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	345317	A. BUILDING _____ B. WING _____	C 10/23/2024

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CLAYTON REHABILITATION AND HEALTHCARE CENTER	204 DAIRY ROAD CLAYTON, NC 27520

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F 000	INITIAL COMMENTS The survey entered the facility on 10/15/24 to conduct a complaint survey and exited on 10/16/24. The surveyor returned to the facility 10/21/24 to obtain additional information and exited on 10/21/24. Additional information was also obtained on 10/17/24, 10/18/24, 10/22/24, and 10/23/24. Therefore, the exit date was changed to 10/23/24. (Event MV1511) The following intakes were investigated: NC00222703 and NC00223283. Two of the eight allegations resulted in deficiencies.	F 000		
F 660 SS=D	Discharge Planning Process CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan.	F 660		11/8/24

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

Electronically Signed | 11/06/2024

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F 660	Continued From page 1 (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to	F 660		

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F 660	Continued From page 2 the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident and staff the facility failed to provide discharge planning for a cognitively intact resident who was admitted to the facility for short term rehabilitation with the goal to discharge home to her previous residence in the community. Soon after admission, Resident #9 decided she was unhappy at the facility and preferred to receive rehabilitation at home rather than the facility and she voiced her desire to return to home to staff. Discharge planning had not been addressed with the resident resulting in the resident leaving the facility with transportation provided by her friend. This was for one of four sampled residents discharged during the week or following the week of the facility's social worker's absence due to illness. The findings included: Resident # 9 was admitted to the facility on 8/21/24. Review of Resident # 9's hospital discharge summary, dated 8/21/24, revealed the following information. The resident had spinal stenosis and had been identified to have a bulging disc	F 660	F660 1-Resident #9 left the facility AMA on 08/27/2024. 2-All residents that require discharge planning can be affected by this deficient practice. A 100% audit of all residents was completed on 11/06/2024 to ensure discharge planning was initiated on admission and their Care Plan includes discharge planning. 3-All staff will be in serviced on ensuring residents discharge plan are initiated on admission and that their care plan will include discharge planning with proper follow through. Staff also will be randomly audited to ensure they know our process and who to report to immediately; if a patient states they want to discharge from the facility. Audit will include our AMA process and review of our policy by the Assistant Director of Nursing/ designee. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff. 4-A daily audit will be performed by the	

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F 660	Continued From page 3 resulting in lower extremity weakness and recurrent falls. The discharging hospital physician recommended the resident go to rehabilitation for therapy and the resident was in agreement. Additionally, the resident had diagnoses which in part included a history of stroke without any residual effects, hyperthyroidism, depression, chronic obstructive pulmonary disease, and insomnia. Review of Resident #9's admission MDS (Minimum Data Set) assessment, dated 8/27/24, revealed the resident was cognitively intact. Her discharge plan was to return to the community setting. Review of Resident # 9's care plan, dated 8/21/24, revealed no discharge plan. Review of Resident # 9's last skilled nursing progress note revealed it was dated 8/27/24 at 4:22 PM and made no mention of the resident discharging home. Review of an occupational therapy (OT) discharge summary, signed on 8/28/24, revealed the resident had received OT form 8/22/24 to 8/27/24. Her prior living arrangements before hospitalization included that she had lived in a one- story home which had a ramp entrance. A walk- in shower was in her bathroom. She had been independent in her activity of daily living activities and had a home health aide who visited her twice per week. She also had transportation if needed. On the date of 8/27/24 (the date of last facility therapy) the resident was documented as needing "supervision or touching" for dressing, bathing, and toileting.	F 660	Administrator/Social Service Director/ designee to ensure discharging residents had their discharge plans initiated at admission and that they were included in the care plan 5 days a week times twelve weeks. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 11/08/24	

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F 660	Continued From page 4	F 660		

Review of a physical therapy discharge summary, signed as completed on 8/30/24, revealed the following information. Resident # 9 received services from 8/22/24 to 8/27/24. The resident had been discharged because she declined further treatment. On 8/27/24 she was able to walk 50 feet while making turns and while using a two wheeled walker. On 8/27/24 she needed supervision or touching for transfer assistance.

Review of social service notes revealed an "initial assessment" was completed on 8/27/24. Within the "summary portion" of the assessment, there was documentation which read "plans to return home." The assessment also included a notation that the resident "does not adjust well to change." There were no notations about efforts that had been made between the date of 8/21/24 and 8/27/24 to assist the resident with discharge planning.

There were no discharge orders for Resident # 9.

Review of the record revealed a form entitled "Statement of Resident Releasing Facility from Liability Upon Leaving Facility Against Medical Advice." The form included a signature that was not clearly legible and which appeared by "resident signature." It was dated 8/27/24 at 8:57 PM indicating the resident had left the facility against medical advice on the evening of 8/27/24.

Nurse # 2 had been assigned to care for Resident # 9 on the 3:00 to 11:00 PM shift on 8/27/24. Nurse # 2 was interviewed on 10/21/24 at 2:00 PM and reported the following information. Resident # 9 had not gone home AMA (against medical advice) on her shift nor had she signed anything that she was leaving. She (Nurse #2)

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F 660	Continued From page 5	F 660		

had checked on the resident shortly before the end of her shift and the resident was at the facility. The next morning (on 8/27/24) she received a phone call from another facility staff member asking where the resident was. She had let the staff member know that the resident had been at the facility when she left work at 11:00 PM on 8/27/24.

Nurse # 5 had been assigned to care for Resident # 9 on 8/27/24 starting at 11:00 PM and ending at 7:00 AM on 8/28/24. Nurse # 5 was interviewed on 10/21/24 at 2:39 PM and reported the following information. Based on her understanding from shift change report on 8/27/24 at 11:00 PM, Resident # 9 had been sent to the hospital. That is what she recalled was told to her.

Resident # 9 was interviewed via phone on 10/21/24 at 10:26 AM and reported the following information. She was a retired nurse and was very knowledgeable about her health care needs and how to obtain health care services. At time of discharge from the hospital on 8/21/24 the hospital physician had recommended she go to a rehab facility for therapy for a short term. She had been to the facility years before and agreed once again to go for a short time period. Once at the facility, there were some things she was unhappy with and she preferred to be at home. She knew she could get therapy at home. She had asked about going home. The therapy department knew she was unhappy. There did not seem to be any communication between staff, and no one was helping her get home. The facility seemed to be in transition with some of the staff. On her last day at the facility the staff moved her to another room thinking that would make her happier, but

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that was not what she wanted. She did not recall ever speaking to the social worker. If the social worker had talked to her, then the social worker had not identified herself by name. On 8/27/24 she had specifically spoken to the Assistant Director of Nursing and let her know she wanted to leave that day. She was told that someone would get back to her. She waited and waited and no one came to discuss helping her go home. That evening her friend came to visit. Since no one had helped her, she then decided to just leave with her friend's assistance. She had her own rollator walker, and she had gone part way to leave. While still in the hallway, a nurse (who she did not know her name) walked up to her to try to give evening medications which were due. She let the nurse know she did not want to take them in the hallway, and the nurse replied she would leave them in her room and walked away. She did not tell the nurse she was leaving. She just went ahead and left and walked out the front door with her friend. At the time the front door was unlocked and no one stopped her. It was around 8:00 PM. She safely got home with her friend's assistance and had what she needed. She knew how to set up home health therapy services herself and did that independently. The facility had tried to call her the next day to find out where she was, but she did not want to talk to them. She felt that the facility had not been of any assistance prior to her leaving and therefore she did not need or want their help after she left. She had never signed anything signifying she had left the facility because no one had noted she left until the next day. The facility had alerted DSS (the Department of Social Services) she had left the facility. Being reported to DSS as leaving against medical advice had upset her because the reason she left was because no one would help her get

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F 660	Continued From page 7	F 660		

home. She felt that had been uncalled for.

The ADON (Assistant Director of Nursing) was interviewed on 10/22/24 at 1:22 PM and reported the following information. She had spoken to Resident # 9 sometime on 8/27/24 and the resident had mentioned wanting to go home, but she had not indicated any urgency to the matter or that she was planning to leave that day. She (the ADON) always tried to tell the social worker right away about requests for discharge so that she would not forget. She thought she had mentioned to the social worker on 8/27/24 that the resident was wanting to go home. The next morning (8/28/24) during clinical morning meeting, which is attended by administrative staff members, it came up that the resident was gone. She could not recall who had reported it. She was shocked because the resident had not indicated she was going to leave. She called and talked to the resident at home. The resident was short in her answers but let her (the ADON) know that she was okay and had home health and all her follow-up appointments handled herself.

The facility social worker was interviewed on 10/21/24 at 10:00 AM and again on 10/22/24 at 3:48 PM and reported the following information. She had not been at work due to illness when Resident # 9 was admitted on 8/21/24. Her first day back was on 8/26/24 and she did see the resident at one point when she was back. She knew the resident was having some adjustment problems. The resident tended to like to be by herself. She (the SW) arranged for the resident to go to a private room and thought she was happy. She did not recall the ADON or anyone else letting her know on 8/27/24 that the resident was wanting to go home. While she (the SW) had

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F 660	Continued From page 8 been gone during her illness, usually everyone pitched in to help perform duties she typically did. If a resident needed discharge assistance for things to be set up, then they could have contacted a social worker at the facility's sister facility also. The Director of Rehabilitation was interviewed on 10/22/24 at 10:00 AM and reported the following information. She recalled the resident expressed it was her goal to eventually go home, but did not recall the resident being unhappy. By the date of 8/27/24 the resident was safe to go home as far as mobility, and the resident's initial assessment had shown she had accommodations at home to be safe when she went home. The Administrator was interviewed on 10/22/24 at 12:54 PM and reported the following information. The date of 8/27/24 was either her first or second day as the Administrator, and she had not been made aware of any problems with the resident. The staff had called the resident after they found out she left AMA and made sure she was okay.	F 660		
F 684 SS=D	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:	F 684		11/8/24

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F 684	Continued From page 9 Based on record review and interviews with staff, family, and physicians, and laboratory employees the facility failed to 1) ensure they identified when a resident initially developed arterial wounds to his feet to ensure the resident received treatment and services at onset of the wounds and 2) recognize a critical hemoglobin level reported to them needed follow up and the lab needed redrawn as ordered by the physician so a determination could be made if the hemoglobin was continuing to drop (Resident # 2). This was for two (Resident # 1 and # 2) of three residents reviewed for medical services being provided per professional standards of care. The findings included: 1. Resident # 1 was admitted to the facility on 8/2/24 after undergoing surgery for a fractured hip on 7/30/24. Additionally. the resident had diagnoses of dementia, peripheral vascular disease, pulmonary fibrosis, emphysema, chronic kidney disease, benign prostate hypertrophy, hyperlipidemia, anemia, and protein calorie malnutrition. Resident # 1's admission Minimum Data Set assessment, dated 8/6/24, coded the resident as cognitively impaired and as needing substantial to maximum assistance with his hygiene needs. The resident was not assessed to have arterial or venous wounds. Resident # 1's care plan included the information that the resident had impaired mobility. Staff were directed on the care plan to perform a full body check weekly of his skin. This was added to the resident's care plan on 8/15/24. Review of skin assessments revealed on 8/17/24	F 684	F684 1-Resident #1 had treatments in place on 08/22/2024 for left heel, right heel, left first distal toe, and right great toe. Resident # 2 received a blood transfusion on 08/17/24. 2-Any resident with wounds has the potential to be affected by this deficient practice. 100% skin audit was completed on 8/26/32024 by Nurse Managers/ designee. All residents with wounds identified from 100% skin audit were validated to have correct treatments in place by` the Nurse Managers/ designee on 8/26/2024. Any resident that has labs ordered has the potential to be affected by this deficient practice. All residents orders were audited on 10/15/2024 to ensure lab orders were followed through for STAT and routine labs, placing in lab book, obtaining specimen and follow through with laboratory results to ensure labs were drawn on the date the physician ordered, and results are reviewed when results are obtained from the lab by the Nurse Managers/ designee. 3- All nursing staff will be in serviced on identification of wounds during ADL care and general observation, communication to nurse managers when identified ensuring appropriate treatments are ordered per physician, and documentation of wounds are completed by Assistant Director of Nursing/ designee. All nursing staff will be in serviced on the lab policy, to include ordering, placing in lab book, obtaining specimen and laboratory results to ensure STAT and routine labs were	

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F 684	Continued From page 10 Nurse # 1 documented the resident was checked for a skin assessment and found to have no issues. On 8/22/24 at 2:53 PM the former Wound Care Nurse documented the following information in a nursing note. The resident's RP (responsible party) had called that morning and requested the wound care nurse to look at the resident's two great toes. The former Wound Care nurse had assessed the resident and found him to have deep tissue injuries to bilateral great toes and also to his heels. Treatments were initiated on that date. On 8/22/24 an order was given to apply skin prep to the resident's great toes and bilateral heels. Resident # 1's RP was interviewed on 10/15/24 at 11:17 AM and again on 10/16/24 at 12:47 PM and reported the following information. She visited Resident # 1 one evening and looked at his feet. She saw that his toes had turned black. She mentioned it to a male staff member. She did not recall the staff member's name. The staff member informed her she needed to talk to a nurse. She went to the nursing desk and spoke to a Medication Aide. She did not recall the Medication Aide's name. The Medication Aide stated she would tell the nurse. She had been concerned that the message would not get passed on to the appropriate staff. Therefore, she called the next morning and spoke to the nurse, who was the Wound Nurse at that time. The Wound Nurse had not gotten any message and had not realized there was a problem. The evening she had first reported the resident's toes to the Medication Aide had been on the evening (8/21/24) before she talked to the Wound Nurse.	F 684	drawn on the date the physician ordered, and results are reviewed when results are obtained from the lab. If a lab is not resulted when reviewed facility will follow up with the lab by the Assistant Director of Nursing/ designee. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff. 4-A daily audit of wounds such as orders, notifications, skin checks, and assessments will be completed 5 days a week times twelve weeks to ensure identification, treatments are ordered, and documentation is completed by the Nurse Managers/ designee. A daily audit of labs will be completed 5 days a week times twelve weeks to ensure lab orders are place in lab book and followed through lab policy to include ordering, placing in lab book, obtaining specimen and follow through with laboratory results to ensure routine and STAT labs were drawn on the date the physician ordered, and results are reviewed when results are obtained from the lab by the Nurse Managers/ designee. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 11/08/2024	

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Review of staffing sheets revealed MA # 1 had worked on the 3:00 to 11:00 PM shift on 8/21/24 and was assigned to Resident # 1. MA # 1 was interviewed on 10/16/24 at 2:31 PM and reported the following information. She recalled Resident # 1's RP speaking to her one evening about the resident's feet. She did not recall the specific date. She recalled that the RP told her that the resident's toes were black. She (MA #1) went with the RP to look at the resident's feet and saw that the tip of one of his toes was black. She did not look at all of his feet and did not recall the RP saying anything about the resident's heels. She recalled she had told Nurse # 1.

Review of staffing sheets revealed Nurse # 1 had not worked on the date of 8/21/24.

According to staffing sheets, Nurse # 4 was the nurse who was covering for MA # 1 on the evening shift of 8/21/24. Nurse # 4 was interviewed on 10/17/24 at 3:58 PM and reported she had not been told about the resident's toes turning black. If she had been told this, then she would have done an assessment of the resident and taken action.

According to staffing sheets, NA # 1 had been assigned to care for Resident # 1 on the day shift and evening shift of 8/21/24. NA # 1 was interviewed on 10/15/24 at 3:05 PM and reported the following information. He did not recall being assigned to Resident # 1 on 8/21/24. He recalled assisting with him when other Nurse Aides were assigned to him. He did not recall any problems with his feet.

According to staffing sheets, NA # 2 had been

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assigned to care for Resident # 1 on the 11:00 PM to 7:00 AM shift which began on 8/21/24. An attempt was made to interview NA # 2 during the survey and he could not be reached for interview.

According to staffing sheets, Nurse # 2 had cared for Resident # 1 on the 11:00 PM to 7:00 AM shift which began on 8/21/24. Nurse # 2 was interviewed on 10/15/24 at 5:15 PM and reported she had only cared for the resident one or two times. She did not recall anyone mentioning to her that the resident's toes had turned black, and this had not been passed along in report to her.

The former facility Wound Care Nurse was interviewed on 10/15/24 at 2:06 PM and reported the following information. She did not learn about Resident # 1's skin problems from other staff members. She was told by the RP, who called her on the morning of 8/22/24. The RP called early, around 7:30 AM to 8:00 AM. Following the phone call with the RP, she went to do a full body assessment and found the resident had unstageable areas on his heels and also saw that the tips of both of his great toes were black. She obtained and initiated orders and ensured the resident would be seen the following day by the Wound Physician.

Review of the Wound Physician's notes revealed the resident was first seen by the Wound Physician on 8/23/24. The Wound Physician documented the following information. The resident had an arterial wound to the left heel that measured 5.5 cm (centimeters) X 6.5 cm X unmeasurable depth. The left heel wound was 100 % thick adherent black necrotic tissue (dead tissue). The resident had an arterial wound on his right heel. The right heel measured 4 cm X 6 cm

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X an unmeasurable depth. The right heel wound was also 100 % thick adherent black necrotic tissue. The resident had a deep tissue injury to his left first distal toe which measured 1 cm X 1.1 CM by unmeasurable depth. The skin was intact with purple/maroon discoloration. The resident had a deep tissue injury wound to his right great toe that measured 1.5 cm X 1.4 cm by unmeasurable depth. The skin was intact with purple/maroon discoloration. The Wound Physician noted the resident should follow up with a vascular surgeon as soon as possible as an outpatient.

On 8/23/24 at 1:24 PM Nurse # 3 documented in a nursing note that she had been in communication with the resident's vascular physician's office and they were to call back with an appointment.

Nurse # 3 was interviewed on 10/17/24 at 1:06 PM and reported the following information. She had been working as the Unit Manager at the time Resident # 1 resided at the facility. When the resident was first admitted to the facility, he had a scheduled appointment with a vascular physician, but the resident's RP decided to reschedule it. This had been discussed in the resident's first care plan meeting. When the facility's Wound Physician noted that the resident needed to see a vascular physician, she called the office to facilitate getting the resident worked into the earliest appointment they had. This did not take place before the resident was discharged.

Review of Resident # 1's record revealed a discharge summary which was not dated under the signature portion. It was signed by the facility

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social worker and Nurse # 3.

Interview with the facility social worker on 10/15/24 at 2:20 PM revealed the resident was discharged on 8/26/24.

During the interviews with Resident # 1's RP on 10/15/24 at 11:17 AM and again on 10/16/24 at 12:47 PM the RP reported the following information. She did not feel the facility was caring for the resident's feet and was worried about the wounds he had developed. She also felt the facility should have worked to ensure the resident was moving and his blood was circulating. Therefore, she asked for a discharge to be arranged for him. Once home on 8/26/24, she arranged to take him to his appointments. It was her hope that the resident would be able to undergo revascularization surgery so his feet wounds would heal, but he was not able to do so. She felt as if the staff had not cared for the resident's feet and observed that he was developing wounds prior to her finding them herself. She felt as if the delay and lack of care had led to him not being able to obtain timely medical care and possible revascularization.

A review of Resident # 1's 8/27/24 vascular clinic notes and 9/11/24 to 9/13/24 hospital records revealed the following information. Resident # 1 was seen on 8/27/24 by the vascular physician who noted the resident had critical limb ischemia (lack of oxygenated blood flow). The plan was for the resident to have a bilateral lower extremity angiogram (a test to determine blood flow) with possible angioplasty (a procedure to open blocked arteries), atherectomy (a procedure to remove plaque), and/or stenting (placing a tube in an artery to keep the artery open) for the

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ischemia to his feet. The vascular physician noted the resident would need to be hospitalized over night and the plan was for this to be done the following week. On 9/11/24 the resident was admitted to the hospital. During this time an arteriogram was conducted and showed the following results. The resident's entire right external and common iliac artery were occluded to the level of the aorta (the largest blood vessel in a person's body) and could not be recanalized (the process to restore blood flow). The entire left SFA (superficial femoral artery) and popliteal arteries were occluded. There was diminutive collaterals (this is when an individual's vascular system compensates for the blocked artery by forming alternate routes to bypass the blocked artery). The right SFA was patent with severe tibial disease. The arteriogram study noted, "unfortunately options severely limited." The resident's hospital discharge summary, 9/13/24, read "Unfortunately, no revascularization options for patient and he would be a poor surgical candidate overall for surgical revascularization. If patient were to develop infectious gangrene and/or uncontrollable pain, he would be offered bilateral above the knee amputations. Discussed with daughter and they would not want to pursue amputation. Discussions had about transitioning to hospice care given his underlying comorbidities and dementia and she was agreeable. Arrangements made for discharge home with hospice care.

The facility's Wound Physician was interviewed on 10/16/24 at 4:01 PM. During the interview, Resident # 1's angiogram results were discussed with the physician. The Wound physician reported the following. For someone to have occlusions in their arteries which extended all the way to the

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aorta, would indicate that the problem had developed many years prior. The resident would have probably been getting circulation to his feet from collateral blood flow. When the collateral blood flow also fails, then the resident can develop wounds. Usually when the collateral blood flow fails, wounds can develop from three to four days. Theoretically he would think someone would see the wounds as they started to show up as they were bathing him, but he did not know what else to comment regarding that. It was his medical opinion given the severity of the arterial disease that even if someone had identified the wounds on his feet on the first day that they appeared the outcome for the resident would have been the same.

Resident # 1's facility physician was interviewed on 10/16/24 at 3:24 PM and reported the following information. The resident's wounds were considered unavoidable vascular wounds secondary to the resident's severe peripheral artery disease. The rehab department was very good to help with mobility and ensure residents were moving as quickly as possible after surgery.

The facility's Administrator, who by profession is a nurse, was interviewed on 10/16/24 at 5:00 PM and reported the following information. She had just become employed as Administrator at the end of August, 2024. Since she had been Administrator the facility had taken action to make sure the facility was identifying and treating wounds.

2. Resident # 2 was admitted to the facility on 7/12/21. The resident's diagnoses in part included stroke, vascular dementia, and anemia.

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Resident # 2's quarterly Minimum Data Set assessment, dated 8/27/24, coded the resident as cognitively intact and as having an active diagnosis of anemia.

Review of physician orders revealed an order on 8/2/24 for a CBC (complete blood count) to be completed on 8/6/24.

On 8/6/24 the resident's CBC result revealed the resident's Hgb (hemoglobin) was 6.3. The lab result noted this was a critical level. (Normal is 14 to 18). The resident's Hct (hematocrit) was 22.4. (Normal is 42.0 to 52.0).

There was also documentation on the 8/6/24 lab report which noted the lab company had made multiple unsuccessful attempts by phone on 8/6/24 to notify the facility of the critical lab result and would try again in the morning.

Review of physician orders revealed an order on 8/7/24 to collect a CBC on 8/8/24.

On 8/8/24 Nurse # 3 documented in a nursing note that Resident # 2's labs were reviewed with the physician and orders received for a CBC on 8/8/24 and 8/13/24.

Review of physician orders revealed an order on 8/8/24 to draw a CBC on 8/13/24. (This order was in addition to the order already written for the CBC to be done on 8/8/24).

Following the order on 8/8/24 nine days lapsed without any documentation in the progress notes the facility was attempting to verify if the resident's lab results showed the resident's Hgb and Hct had dropped further following the already

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critical value reported to them.

The first CBC lab result after the resident was to have the CBC drawn on 8/8/24 was nine days later on the date of 8/17/24. The result showed the resident's Hgb and Hct had dropped further. Specifically, the resident's Hgb was 5.6. His Hct dropped to 20.1.
Review of orders revealed the physician ordered the resident to be sent to the hospital on 8/17/24 once the resident was identified to have a further decrease in his Hgb and Hct.

A hospital discharge summary, dated 8/21/24, revealed the following information. The resident had been hospitalized from 8/17/24 to 8/21/24. The hospital physician noted the resident was alert but a poor historian in regards to reporting his medical history. The resident's discharging main diagnosis was severe anemia. The resident underwent diagnostic tests while hospitalized which revealed no gastrointestinal bleeding. He was transfused with an improvement of his hemoglobin and discharged back to the facility.

Nurse # 3 was interviewed on 10/17/24 at 1:06 PM and reported the following information. She had been working as the Unit Manager when Resident # 2's blood work was due to be drawn in August 2024. She had spoken to the physician about the low Hgb on 8/8/24. At the time, the resident was stable and not showing problems related to a low Hgb. The physician wanted it redrawn. The facility kept a book with labs that were to be drawn each day with a lab requisition. The phlebotomist routinely came in early every morning, referenced the book, and knew which blood samples to drawn. Resident # 2's name was in the book for 8/8/24 and initialed by the

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phlebotomist as drawn on that date. Therefore they had not questioned that it had been drawn on 8/8/24. The Unit Manager was interviewed regarding the long timeframe between when the facility knew the resident had a critically low Hgb and the time it took for the facility to repeat a critical lab and therefore know if his Hgb was continuing to drop. The Unit Manager reported the facility was waiting for the result and she did not recall hearing from the lab that there was any problem with the lab needing to be redrawn. She also reported the resident had not been reporting or showing symptoms while they were waiting.

Two employees of the facility's lab company were interviewed by phone on 10/17/24 at 9:26 AM and verified that the first successful lab result following the order on 8/8/24 was on the date of 8/17/24. At that time (8/17/24) the Hgb value was critical. There had been trouble with lab specimens drawn on 8/9/24 and 8/12/24 which contributed to the specimens not being able to yield a result. The lab employees reported attempts were made to convey the critical results to the facility on the day the result was determined to be critical. According to the lab employees the facility was routinely told about problems with the specimen so the facility could take action by putting in a requisition in their facility lab book for the lab to be repeated. The book is located at the facility and is referenced daily by the phlebotomist. According to the lab employees this would have enabled the facility to get a successful result back sooner so they could determine if the resident's Hgb was continuing to drop. Otherwise the facility would have to wait until the lab's internal system generated a redraw request to the phlebotomist.

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F 684	Continued From page 20 Interview with Resident # 2's physician revealed the resident had not been symptomatic with the low Hgb and there had been no negative problem due to the delay in getting the redraws done. Interview with the Administrator on 10/16/24 at 3:00 PM revealed she had not been the Administrator at the time of Resident # 2's failed lab attempts and lack of follow up by the staff who were to be monitoring the resident's critical values. She was trying to call and talk to the lab company but they were not giving her a lot of information about the delay in getting the labs.	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. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with resident and staff, the facility failed to identify a resident, for whom they were accountable, was missing from the facility. The resident left the facility and returned home without anyone realizing she was missing until the day following her departure. This was for one (Resident #9) of one resident reviewed for supervision. The findings included: Resident # 9 was admitted to the facility on 8/21/24. Review of Resident # 9's hospital	F 689	F689 1-Per 2567 the facility failed to identify a resident was missing from the facility. The resident left and returned home without anyone realizing the resident was missing until following day of resident departure. Resident #9 no longer resides in the facility. The ADON of the Facility did contact the resident to ensure she arrived home safely with her friend□s assistance and stated she had what she needed and	11/8/24

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discharge summary, dated 8/21/24, revealed the following information. The resident had spinal stenosis and had been identified to have a bulging disc resulting in lower extremity weakness and recurrent falls. The discharging hospital physician recommended the resident go to a rehabilitation facility for therapy and the resident was in agreement. Additionally, the resident had diagnoses which in part included a history of stroke without any residual effects, hyperthyroidism, depression, chronic obstructive pulmonary disease, and insomnia.

Review of Resident #9's facility admission MDS (Minimum Data Set) assessment, dated 8/27/24, revealed the resident was cognitively intact.

Review of Resident # 9's last skilled nursing progress note revealed it was dated 8/27/24 at 4:22 PM and made no mention of the resident discharging home. The note indicated the resident was at the facility.

Review of Resident # 9's August 2024 Medication Administration Record revealed Nurse # 5 had documented Resident #9 was in the hospital beside duties or observations she was accountable for performing during the night shift which began on 8/27/24 at 11:00 PM.

Review of an occupational therapy (OT) discharge summary, signed on 8/28/24, revealed the resident had received OT from 8/22/24 to 8/27/24. Her prior living arrangements before hospitalization included that she had lived in a one- story home which had a ramp entrance. A walk- in shower was in her bathroom. She had been independent in her activity of daily living activities and had a home health aide who visited

knew how to set up home health and therapy services herself.
2-Facility ADON immediately ran a census and completed audit/safety check of all current residents in the facility on 8/28/2024 to ensure all residents were accounted for with all residents accounted for.
3-The Administrator/designee will complete education with all staff regarding the facility AMA procedure, missing resident/elopement protocol, notifications, how to keep wandering residents safe, and the importance of rounding frequently during their shift to visibly see their residents by the Administrator or designee by 11/8/24. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff.
4-To ensure ongoing compliance the Administrator and or designee will review the midnight census and conduct weekly room to room census audits to ensure 100% compliance of all residents are accounted for x 12 weeks. On 11/6/20245 the Administrator will initiate and audit tool randomly picking 3 staff members a week x 12 weeks to continue review of AMA procedure, elopement protocol/missing resident to monitor and ensure staff competency. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns.
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her twice per week. She also had transportation if needed. On the date of 8/27/24 (the date of last facility therapy) the resident was documented as needing "supervision or touching" for dressing, bathing, and toileting.

Review of a physical therapy discharge summary revealed as of 8/27/24 the resident was able to walk 50 feet while making turns and while using a two wheeled walker. On 8/27/24 she needed supervision or touching for transfer assistance.

Resident # 9 was interviewed via phone on 10/21/24 at 10:26 AM and reported the following information. While residing at the facility, she had been requesting to go home and no one had helped her. The facility staff had moved her to a new room, thinking that would make her happy at the facility, but she wanted to go home. The new room did not help. She was a retired nurse and had decided therapy at home would be better. On 8/27/24 she had specifically spoken to the Assistant Director of Nursing and let her know she wanted to leave that day. She was told that someone would get back to her. She waited and waited, and no one came to discuss helping her go home. That evening her friend came to visit. Since no one had helped her, she then decided to just leave with her friend's assistance. She had her own rollator walker, and she had gone part way to leave. While still in the hallway, a nurse (name unknown to the resident) walked up to her to try to give evening medications which were due. She let the nurse know she did not want to take them in the hallway, and the nurse replied she would leave the medications in her room. The nurse then walked away. She did not tell the nurse she was leaving. She just went ahead and left and walked out the front door with her friend.

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At the time the front door was unlocked and no one stopped her or asked what she was doing. It was around 8:00 PM. She safely got home with her friend's assistance and had what she needed. She knew how to set up home health therapy services herself and did that independently. The facility called her the next day to see where she was. No one called her before that time.

Nurse # 2 had been assigned to care for Resident # 9 on the 3:00 to 11:00 PM shift on 8/27/24. Nurse # 2 was interviewed on 10/21/24 at 2:00 PM and reported the following information. Resident # 9 had not gone home AMA (against medical advice) on her shift nor had she signed anything that she was leaving. She (Nurse #2) had checked on the resident shortly before the end of her evening shift and the resident was at the facility. Resident # 9 had been assigned to another room earlier on the date of 8/27/24. The resident's new room had been on a different hall than her former room and during shift report she told Nurse # 5, to whom she was reporting off, that the resident had been moved. Nurse # 5 did not want to make walking rounds with her at 11:00 PM and therefore they did not go together and look in on Resident # 9 at shift change. If Nurse # 5 had agreed to do so, then she would have made walking rounds, and it would have been clear that the resident was there and in her new room. The next day the former DON was asking about the resident being missing. Nurse # 5 had taken responsibility for the resident at 11:00 PM on 8/27/24. She (Nurse # 2) learned that Nurse # 5 had reported to the former DON that she (Nurse # 2) had said in shift change report that Resident # 9 was in the hospital. She (Nurse # 2) never told Nurse # 5 the resident was in the hospital and Nurse # 5 was not being honest.

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Nurse Aide (NA)# 3 had been assigned to care for Resident # 9 on the 3:00 to 11:00 PM shift on 8/27/24. NA # 3 was interviewed on 10/22/24 at 12:05 PM and reported the following information. She had made rounds during her shift and checked on Resident # 9. She had last seen the resident around 10:45 PM in her room going through papers with the light on in her room. Earlier in the evening she saw someone visiting Resident # 9, but she did not see the resident leave with the friend. At 9:00 PM the front door of the facility is locked, and staff must enter a code in order to open it and allow people to enter and leave. The following day (8/27/24) she (NA # 3) received a phone call from the former DON (Director of Nursing). The phone call from the former DON was at a time past 9:00 AM. The former DON seemed frantic and wanted to know when the resident had left. She (NA # 3) had let the former DON know she had not seen the resident leave and the resident was there on her shift.

Nurse # 5 had been assigned to care for Resident # 9 on 8/27/24 starting at 11:00 PM and ending at 7:00 AM on 8/28/24. Nurse # 5 was interviewed on 10/21/24 at 2:39 PM and reported the following information. Based on her understanding from shift change report on 8/27/24 at 11:00 PM, Resident # 9 had been sent to the hospital. That is what she recalled was told to her.

NA # # 4 had been assigned to care for Resident # 9 on the shift which began at 11:00 PM on 8/27/24 and ended at 7:00 AM on 8/28/24. An attempt was made to interview NA # 4 on 10/23/24 at 11:39 AM about the occurrences of

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her shift on the night of 8/27/24 and the NA could not be reached.

The Administrator and Corporate Nurse Consultant were interviewed on 10/23/24 at 12:09 PM and reported the following information. The former DON had made notations about her investigation into the missing resident and noted that NA # 4 reported during the facility's investigation that the resident had not been seen on the 11:00 PM to 7:00 AM shift which began on 8/27/24.

The ADON (Assistant Director of Nursing) was interviewed on 10/21/24 at 5:00 PM and again on 10/22/24 at 1:22 PM and reported the following information. There had been several nurses who had left the facility recently and seemed to have personal issues with other staff members. Regarding Resident #9 leaving, she (the ADON) had spoken to Resident # 9 sometime on 8/27/24 and the resident had mentioned wanting to go home, but the resident had not indicated any urgency to the matter or that she was planning to leave that day. She (the ADON) always tried to tell the social worker right away about requests for discharge so that she would not forget. She thought she had mentioned to the social worker on 8/27/24 that the resident was wanting to go home. The next morning (8/28/24) during clinical morning meeting, which is attended by administrative staff members, it came up that the resident was gone. She could not recall who had reported it. She was shocked because the resident had not indicated she was going to leave. She called and talked to the resident at home. The resident was short in her answers but let her (the ADON) know that she was okay and had home health and all her follow- up

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F 689	Continued From page 26 appointments handled herself. The Administrator was interviewed on 10/22/24 at 12:54 PM and reported the following information. The date of 8/27/24 was either her first or second day as the Administrator, and she had not been made aware of any problems Resident # 9 was having. The staff had called the resident on 8/28/24 after they found out she left without discharge arrangements and made sure she was okay. The facility had conducted an investigation into the matter of what had occurred that might have contributed to the resident being missing for a time period without anyone knowing she was gone. Based on staff member's interviews, the facility could not identify exactly when the resident left. The front door did lock at 9:00 PM so someone would have needed staff assistance to enter or exit after that time. The Administrator further reported it was important to be honest in what had occurred which allowed Resident # 9 to leave without anyone knowing, and she felt some of the staff were not being honest, which had in turn made it difficult to determine what had transpired.	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §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(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		11/8/24

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F 755	Continued From page 27 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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §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: Based on record review and interviews with staff, pharmacist and physician the facility failed to ensure a resident's medications were available for administration for one (Resident # 9) of one sampled resident reviewed for medication administration. The findings included: Resident # 9 was admitted to the facility on 8/21/24. Two of the resident's diagnoses included insomnia and hyperthyroidism. Review of nursing notes revealed Resident # 9 arrived at 5:15 PM on the date of 8/21/24. Review of Resident #9's admission MDS (Minimum Data Set) assessment, dated 8/27/24,	F 755	F755 1- Resident #9 received her Temazepam and Methimazole on 08/23/2024. 2-All residents have the potential to be affected by this alleged deficient practice; no other residents were identified as being negatively impacted after an audit initiated at 100% on all residents within the facility completed on 10/18/2024 by the Nurse Managers/ designee. Pharmacy conducted a QA plan and reeducation to prevent future occurrences. 3-All licensed staff were educated on the requirements of F755; specifically, the nursing staff on the importance of the availability of medications and to be given	

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F 755	Continued From page 28 revealed the resident was cognitively intact. Review of Resident #9's orders and August 2024 MAR (Medication Administration Record revealed the following information: On 8/21/24 Resident # 9 was ordered to receive Methimazole 10 mg (milligrams) daily for hyperthyroidism. The first dose that was documented as administered was on the date of 8/23/24. Nurse # 6 did not document a check mark on the date of 8/22/24 indicating the methimazole was given. The date of 8/22/24 was the first date the daily methimazole was due following the resident's admission date of 8/21/24. On 8/21/24 Resident # 9 was ordered to receive Temazepam 30 milligrams every night for insomnia. The MAR showed the medication was scheduled to be given every night at 9:00 PM. The MAR was blank on the first night of the resident's admission (8/21/24). On 8/22/24 Nurse # 7 documented the facility was awaiting the medication to be delivered from the pharmacy. The first night the Temazepam was administered was documented on 8/23/24. Resident # 9 was interviewed on 10/21/24 at 10:26 AM and reported the following information. The facility didn't have all her medications when she was admitted. She did not recall all of the medications but knew one was her sleeping pill. She had been having problems for a long time with sleeping and had been accustomed to getting the medication. She felt the facility should have had a better system to get her medication for her. A Pharmacist, who works with the pharmacy	F 755	as ordered, and if not available to notify the Director of Nursing and send script to a backup pharmacy to prevent any delay of medications. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff. This in service will be completed by the Assistant Director of Nursing / designee. The facility completes daily medication availability audit 5 days a week. 4-The DON or designee will monitor daily (5 days a week) all new orders for medication to ensure the medications have arrived in the facility and are given as ordered. A medication availability audit tool was implemented and will be completed daily (5 days a week). This audit is given to the Administrator. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns.	

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company that supplies the facility's medications, was interviewed on 10/23/24 at 8:27 AM and reported the following information. The pharmacy did not receive Resident # 9's orders for medications until the day following her admission, on 8/22/24 at 2:30 PM. The orders were transmitted to the pharmacy at that time. The pharmacy typically did two runs (deliveries). If the pharmacy received orders by 7:30 PM then they routinely sent medications out that same day. If a facility needed medications after 7:30 PM, the facility staff could call and speak to a pharmacist and they would arrange delivery. If the pharmacy company had received the orders when the resident was admitted on 8/21/24 at 5:15 PM, then they would have sent Resident # 9's medications without the facility having to call. Some medications were kept at the facility for emergency purposes. He knew Temazepam would not have been in the facility's emergency supply. He did not think that methimazole was kept at the facility either, and reported he would check. He did not know there had been a problem with the delivery of Resident # 9's medications until the day before (10/22/24). On 10/22/24 he started to look into the problem and learned some details (in addition to the problem of the pharmacy receiving the orders late) that had also contributed to a delay in getting Resident # 9's medications to the facility. The pharmacy used a third- party courier to deliver medications to facilities. On 8/22/24 the pharmacy had packaged Resident # 9's medications correctly and labeled them correctly. The medications should have left the pharmacy at 9 PM and been delivered to the facility around 2 AM. The courier had tried to deliver the medications to the wrong facility although the medications had been marked correctly. That

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wrong facility had rejected the delivery. The courier did not alert a pharmacist that there had been a problem (rejection by the wrong facility). There was a place at the pharmacy where a rejected delivery could be dropped back off at the pharmacy by the courier, and the pharmacy would know to look for any delivery problems. If Resident # 9's medications had been left at that designated place, then a pharmacist would have noted the problem and sent the medications stat (right away) to the facility the next morning when they arrived. He was still looking into the matter and trying to find out what happened. He thought the courier might have possibly handed off the bag to another courier or kept it for another delivery without involving the pharmacy. He was not sure at that point. The pharmacy records showed the Temazepam did not get delivered till 8/24/24 at 2:00 AM. The pharmacy had sent two supplies of the methimazole to the facility. The first was a partial fill because they could not fill the entire prescription. The first partial fill also got delivered on 8/24/24 at 2:00 AM and had been part of the temporarily lost medications. Not knowing the first supply had gotten lost but realizing the pharmacy still needed to send the last supply of the methimazole, the pharmacy sent the second half of the methimazole on 8/23/24 on a first run to the facility. The pharmacist reported that he would need to talk to the third- party carrier and inform them that the couriers needed to alert the pharmacy when a delivery was rejected by a facility so they could determine what needed to be done. The Pharmacist also said they had no notes regarding whether the facility had called to question why the resident's medications had not arrived.

During a follow up interview with the Pharmacist

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on 10/23/24 at 3:06 PM the Pharmacist reported he had verified the facility did not keep methimazole in their emergency supply and therefore the nurses would not have had any methimazole to give the resident on 8/22/24 when Nurse # 6 was scheduled to administer the medication.

The former Unit Manager for Resident # 9's unit was interviewed on 10/23/24 at 10:25 AM and reported the following information. She had entered Resident #9's orders into the computer system prior to the resident arriving on 8/21/24. The orders were put on hold in the computer system until the resident arrived. Once the resident arrived at the facility, then the admitting nurse should have transmitted the orders to the pharmacy for processing. She was not present when the resident arrived.

Record review revealed Nurse # 8 was the admitting nurse for Resident # 9. An attempt was made to interview Nurse # 8 on 10/23/24 at 11:34 AM, and the nurse could not be reached.

Nurse # 6 was interviewed on 10/23/24 at 11:29 AM and reported the following. She could not recall the specifics related to Resident # 9's missed dose of methimazole on 8/22/24. Nurse # 6 reported it was her routine that if when a medication was not available she would tell the unit manager and call the pharmacy.

An attempt was made to interview Nurse # 7 on 10/23/24 at 10:34 AM and the nurse could not be reached. (This was the nurse who charted she was awaiting the delivery of the Temazepam).

Interview with Resident # 9's physician on

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F 755	Continued From page 32 10/23/24 at 12:50 PM revealed missing one dose of methimazole would not be significant. The physician reported it took several weeks of daily administration to change a person's blood level.	F 755		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and the facility's lab company employees, the facility failed to ensure there was effective communication between facility staff and the lab company to avoid a lapse of multiple days between a failed lab draws and the next attempt to obtain a successful lab result for a physician ordered lab. This was for one (Resident # 2) of three residents whose labs were reviewed. The findings included: Resident # 2 was admitted to the facility on 7/12/21. The resident's diagnoses in part included stroke, vascular dementia, and anemia. Review of physician orders revealed an order on 8/2/24 for a CBC (complete blood count) to be completed on 8/6/24. On 8/6/24 the resident's CBC result revealed the	F 770	F770 1-. Resident # 2 received a blood transfusion on 08/17/24. 2- Any resident that has labs ordered has the potential to be affected by this deficient practice. All residents□ orders were audited on 10/15/2024 to ensure STAT and routine lab orders were followed up on and results were reviewed by the Nurse Managers/ designee. 3- All nursing staff will be in serviced on lab policy to include ordering, placing in lab book, obtaining specimen and follow through with laboratory results to ensure labs were drawn on the date the physician ordered, and results are reviewed when results are obtained from the lab by the Assistant Director of Nursing/ designee. This in-service will be part of the orientation process for all newly hired	11/8/24

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F 770	Continued From page 33 resident's Hgb (hemoglobin) was a 6.3. The lab result noted this was a critical level. (Normal is 14 to 18). The resident's Hct (hematocrit) was 22.4. (Normal is 42.0 to 52.0). There was also a documentation on the 8/6/24 lab report which noted the lab company had made multiple unsuccessful attempts by phone on 8/6/24 to notify the facility of the critical lab result and would try again in the morning. Review of physician orders revealed an order on 8/7/24 to collect a CBC on 8/8/24. On 8/8/24 Nurse # 3 documented in a nursing note that Resident # 2's labs were reviewed with the physician and orders received for a CBC on 8/8/24 and 8/13/24. Review of physician orders revealed an order on 8/8/24 to draw a CBC on 8/13/24. (This order was in addition to the order already written for the CBC to be done on 8/8/24). The first CBC lab result after the resident was to have the CBC drawn on 8/8/24 was nine days later on the date o 8/17/24. The result showed the resident's Hgb and Hct had dropped further. Specifically, the resident's Hgb was 5.6. His Hct dropped to 20.1. Review of orders revealed the physician ordered the resident to be sent to the hospital on 8/17/24. A hospital discharge summary, dated 8/21/24, revealed the resident's discharging main diagnosis was severe anemia. The resident underwent diagnostic tests while hospitalized which revealed no gastrointestinal bleeding. He was transfused with an improvement of his	F 770	licensed nursing staff and agency staff. 4- A daily audit of lab results, orders, date physician notified, and any new orders will be completed 5 days a week times twelve weeks to ensure lab orders are placed in lab book and followed through timely by the Nurse Managers/ designee. The results of these audits/ concerns will be tracked and trended then forwarded to the Quality Assurance Performance Improvement committee monthly times three by the Director of Nursing/ Administrator/ designee to ensure solutions are sustained and to address any concerns. 11/08/2024	

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hemoglobin and discharged back to the faciity.

Two employees of the facility's lab company were interviewed by phone on 10/17/24 at 9:26 AM. The first employee reported the following information. The blood sample for the ordered 8/8/24 lab did not show up in the lab's records as drawn until 8/9/24. There were notes that the resident was a "hard stick," the sample was cloudy, and the sample needed to be recollected. When this occurs then the lab routinely makes a call to the facility to alert them there was a problem with the sample. The facility can then put the blood draw back in the book located at the facility and which the plebotimist references when she arrives to draw blood. That way the blood draw can occur the next day following a poor sample. They also send a message internally within their lab company that a redraw needs to be done. The redraw is processed on their end and the plebotomist gets a message internally also. Following the unsuccesful blood draw on 8/9/24, the next sample was drawn on 8/12/24. The lab's records showed this 8/12/24 blood sample was a "short sample" and again it could not be used. The next sample was then drawn on 8/17/24 and yielded a successful result. During the phone interivew, the lab employee then transferred the surveyor to the second employee, who was in the department which managed recollections. This second employee reported the following information. In the lab company's recollection department, their records showed they received a message on 8/10/24 that the sample had been clotted and needed to be drawn. They put in a requistion for the plebotomist to do a redraw. The next redraw was done on 8/12/24. The sample was "short." The next recollection time was on 8/17/24. Therefore,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 770	Continued From page 35	F 770		

it was validated that the first CBC result was on 8/17/24 after it was ordered to be done on 8/8/24. This second employee also reported when there was a problem with the lab specimen that they routinely called the faclity. The second employee did not have records of communication with the facility. They did not routinely keep records of communication with the facilities due to the high volume of labwork they do. The second employee also reported they routinely reached out to the facility if there was a problem with a blood specimen. If no one picked up the phone and the phone was directed to a generic voice mail, then the lab company was not able to leave a message on a generic voice mail.

Nurse # 3 was interviewed on 10/17/24 at 1:06 PM and reported the following information. She had been working as the Unit Manager when Resident # 2's blood work was due to be drawn in August 2024. She had spoken to the physician about the low Hgb on 8/8/24. At the time, the resident was stable and not showing problems related to a low Hgb. The physician wanted it redrawn.
The facility kept a book with labs that were to be drawn each day with a lab requistion. The phebotomist routinely came in early every morning, referenced the book, and knew which blood samples to drawn. Resident # 2's name was in the book for 8/8/24 and intialed by the phlebotoimst as drawn on that date. They had waited for the result and she did not recall hearing from the lab that there was any problem with the lab needing to be redrawn. The receptionist was present at the facility until 8:00 PM daily. If the lab had called and the receptionist had forwarded the call to the nursing desk without a nurse being able to pick up, then the

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	345317	A. BUILDING _____ B. WING _____	C 10/23/2024

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F 770	Continued From page 36 receptionist always walked to the nursing desk to find someone to take the call. Interview with Resident # 2's physicain revealed the resident had not been symptomatic with the low Hgb and there had been no negative problem due to the delay in getting the redraws done. Interview with the Administrator on 10/16/24 at 3:00 PM revealed she had not been the Administrator at the time of Resident # 2's failed lab attempts and she was trying to call and talk to the lab company but they were not giving her a lot of information about the delay in getting the labs.	F 770		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(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(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential	F 842		11/8/24

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F 842	Continued From page 37	F 842		

all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

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

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

§483.70(h)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

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F 842	Continued From page 38 (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and resident interview the facility failed to ensure a resident's record accurately reflected a resident's signature on a form indicating the resident left the facility against medical advice. This was for one (Resident # 9) of one sampled resident who had documentation the resident left against medical advice. The findings included: Resident # 9 was admitted to the facility on 8/21/24. Review of Resident #9's admission MDS (Minimum Data Set) assessment, dated 8/27/24, revealed the resident was cognitively intact. Review of Resident # 9's orders revealed no discharge orders. Review of the record revealed a form entitled "Statement of Resident Releasing Facility from Liability Upon Leaving Facility Against Medical Advice." The form included a signature that was not clearly legible and which appeared by "resident signature." It was dated 8/27/24 at 8:57 PM indicating the resident had left the facility against medical advice on the evening of 8/27/24. There were two witnesses signatures on the form. One signature was not clear and the second appeared as the former Unit Manager. Interview with Resident #9 on 10/21/24 at 10:26 AM revealed she had left the facility around 8 PM	F 842	F842 1-Resident #9 had their AMA form filled out on 08/28/24. 2-Any resident that leaves AMA has the potential to be affected by this deficient practice. Any AMA's for the past month were reviewed to ensure the AMA paperwork was completed properly by Nurse Managers/ designee on 11/5/2024. 3-All staff will be in serviced on proper completion of an AMA form by the Assistant Director of Nursing/ Designee. This in-service will be part of the orientation process for all newly hired licensed nursing staff and agency staff. 4-A daily audit (5 days a week) will be completed to ensure that the AMA will be completed correctly by the Administrator/ designee times twelve weeks. The results of this audit will be addressed and reported to the Quality Assurance Performance Improvement (QAPI) Committee by the Administrator for review monthly x 3 months or until substantial compliance is achieved then quarterly.	

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F 842	Continued From page 39	F 842		

on 8/27/24 without signing any paperwork. She had asked staff to assist her to go home prior to that time and when staff had not assisted her, she left with a friend on the evening of 8/27/24. Resident # 9 further reported staff did not try to stop her and she walked out the door without anyone questioning her or asking her to sign anything. She went home and did not receive a phone call till the next day from the facility wanting to know where she was.

Interview with a corporate Nurse Consultant on 10/23/24 at 12:09 PM revealed the former DON and Assistant Director of Nursing had called the resident to make sure she was okay on the date of 8/28/24. The Nurse Consultant reported the former DON (Director of Nursing) had dealt with investigating why the resident had left and how she had left without anyone knowing. The Nurse Consultant reported the form in the resident's medical record should have been filled out correctly to reflect that the discharge against medical advice was verified by a phone call to the resident on the date of 8/28/24.