirm all safety techniques including having the lift gate level are in place prior to unloading a patient.

Resident #7 returned to the facility on 8/21/2024 with no injuries.

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Resident #7 statement was obtained on 8/21/2024 and she stated she remembered talking to the driver and the driver tripped on something causing her to fall backward with the driver on top of her.

On 8/21/2024 a trauma screen was performed on resident #7 and she reported no concerns from the incident. On 8/23/2024 during care resident #7 reported the incident again and another trauma screen was completed and she was concerned about future transportation. On 9/12/2024 resident #7 had her first appointment out of the facility since the incident the aide went with her and provided support of her safety during the transport process. Resident #7 expressed no further concern related to transport.

The facility failed to ensure resident #7 was safe during the unloading process of transport resulting in fall from the van.

2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Any residents receiving transports are affected by this practice. The transport company implemented 8/21/2024 that when working alone all drivers will be required to confirm the lift is floor level by walking on the lift and notifying their administration, prior to unloading all residents, that lift is level and safe.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

All drivers received education by the transport

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company owners on Passenger Assistance Safety which includes lift operating procedures and safety harnesses. This was completed 8/22/2024. This was supplied to the facility by the transport company on 8/22/2024. Any new driver will receive education by the transport company in orientation and will be sent to administrator as needed. The center contracts with no other transportation company and therefore no further education was required from other companies.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained;

The Quality Assurance Committee (Regional Director of Clinical Services, administrator, Director of Nursing, Assistant Director of Nursing) met on 8/22/2024 to review the findings and initiated a plan.

Unit secretary or designee will ride on transport for an audit of 2 transports weekly x 4 weeks, weekly x 8 weeks to ensure the lift gate is level prior to wheeling patient off the van and driver has made all safety checks prior to unloading a patient.

The audits will be reported to Quality Assurance for further review quarterly x 2.

Include dates when corrective action will be completed.

Completion date: 8/23/2024

The facility's corrective action plan was validated by the following:

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F 689	Continued From page 19 Beginning on 10/29/24 at 9:54 AM a tour of the facility was conducted. Multiple residents, who were interviewed, did not report a problem with safety or transportation. The facility provided documentation they had communicated and worked with their contracted van company to implement their plan of correction. There was documentation the van company provided education to their van drivers and the drivers completed a two day course entitled "Passenger Assistance Safety and Sensitivity driver certification program," which included instruction on lift operating procedures, wheelchair and occupant securement training. The van drivers had a certificate of completion awarded from the Community Transportation Association of America. The facility provided evidence of their audits as outlined in their plan of correction. Their audits included checking for ramp and boarding safety, patient securement, and patient assistance. Resident # 7 was part of their audits, and the audit showed the resident had been transported safely following the incident to another office visit. It was confirmed with the Administrator that they only used this transportation company currently for transportation needs, and there had been no further incidents. The facility's correction date of 8/23/24 was validated on 11/1/24.	F 689		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		11/5/24

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F 760	Continued From page 20 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident, staff, physician, and pharmacist the facility failed to administer a daily intravenous antibiotic on two consecutive days. This was for one (Resident # 6) of one sampled resident whose medications were reviewed. The findings included: Resident # 6 was admitted to the facility on 10/24/24. Review of a hospital discharge summary, dated 10/24/24, revealed the following information. Resident # 6 had a stage 4 pressure sore and osteomyelitis. While hospitalized a culture of the sacral pressure sore grew bacteria. One of the bacteria was extended spectrum beta lactamase (ESBL) Escherichia Coli (A type of bacteria which is resistant to several antibiotics). She had also been diagnosed with a urinary tract infection due to (ESBL) Escherichia Coli. A PICC (peripherally inserted central catheterization) was placed for Intravenous antibiotics. According to the discharge summary the resident was scheduled to receive Ertapenem (an antibiotic) for a total of 6 weeks. The course of treatment was to run from 10/6/24 through 11/17/24. Review of Resident # 6's facility admission orders revealed on 10/24/24 Resident # 6 was ordered to receive Ertapenem 1 gram intravenously daily through 11/17/24. Review of Resident # 6's October 2024 Medication Administration Record (MAR) revealed Resident # 6 was not documented as receiving the Ertapenem on 10/26/24 and	F 760	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F760 1. Resident # 6 is receiving IV medications as ordered and antibiotic was extended by MD. 2. On 10/30/2024, the DON reviewed all other residents on IV antibiotics. There were no other residents receiving IV antibiotics in the facility. 3. The DON and ADON educated all licensed nurses on medication errors related to omissions to include checking the med prep room for deliveries, accessing the pyxis for medications, contacting the MD for alternate orders, notifying nurse management when a medication is not available and contacting pharmacy for any available back up options. This education was completed 11/1/2024. All newly hired nurses will receive this education on orientation prior to assignment. No nurse will be able to work until the education is completed. 4. The Unit managers or designee will review medications not administered	

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F 760	Continued From page 21 10/27/24. Nurse # 1 did not document a check mark on the MAR indicating the IV antibiotic was administered. Resident # 6 was interviewed on 10/29/24 at 10:05 AM and reported the facility had missed giving her antibiotics over the weekend of 10/26/24 and 10/27/24. Nurse # 1 was interviewed on 10/30/24 at 3:41 PM and reported the following information. She confirmed she had not given Resident # 6 the antibiotic Ertapenem on 10/26/24 and 10/27/24. She could not find the antibiotic and had looked for it multiple places. She called the pharmacy and thought there was a problem with processing the medication order. She had let the physician know and spoken to the Director of Nursing. The DON (Director of Nursing) was interviewed on 10/30/24 at 11:55 AM and reported the following information. She had checked with the pharmacy, and they had sent the antibiotic. It would have been at the facility for administration over the weekend of 10/26/24 and 10/27/24. When the issue had first been brought to her attention, she had thought that the missed doses were due to something that had happened on the pharmacy's end. It had just recently been brought to her attention that the antibiotic was actually in the facility and had not been given. She did not know why Nurse # 1 had not administered the antibiotic or why Nurse # 1 was saying that it was a pharmacy issue. A pharmacist from the facility's pharmacy was interviewed on 10/30/24 at 1:15 PM and reported they had sent a four -day supply of Resident # 6's IV Ertapenem to the facility on 10/25/24 at 5:16	F 760	report daily M-F to ensure IV medications are given x 4 weeks, 3 x weekly x 4 weeks and then weekly x 4 weeks. 5. The results will be reported to the monthly QAPI committee for review and discussion to ensure substantial compliance. Once the QA committee determines the problem no longer exists, then review will be completed on a random basis. 6. Compliance date: 11/5/2024	

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F 760	Continued From page 22 AM. Therefore, the facility would have had antibiotic doses through 10/28/24. Then they sent more doses on 10/29/24. They had no record of a nurse calling over the weekend of 10/26/24 and 10/27/24 about the antibiotic not being at the facility. There had been no processing issues for the delivery of the antibiotic. Resident # 6's physician was interviewed on 10/31/24 at 12:00 PM and reported the following information. He did not recall whether the staff had mentioned to him over the weekend about Resident # 6 missing her antibiotic on 10/26/24 and 10/27/24. He knew staff had mentioned it on Monday (10/28/24) and he had extended the order to include two additional doses to be given at the end of the resident's antibiotic therapy to adjust for the missed doses. He did not feel the two missed doses had adversely affected Resident #6.	F 760		