

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 065394	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/06/2024
NAME OF PROVIDER OR SUPPLIER Bruce McCandless CO State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 903 Moore Dr Florence, CO 81226	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>Based on record review and interviews, the facility failed to take steps to protect two (#35 and #36) of two residents reviewed for abuse out of 34 sample residents.</p> <p>Specifically, the facility failed to prevent a physical altercation between Resident #36 and Resident #35.</p> <p>Findings include:</p> <p>I. Facility policy</p> <p>The Abuse policy, revised 10/16/23, was provided by the nursing home administrator (NHA) on 1/22/24 at 2:30 p.m. It read in pertinent part, Every resident has the right to be free from mistreatment, abuse, neglect and exploitation.</p> <p>Staff will receive annual education in prevention of abuse and include the following topics: Understanding behavioral symptoms of residents that may increase the risk of abuse and neglect, such as aggressive reactions of residents, outbursts or yelling out, and difficulty in adjusting to new routines or new staff.</p> <p>Identification of Abuse/possible indicators of abuse: physical abuse of a resident is observed; and verbal abuse of a resident is overheard.</p> <p>Residents at risk for abuse situations are identified and appropriate care plans are developed.</p> <p>If a resident experiences a change in behavior resulting in aggression towards other residents, the facility conducts further psychiatric evaluation and revisions to the care plan to reduce or eliminate chances for abuse. Recommendations for appropriate intervention can be implemented.</p> <p>Resident roommates are selected or changed to reduce any identified risk of resident-to-resident conflict or abuse.</p> <p>Protection of Residents: the facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Residents involved in the allegation of abuse will be separated by staff.</p> <p>Providing emotional support and counseling to the resident during and after the investigation, as needed.</p> <p>II. Incident of physical abuse between Resident #36 and Resident #35 on on 5/21/24</p> <p>The witness, activities director (AD) documented he saw Resident #36 and Resident #35 have a verbal altercation and Resident #36 slapped Resident #35 on the back of her hand.</p> <p>A nurse progress note for Resident #35, dated 5/21/24, revealed an altercation occurred with Resident #36.</p> <p>A nurse progress note for Resident #36, dated 5/21/24, revealed an altercation occurred with Resident #35.</p> <p>The altercation occurred in the activities room and was witnessed by staff. Staff immediately interviewed and separated Resident #36 and Resident #35.</p> <p>The 5/21/24 nurse progress note documented in Resident #35's electronic medical record (EMR) revealed she had redness on the back of her hand and said she was not fearful of Resident #36.</p> <p>-However, a nurse assessment completed on 5/21/24 documented Resident #35 did not have any visible injury/bruising (see record review below).</p> <p>According to the facility investigation, the abuse was substantiated.</p> <p>III. Resident #35</p> <p>A. Resident status</p> <p>Resident #35, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included right-side paralysis, stroke, and hearing loss.</p> <p>The 4/24/24 minimum data set (MDS) assessment documented Resident #35 had severe cognitive impairments with a brief interview for mental status (BIMS) score of seven out of 15. She needed set-up assistance from staff for eating and hygiene. She required supervision and touching assistance from staff for transfers and bed mobility. She required substantial assistance from staff for dressing and bathing.</p> <p>The assessment documented Resident #35 had no behavioral symptoms.</p> <p>B. Record review</p> <p>The 5/21/24 nurse assessment documented Resident #35 had no visible injury/bruising and denied pain. Resident #35 told staff she was not fearful of Resident #36.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-However, a nurse progress note on 5/21/24 documented the resident had redness on the back of her hand.</p> <p>The 5/22/24 social services progress note, documented at 2:31 p.m., revealed the social worker educated Resident #35 to let staff assist her with her needs to prevent further altercations. The social worker documented the resident was not fearful and did not feel threatened by Resident #36.</p> <p>Resident #35's psychosocial well-being care plan, initiated on 7/26/23 and revised on 4/23/24, revealed Resident #35 had adjustment issues from her admission to the facility. Interventions included: encouraging the resident to participate in activities of choice and facilitate attendance as required and learning to recognize and help the resident identify the stressors that may be early warning signs of problem behavior. Intervene and remove stressors where possible.</p> <p>On 5/22/24, a referral was made to occupational therapy to evaluate the resident for communication strategies for the resident due to hearing/vision deficits.</p> <p>IV. Resident #36</p> <p>A. Resident status</p> <p>Resident #36, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included unspecified dementia and major depression.</p> <p>The 3/6/24 MDS assessment documented Resident #36 had severe cognitive impairments with a BIMS score of seven out of 15. He was independent for transfers and bed mobility. He required partial assistance from staff for dressing, personal hygiene and toileting.</p> <p>The assessment indicated Resident #36 had verbal behavioral symptoms directed toward others and wandering behavior.</p> <p>The MDS assessment documented Resident #36 had verbal behavioral symptoms for one to three days during the assessment period.</p> <p>B. Record review</p> <p>The record review documented in nurse progress notes, behavior-tracking flowsheets and on the care plan that Resident #36 had behaviors of agitation and frustration before the altercation on 5/21/24.</p> <p>The 5/21/24 nurse progress note documented Resident #35 had an altercation with Resident #36. The altercation led to Resident #36 slapping Resident #35 on the back of her hand.</p> <p>Resident #36's behaviors and responses to interventions were documented in nurse progress notes and behavior-tracking flowsheets. A review of the behavior tracking in Resident #36's EMR (from 3/15/24 to 6/5/24, the resident had 19 episodes of agitation and frustration.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #36's behavior care plan, initiated on 2/28/24 and revised on 4/8/24, revealed the resident had a history and current behaviors of being verbally aggressive towards other residents and staff with threats of physical aggression related to dementia, ineffective coping skills and poor impulse control. Interventions included analyzing and documenting key times, places, circumstances, triggers, and what de-escalates behaviors assessing and anticipating Resident #36's needs and compliance with oxygen use, placing on 15-minute checks for safety and attempting to divert Resident #36's attention from other residents/situations that could trigger his behavior.</p> <p>On 5/21/24 the nurse progress note documented the altercation occurred in the activities room and was witnessed by staff. Staff immediately interviewed and separated Resident #36 and Resident #35.</p> <p>After the altercation, on 5/21/24, the resident's physician completed a medication evaluation and increased the prescribed Divalproex 250 milligrams (mg) from one tablet daily to two tablets.</p> <p>IV. Staff interviews</p> <p>Certified nurse aide (CNA) #4 was interviewed on 6/6/24 at 12:05 p.m. CNA #4 said she worked in the facility for approximately two years and worked on the unit where Residents #35 and #36 resided. She said she knew there was an altercation between Resident #35 and #36 on 5/21/24 but she had not seen any behavioral concerns between them after the altercation. CNA #4 said Resident #36 did not seek out any residents and she had not heard Resident #36 threaten any other resident. CNA #4 said Resident #36 had a personality that led him to be short with staff and when other residents walked past his room or stopped in his doorway. She said Resident #36 shouted out to them to leave his space. CNA #4 said Resident #36 was on a guardian program and staff observed his activity and mood every 15 minutes. She said Resident #36 spent most of his time in his room and the dining room. She said when Resident #36 went to the dining room, she followed him and continued the fifteen-minute observations.</p> <p>RN #4 was interviewed on 6/6/24 at 12:45 p.m. RN #4 said Resident #36 had a history of behavior concerns that included yelling at staff and the residents. She said Resident #36 was frustrated because his spouse was also a resident in the facility and she preferred not to share the same room. RN #4 said Resident #36 expressed his frustration by yelling out and did not understand that his behavior could be intimidating to others. RN #4 said staff were aware of the care needs of Resident #36 and worked to eliminate stressors and tried to keep him involved in structured activities.</p> <p>RN #4 said Resident #35 had no injury from the 5/21/24 altercation and reported to staff that she was not fearful of Resident #36. RN #4 said staff knew Resident #35 had a hearing loss and assisted the resident to her preferred seating in the dining room.</p> <p>The NHA was interviewed on 6/6/24 at 9:25 a.m. The NHA said Resident #36 had been a resident at the facility since August 2022. The NHA said Resident #36 had difficulty living in the facility and wanted his spouse to share the same room with him. The NHA said Resident #36's spouse did not share the room because she could not tend to Resident #36 as he requested. The NHA said Resident #36's spouse resided in the facility and could visit Resident #36, but he could not process the reason for separation. The NHA said Resident #36 and his spouse had been evaluated and received psychological and psychiatric counseling to help them adjust to their changes in life and residing in the long-term care facility.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>Based on observations, record review and staff interviews, the facility failed to ensure four (#10, #26, #21, #44) of eight out of 34 sample residents were provided services that meet professional standards of quality.</p> <p>Specifically, the facility failed to:</p> <ul style="list-style-type: none"> -Clarify the physician's orders with dose information for Residents #10, #26, #21 and #44 for Voltaren gel (topical pain medication); and, -Ensure Resident # 21 received follow up care with the urologist. <p>Findings include:</p> <p>I. Failure to clarify physician's orders with dose information for Voltaren gel</p> <p>A. Professional reference</p> <p>According to the Voltaren gel drug information, retrieved on 6/4/24 from https://www.pdr.net/drug-summary/Voltaren-XR-diclofenac-sodium-2033. Voltaren is a nonsteroidal anti-inflammatory (NSAID) medication that can be prescribed in intravenous, oral, topical, and ophthalmic formulations.</p> <p>The use of analgesic and antipyretic properties increases the risk of serious gastrointestinal events and may increase serious cardiovascular events; use the lowest dose in the shortest time.</p> <p>The topical dosage of Voltaren gel is prescribed as four grams (four and a half inches) topically four times a day, with a maximum of 16 grams a day per lower extremity joint) and/or two grams (two and a quarter inches) topically four times daily per upper extremity joint. Do not exceed a total dose of 32 grams over all affected joints.</p> <p>B. Facility policy</p> <p>The Medication Administration policy, revised 10/20/2023, was received by the nursing home administrator (NHA) on 6/6/24 at 11:24 a.m. It read in pertinent part;</p> <p>It is the facility's policy that medications are administered as ordered by the provider and in accordance with professional standards of practice to prevent errors.</p> <p>Procedure:</p> <p>The nurse is responsible for following the seven rights of medication administration:</p> <ul style="list-style-type: none"> -Right resident; -Right medication; <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-Right dose;</p> <p>-Right time;</p> <p>-Right medication; and,</p> <p>-Right to refuse.</p> <p>Review the medication administration record (MAR) to identify medication to be administered. The MAR is used to reflect current orders for medication administration and document medication administration.</p> <p>Administer medications as ordered in accordance with manufacturer specification.</p> <p>Correct any discrepancies and report to the nurse manager.</p> <p>C Record review</p> <p>Resident #10 had a physician's order, apply Voltaren gel 1% to the left hand, left upper extremity and left shoulder topically three times a day for pain in the left arm, pain in joints of the left hand, contracture of muscle in the left hand, dorsal left hand, inner left forearm, left bicep muscle and left shoulder, ordered 3/10/24.</p> <p>-The medication order did not include a dose.</p> <p>Resident #26 had a physician's order for Voltaren external gel 1%, apply to both knees topically three times a day related to right knee primary arthritis, ordered 2/19/24.</p> <p>-The medication order did not include a dose.</p> <p>Resident #44 had a physician's order for Voltaren gel 1% ,apply to back topically three times daily for discomfort and pain, ordered 1/29/24.</p> <p>-The medication order did not include a dose.</p> <p>Resident #21 had a physician's order for Voltaren gel 1%, apply to the right hand topically three times a day related to polyosteoarthritis, ordered 5/31/24.</p> <p>-The medication order did not include a dose.</p> <p>D. Staff interviews</p> <p>(continued on next page)</p>

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>RN #4 was interviewed on 6/6/23 at 10:45 a.m. RN #4 said she followed the physician's orders to administer medications. RN #4 said if an order was unclear, she would contact the physician for clarification. RN #4 said the dosage was not present and was required for Voltaren gel. She said there was a dosing guide that was provided with the medication. RN #4 said she knew Voltaren gel required a measured dose for administration. RN #4 said when the physician's order for Voltaren did not include a dose, she just used the standard dose. She said the standard dose was two grams but she said there was not a physician's order for the standard dose.</p> <p>The director of nursing (DON) was interviewed on 6/6/24 at 11:05 a.m. The DON said she was unaware that the Voltaren gel orders did not include a dose for the medication. The DON said a measured dose was necessary to ensure the correct dose was applied as ordered and in accordance with manufacturer specifications. The DON said Voltaren gel was classified as an NSAID. She said the use of NSAID medications should be monitored for adverse side effects. The DON said when medication orders were incomplete the nurse needed to clarify the order with the physician before administering the medication.</p> <p>The DON said she would complete an audit of all Voltaren gel orders and ensure each order included a dose. She said she would also educate the nursing staff to contact the physician when medication orders require physician clarification.</p> <p>II. Failure to provide follow-up care coordination</p> <p>A. Resident #21</p> <p>1. Resident status</p> <p>Resident #21, over 65, was admitted on [DATE]. According to the June 2024 computerized physician order (CPO), the diagnoses included Alzheimer's dementia, diabetes and a history of UTI.</p> <p>The 4/3/24 minimum data set (MDS) documented Resident #21 was cognitively intact, as evidenced by a brief interview for mentals status (BIMS) score of 15 out of 15. She required substantial/maximum assistance with bathing, toileting, and transfers and partial/moderate assistance with dressing and hygiene.</p> <p>The assessment documented Resident #21 was taking antibiotics and occasionally leaked urine from her bladder.</p> <p>2. Record review</p> <p>The 12/15/22 urologist note documented Resident #21 was evaluated and treated by the urologist for botox treatments to treat her bladder incontinence. The urologist documented on 12/15/22 the resident was to return in six months for a follow-up evaluation.</p> <p>-A review of Resident #21's electronic medical record (EMR) revealed the facility had not arranged the follow-up care.</p> <p>The 6/6/24 (during the survey process) pharmacy technician progress note documented the resident was scheduled for a follow-up appointment with the urologist on 6/12/24.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151</p> <p>Based on record review and interviews, the facility failed to provide treatment and care in accordance with professional standards of practice for one (#10) of one resident out of 34 sample residents.</p> <p>Specifically, the facility failed to ensure Resident #10's blood pressure medication was consistently held when her diastolic blood pressure (the bottom number of a blood pressure reading) was below the physician ordered parameters.</p> <p>Findings include:</p> <p>I. Professional reference:</p> <p>According to [NAME], P.A. A.G., et al., Fundamentals of Nursing, 10 ed. (2022) E. [NAME], St. Louis Missouri, pp. 606-607, Take appropriate actions to ensure the patient receives medication as prescribed and within the times prescribed and in the appropriate environment.</p> <p>Professional standards such as nursing scope and standards of practice apply to the activity of medication administration. To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:</p> <ol style="list-style-type: none"> 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication. <p>II. Resident status</p> <p>Resident #10, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included hemiparesis (partial paralysis) of the left side, multiple sclerosis, congestive heart failure, dysphagia, Alzheimers's disease, dementia, hypertension and history of falling.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The 5/15/24 minimum data set (MDS) assessment revealed the resident was moderately impaired regarding her tasks in daily life and needed cues and supervision based on the staff assessment for mental status. She was dependent on care for toileting hygiene, showering and bathing, and transfers. She needed substantial to maximum assistance with bed mobility including movement left to right and lying in bed and sitting to stand, dressing and personal hygiene.</p> <p>III. Record review</p> <p>A review of Resident #10's June 2024 CPO revealed she was taking the following medication that required monitoring of blood pressure parameters prior to administration:</p> <p>Amlodipine besylate (a blood pressure medication) 10 milligram (mg) tablet to be taken by mouth in the morning for essential (primary) hypertension; hold the medication if sbp (systolic blood pressure) was less than 100 millimeters of mercury (mmHg) or diastolic blood pressure was less than 60 mmHg, ordered on 1/19/24.</p> <p>Resident #10's medication administration records (MAR) for amlodipine besylate were reviewed from February 2024 through May 2024. The MARS documented the following:</p> <p>On 2/9/24 amlodipine besylate was administered and Resident #10's blood pressure was documented as 170/53 mmHg.</p> <p>-The resident's diastolic blood pressure was below the physician ordered parameter of 60 mmHg and the medication should not have been administered to the resident.</p> <p>On 2/29/24 amlodipine besylate was administered and Resident #10's blood pressure was documented as 141/57 mmHg.</p> <p>-The resident's diastolic blood pressure was below the physician ordered parameter of 60 mmHg and the medication should not have been administered to the resident.</p> <p>On 3/21/24 amlodipine besylate was administered and Resident #10's blood pressure was documented as 155/56 mmHg.</p> <p>-The resident's diastolic blood pressure was below the physician ordered parameter of 60 mmHg and the medication should not have been administered to the resident.</p> <p>On 4/30/24 amlodipine besylate was administered and Resident #10's blood pressure was documented as 115/54 mmHg.</p> <p>-The resident's diastolic blood pressure was below the physician ordered parameter of 60 mmHg and the medication should not have been administered to the resident.</p> <p>On 5/5/24 amlodipine besylate was administered and Resident #10's blood pressure was documented as 138/54 mmHg.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bruce McCandless CO State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 903 Moore Dr Florence, CO 81226	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The resident's diastolic blood pressure was below the physician ordered parameter of 60 mmHg and the medication should not have been administered to the resident.</p> <p>-A review of Resident #10's progress notes revealed there was no written documentation to indicate the resident's physician was notified when the resident's diastolic blood pressure was below the parameters of the physician's order.</p> <p>IV. Staff interviews</p> <p>Registered nurse (RN) #1 was interviewed on 6/6/24 at 10:25 a.m. RN #1 said Resident #10's blood pressure medication was not to be administered if the resident's blood pressure was outside the parameters prescribed by the physician. RN #1 said the check marks in Resident #10's MAR documented her blood pressure medication was administered when the resident's diastolic blood pressure was below 60 mmHg, which was an error, and her medication should have been held. RN #1 said the nurses were to take the resident's blood pressure immediately prior to medication administration. RN #1 said if the medication was not administered, the nurse would write a progress note and call the physician to notify the physician.</p> <p>The director of nursing (DON) was interviewed on 6/6/24 at 2:50 p.m. The DON said a nurse should take the resident's blood pressure to ensure the blood pressure was not outside of the physician ordered parameters and hold the medication if needed. The DON said the nurses should take the blood pressure immediately prior to medication administration.</p> <p>The DON said the nurses administered the medication incorrectly for Resident #10 (see above dates) because the nurses administered the medication when the resident's diastolic blood pressure was below the parameters ordered by the physician. The DON said the risk of administering the medication outside physician ordered parameters could cause increased falls for the resident or cardiac issues. The DON said if the nurses needed help remembering the parameters, they could write the parameters down so they were visible. The DON said the nurse should notify the physician if the medication was administered when it should have been held and the physician could determine if additional follow up was needed for the resident.</p> <p>The nursing home administrator (NHA) was interviewed on 6/6/24 at 2:50 p.m. The NHA said the facility identified the errors in Resident #10's MAR and filled out medication error reports for the medication being administered outside parameters. The medication error report for the 5/5/24 medication error had not yet been completed. The NHA said the pharmacist or the health care technician (HCT) reviewed the MARS and notified the facility of the medication errors.</p> <p>-However, a review of the medication error reports documented two nurses administered Resident #10's blood pressure medication two times each when the resident's blood pressure was outside of the physician prescribed parameters.</p> <p>-There was no follow up to indicate what corrective action was put into place to prevent the nurses from making the same mistake a third time.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151</p> <p>Based on record review and staff interviews, the facility failed to ensure the resident environment remained as free of accident hazards as possible for one (#49) of eight residents reviewed for accident hazards out of 34 sample residents.</p> <p>Resident #49 was identified as a high fall risk through facility assessment. Resident #49 needed substantial to maximum assistance rolling from left to right/right to left in bed. Resident #49's care plan was reviewed on 4/4/24 and included an intervention for the assistance of two people with bed mobility (scooting, rolling, or moving from lying to sitting or sitting to lying) and transfers in and out bed.</p> <p>Resident #49 sustained a fall out of bed on 4/11/24 while receiving incontinence care from certified nurse aide (CNA) #1. CNA #1 was providing care for the resident without another staff member in the room for assistance. When CNA #1 rolled the resident toward her, the resident rolled too far over and began to fall off the bed. CNA #1 was unable to catch the resident and Resident #49 fell to the floor.</p> <p>Resident #49's injuries included two forehead lacerations, bruising to her nose and mouth and bleeding in her mouth with a small laceration of the interior upper lip and bruising to the right eye. She was transported to the hospital for further treatment where imaging tests revealed Resident #49 had sustained C1 and C2 vertebrae (top of the neck) fractures from the fall.</p> <p>Due to the facility's failure to ensure two staff members were present to assist Resident #49 with bed mobility during incontinence care, Resident #49 sustained a fall which resulted in a major injury.</p> <p>Findings include:</p> <p>I. Resident status</p> <p>Resident #49, over the age of 65, was admitted on [DATE], readmitted on [DATE] and passed away at the facility on 4/13/24. According to the April 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia, atrial fibrillation , type II diabetes mellitus, chronic kidney disease, spinal stenosis , osteoarthritis, osteoporosis and history of falling.</p> <p>The 4/1/24 minimum data set (MDS) assessment revealed the resident had a memory problem and was severely impaired in her decision making abilities for everyday life based on staff interview for mental status. She was dependent on care with eating, oral hygiene, toileting, showering and bathing, upper and lower body dressing including footwear, personal hygiene, and all transfers. She needed substantial/maximum assistance rolling from left to right/right to left in bed.</p> <p>II. Record review</p> <p>A. Care plan and interventions</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #49's 4/4/24 care conference summary documented her care plan reflected her current status and she remained needing total care as a resident.</p> <p>The care plan, reviewed 4/4/24, included the following care plan focus areas:</p> <p>The falls care plan, initiated on 12/4/14 and revised on 10/6/21, documented Resident #49 was at high risk for falls due to her previous falls with fracture and surgical repair complicated by her Alzheimer's disease diagnosis and her non-weight bearing status. She utilized a geri chair (padded wheeled chair) and staff assisted the resident with mobility. Resident #49 was unable to stand. Pertinent interventions included the use of a mechanical lift for transfers as the resident was non weight bearing and providing supportive care and assistance as needed with mobility.</p> <p>Resident #49's care plan for self care, initiated on 12/4/14 and revised on 8/28/18, documented she had a deficit related to her diagnosis of advanced dementia and needed assistance with all activities of daily living. Pertinent interventions included the assistance of two people with bed mobility and transfers in and out of bed. The care plan interventions documented she needed assistance with dressing, eating, personal hygiene and toileting as she was completely incontinent of bowel and bladder.</p> <p>B. Fall on 4/11/24</p> <p>The 4/12/24 progress note, written at 1:36 a.m., documented Resident #49 suffered a fall from her bed on 4/11/24 while CNA #1 was providing care. CNA #1 and CNA #2 assisted Resident #49 using the mechanical lift to transfer Resident #49 from a chair to her bed. The sling was detached from the mechanical lift and removed from under the resident. CNA #2 left the room to assist another resident while CNA #1 remained with Resident #49 to change the resident in bed. When CNA #1 turned Resident #49 toward her, she was not close enough to the bedside edge to enable her to effectively brace Resident #49 as she was being turned. Resident #49 rolled farther than CNA #1 anticipated and started to fall off the bed. CNA #1 attempted to catch Resident #49 but was unable to do so. Resident #49 was assessed and sustained two lacerations to her forehead, bruising to her nose and mouth with a small laceration on her interior upper lip, and bruising to her right eye. Resident #49 was sent to the emergency department for further evaluation.</p> <p>-The facility failed to ensure two staff members were present to assist Resident #49 with her bed mobility while providing incontinence care as outlined in her care plan.</p> <p>The 4/13/24 physician communication progress note written at 2:39 p.m. documented Resident #49 was admitted to a local hospital on 4/12/24 and diagnosed with fractures of the C1 and C2 vertebrae. She was readmitted back to the facility on [DATE] at 7:00 p.m. with diagnoses of fractures to the C1 and C2 vertebrae and bilateral nasal displaced bone fractures. She was wearing a neck collar.</p> <p>C. Facility fall investigation and follow up</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #49's post fall assessment documented Resident #49's fall occurred on 4/11/24 at 10:00 p.m. in her room. Resident #49 was in bed and was turned for incontinence care by CNA #1. The assessment documented CNA #1 reported she rolled Resident #49 toward her and the resident rolled farther than CNA #1 anticipated to the edge of the bed. Resident #49 started falling off the bed and CNA #1 attempted to catch her. CNA #1 did not have her arms up by Resident #49's shoulders and she was unable to catch her. Resident #49 was unable to provide information regarding what happened due to her advanced dementia.</p> <p>The interdisciplinary department (IDT) risk management review note, written on 4/17/24 at 1:44 p.m., documented the root cause of Resident #49's fall as the momentum of the resident being rolled toward CNA #1 was too fast during incontinence care performed while the resident was on her bed. Interventions put into place after the fall included the following:</p> <p>Resident #49 was sent to the emergency room for evaluation, given a soft neck collar upon return to the facility on [DATE] and provided the assistance of two people for care provided in the resident's bed.</p> <p>Education for CNAs and nurses in the facility began on 4/12/24 regarding ongoing proper turning of residents in bed during care.</p> <p>D. Post fall training</p> <p>The Positioning a Resident to Perform Incontinence Care education presented to all of the CNAs and licensed nurses after Resident #49's fall was provided by the division director (DD) on 6/5/24 at 5:54 p.m.</p> <p>The education for staff was initiated on 4/12/24 and documented the following in pertinent part,</p> <p>To maneuver or turn a resident when a slide sheet is not used, is performed in the following steps (make sure all supplies are easily accessible: brief, wipes, barrier cream, trash can).</p> <ul style="list-style-type: none"> -Raise the bed to at least waist height; -Cross the resident's arms over their chest; -Bend the resident's leg towards you; -Push gently across the hip and the shoulder so that the resident rolls away from you; -Once the resident is in a side-lying position, ensure the knees and the ankles of the resident do not rest on each other; -Place a wedge behind the upper back, support the top leg using a pillow or an appropriate pad and do the same for the top arm; and, -Check for comfort and readjust. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The education documented additional things to consider, such as the dependency of the person and the level of assistance they can offer during the task, the size of the person (check the width of the bed to ensure staff were able perform the maneuver safely) and the weight of the person (was the manual force provided by a single person enough to perform the task safely by avoiding leaving the patient stranded midway or having a fall).</p> <p>CNA #1 and CNA #2 signed documentation they completed the training on 4/12/24.</p> <p>III. Staff interviews</p> <p>CNA #3 was interviewed on 6/6/24 at 10:30 a.m. CNA #3 said the level of assistance a resident needed for care, including transfers, was found in the resident's care plan. CNA #3 said he reviewed a resident's electronic medical record (EMR) to see their care needs. CNA #3 said he was unable to view multiple residents records at a time and there was not an easier way to review the level of assistance for multiple residents at one time. He said there were a number of reasons a staff member might need to leave a resident's room while performing care tasks for a resident.</p> <p>CNA #3 said any changes to the amount of care needed by a resident were communicated between facility staff during their shift change with other CNAs. He said the nurses also provided updates or changes to care needs of the residents. CNA #3 said all staff received education after Resident #49's fall. He said the training covered resident transfers, understanding when a resident needed assistance from one versus two staff members and how to provide incontinence care. He said the facility was consistent in providing education after a resident's fall.</p> <p>CNA #2 was interviewed on 6/6/24 at 2:20 p.m. CNA #2 said a resident's EMR provided information regarding the level of care assistance a resident needed but the information could also be provided by another CNA at their shift change or a nurse at any time.</p> <p>CNA #2 said he provided care to Resident #49 on 4/11/24. CNA #2 said he and CNA #1 transferred Resident #49 to her bed using a mechanical lift on 4/11/24. CNA #2 said once Resident #49 was on her bed, both he and CNA #1 thought CNA #1 was capable of providing incontinence care to Resident #49 by herself. CNA #2 said after Resident #49 was transferred to her bed he left Resident #49's room. CNA #2 said after Resident #49 fell , he did discuss Resident #49's fall with the facility managers. He said he was aware, after the fall and additional training was provided to the facility staff, that there should have been two people who provided care to Resident #49. CNA #2 said a staff member should not leave a resident's room until the care was complete. He said there was additional training provided to him and other staff after Resident #49's fall that included computer based training, as well as on shift teachings from the nurses.</p> <p>The nursing home administrator (NHA) and the director of nursing (DON) were interviewed together on 6/6/24 on 6/6/24 at 2:50 p.m.</p> <p>The DON said CNA #1 provided incontinence care for Resident #49 while she was on her bed, the resident rolled too fast toward the edge of the bed and started to fall. The DON said CNA #1 stood closer to Resident #49's lower body to provide incontinence care. She said CNA #1 had to move toward the resident's upper body to catch the resident as she started to fall. The DON said CNA #1 was unable to stop the resident from falling. The DON said CNA #1 should have been standing in a different spot at the resident's bedside while providing her incontinence care.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said the facility began to review resident's care plans after Resident #49's fall. She said the residents with care needs most similar to Resident #49 were identified first to prevent a similar situation with other residents. The DON said if a resident's care needs changed the MDS assessment was updated. She said the nurse supervisors would then provide the nursing staff education on the changes.</p> <p>The DON said the facility provided CNA #1 additional training related to turning and lifting of residents with the restorative therapy department. The DON said the facility also had regular meetings with residents to discuss what staff could improve on to prevent falls. The DON said the CNA tasks for daily care in the resident's EMR did not include the residents' level of assistance needed. The DON said the CNA tasks were pre-populated. She said she would look into if the facility would be able to make changes to the pre-populated tasks. The DON said, as a best practice, staff should look at the residents' care needs every day.</p> <p>The NHA said Resident #49 fell toward CNA #1 as she provided incontinence care. The NHA said Resident #49 needed two people while using the mechanical lift, however it was not clear to the staff, based on how her care plan was written, that Resident #49 needed two people for her incontinence care immediately prior to her fall on 4/11/24. The NHA said CNA #1 and CNA #2 had transferred Resident #49 into the bed and then CNA #2 left the room. The NHA said CNA #1 tried to clean the resident and move the resident while she provided incontinence care. The NHA said both CNA #1 and CNA #2 thought they were following the facility's policy while providing care for Resident #49.</p> <p>-However, only one staff member stayed to provide incontinence care, this was not in line with Resident #49's care plan which indicated the resident needed the assistance of two staff members for bed mobility (see record review above).</p> <p>The NHA said the restorative therapy department provided the facility staff with ongoing education for lifting, transferring and resident care. The NHA said the restorative therapy department was reviewing resident care plans after Resident #49's fall but the NHA did not think the reviews had been completed. The NHA said the therapy department staff provided education during the different shifts and on different units that included a demonstration of proper transferring techniques. The NHA said a contracted facility provider also attended the facility fall meetings on a regular basis and provided different resources to the facility for fall prevention.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47151</p> <p>Based on observations, record review and interviews, the facility failed to use a person centered approach when determining the use of bed rails and transfer poles for three (#12, #10 and #20) of eight residents reviewed for accident hazards out of 34 sample residents.</p> <p>Specifically, for Residents #12, #10 and #20, the facility failed to:</p> <ul style="list-style-type: none"> -Review the risks versus the benefits of using a bed rail with the resident or the resident's representative prior to use; -Obtain informed consent for the installation and use of bed rails prior to use; -Obtain physician's orders for bed rails; and, -Conduct routine maintenance of the bed rails to evaluate the continued safety of the bed rails. <p>Findings include:</p> <p>I. Professional reference</p> <p>The U.S. Food and Drug Administration (FDA) Recommendations for Health Care Providers Using Adult Portable Bed Rails (2/27/23) was retrieved on 6/12/24 from https://www.fda.gov/medical-devices/adult-portable-bed-rail-safety/recommendations-health-care-providers-using-adult-portable-bed-rails. It read in pertinent part,</p> <p>Avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment. Evaluation is needed to assess the relative risk of using the bed rail compared with not using it for an individual patient. Follow the health care facility's procedures and manufacturer's recommendations and specifications for installing and maintaining bed rails for the particular bed frame and bed rails used. Inspect, evaluate, maintain, and upgrade equipment (beds, mattresses, and bed rails) to identify and remove potential fall and entrapment hazards.</p> <p>II. Resident #12</p> <p>A. Resident status</p> <p>Resident #12, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included Alzheimer's disease, dementia, right hand contracture, depression and muscle wasting.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The 5/15/24 minimum data set (MDS) assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of six out of 15. He needed substantial to maximum assistance with toileting hygiene, bathing and dressing, partial to moderate assistance with personal hygiene, and toilet transfers and set up help only with eating. He was independent with bed mobility moving left to right, but needed supervision or touching assistance with sitting to lying, sitting to standing and bed to chair transfers.</p> <p>-The MDS assessment documented Resident #12 did not use bed rails.</p> <p>B. Observations and interview</p> <p>On 6/4/24 at 9:25 a.m. Resident #12 was lying in bed with an assist bar/bed rail attached to his bed on each side.</p> <p>On 6/6/24 at approximately 1:30 p.m. Resident #12 was lying in bed with an assist bar attached to his bed on each side. Resident #12 said he used his assist bars/bed rails to reposition himself in bed and the assist bars/bed rails helped him move.</p> <p>C. Record review</p> <p>Resident #12's comprehensive care plan for altered mobility and falls included an intervention of two assist bars/bed rails added to his bed, initiated 12/19/19 and revised 3/16/24.</p> <p>-A comprehensive review of the resident's electronic medical record (EMR) failed to reveal the facility reviewed the risk versus the benefits of using a bed rail with the resident or the resident's representative prior to use, obtained informed consent for the installation and use of bed rails prior to us, obtained physician orders for the bed rails and ensured scheduled maintenance of any bed rail in use according to the manufacturer's recommendations and specifications.</p> <p>The nursing home administrator (NHA) provided Mobile Assisted Device Audits on 6/6/24 at 2:00 p.m. for January 2024 through May 2024. The audits listed beds, wheelchairs, four wheeled walkers, canes and electric wheelchairs. All beds in the facility were marked as completed in the audit.</p> <p>-However, the audit did not list bed rails/assist bars on the audit or what components of the bed rails were inspected during the audit.</p> <p>III. Resident #10</p> <p>Resident #10, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included hemiparesis (partial paralysis) of the left side, multiple sclerosis, congestive heart failure, dysphagia, dementia and anxiety.</p> <p>The 5/15/24 MDS assessment documented the resident was moderately cognitively impaired regarding her tasks in daily life and needed cues and supervision based on staff interview for mental status. She was dependent on care for toileting hygiene, showering and bathing and transfers. She needed substantial to maximum assistance with bed mobility, including movement left to right and lying in bed and sitting to standing, dressing and personal hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The MDS assessment documented Resident #10 did not use bed rails.</p> <p>B. Observations</p> <p>On 6/4/24 at 9:25 a.m. Resident #10's bed was observed with an assist bar/bed rail attached to her bed on each side.</p> <p>On 6/6/24 at approximately 1:30 p.m. Resident #10's bed was observed with an assist bar/bed rail attached to her bed on each side.</p> <p>C. Record review</p> <p>Resident #10's comprehensive care plan for altered mobility and falls included an intervention of two assist bars/bed rails added to her bed, initiated 12/31/19 and revised 3/20/24.</p> <p>-A comprehensive review of the resident's EMR failed to reveal the facility reviewed the risks versus The benefits of using a bed rail with the resident or the resident's representative prior to use, obtained informed consent for the installation and use of bed rails prior to use, obtained physician orders for the bed rails and ensured scheduled maintenance of any bed rail in use according to the manufacturer's recommendations and specifications.</p> <p>The nursing home administrator (NHA) provided Mobile Assisted Device Audits on 6/6/24 at 2:00 p.m. for January 2024 through May 2024. The audits listed beds, wheelchairs, four wheeled walkers, canes and electric wheelchairs. All beds in the facility were marked as completed in the audit.</p> <p>-However, the audit did not list bed rails/assist bars on the audit or what components of the bed rails/assist bars were inspected during the audit.</p> <p>IV. Staff interviews</p> <p>The director of nursing (DON) and the nursing home administrator (NHA) were interviewed together on 6/6/24 at 2:50 p.m.</p> <p>The NHA said the facility had not obtained consents or had a risk versus benefit conversation with the resident or their representative for use of the bed rails/assist bars prior to their use.</p> <p>The NHA said the facility had not considered the assist bars on the resident's beds a bed rail and, consequently, they did not have conversations regarding consent and risk versus benefits with the resident or their representative.</p> <p>The DON said the risk of using bed rails/assist bars was resident entrapment which could result in injury or death. The DON said residents could injure themselves if they bumped the bed rail/assist bar. The DON said the restorative therapy department staff had worked at the facility for a long time and installed the bed rails/assist bars. The DON said she assumed the restorative therapy staff installed the bed rails/assist bars correctly.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Bruce McCandless CO State Veterans Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 903 Moore Dr Florence, CO 81226	
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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Both the NHA and the DON said the restorative therapy department completed the inspections of the bed rails/assist bars monthly. The DON and the NHA said the residents with assist bars/bed rails were assessed quarterly.</p> <p>The NHA said the restorative therapy staff ensured the bed rail/assist bars were installed securely. The NHA said she thought the list of beds in the Mobile Assisted Device Audits (see above) also included the bed rails/assist bars. The NHA said the facility had no documentation that listed what components of the bed rails/assist bars were being inspected. The NHA said the restorative therapy staff ensured the bed rail/assist bars were installed securely.</p> <p>-However, the beds listed in the Mobile Device Audit included every resident bed in the facility. There was no distinction in the audit which beds included the bed rail/assist bar, or if the inspection of the bed rail/assist bar was included as part of the bed inspection.</p> <p>43950</p> <p>V. Resident #20</p> <p>A. Resident status</p> <p>Resident #20, age greater than 65, was admitted on [DATE]. According to the June 2024 CPO, diagnoses included Alzheimer's disease (progressive memory loss), vascular dementia, chronic obstructive pulmonary disease (progressive lung disease) and dependence of supplemental oxygen.</p> <p>The 3/6/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of seven out of 15. She required substantial/maximal assistance for dressing, personal hygiene, bathing/showering, bed mobility and transfers.</p> <p>-The MDS assessment documented Resident #20 did not use bed rails.</p> <p>B. Observations</p> <p>On 6/4/24 at 9:25 a.m. Resident #20 was sleeping in her bed, next to the door, with a bed rail/assist bar attached on each side of the bed.</p> <p>On 6/5/24 at 11:38 a.m. Resident #20's bed, next to the door, was observed with a bed rail/assist bar attached to each side of the bed.</p> <p>C. Record Review</p> <p>Resident #20's altered mobility/high risk for falls care plan, initiated 12/11/23, revealed an intervention of two assist bars to the bed to aid in mobility and positioning.</p> <p>-A comprehensive review of the resident's EMR failed to reveal the facility reviewed the risks versus the benefits of using a bed rail with the resident or the resident's representative prior to use, obtained informed consent for the installation and use of bed rails prior to use, obtained physician orders for the bed rails and ensured scheduled maintenance of any bed rail in use according to the manufacturer's recommendations and specifications.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>D. Staff interviews</p> <p>The director of rehabilitation (DOR) was interviewed on 6/5/24 at 2:59 p.m. The DOR said he had worked at the facility for [AGE] years. He said the restorative nursing program took care of the resident's durable medical equipment and would measure and order the required medical equipment including bed rails and assist bars. The DOR said bed canes/rails recommendations could either come from therapy or the nursing department and they would tell the restorative department. He said the restorative RN (registered nurse) was supposed to get a physician's order for the bed rail.</p> <p>The DOR said the restorative RN or charge nurse should talk to the family about the equipment recommendations. The DOR said he did not know if there was a risk versus benefit form that should be signed prior to the installation.</p> <p>The DOR said he did not know if the maintenance department completed any regular checks on the medical equipment but he thought checking the medical equipment would be a good idea.</p> <p>The maintenance supervisor (MS) was interviewed on 6/6/24 at 1:17 p.m. The MS said he had worked at the facility as the plant manager for [AGE] years. The MS said the bed rail/assist bars were installed by the restorative nursing team under the direction of the restorative RN. The MS said if the bed rails were a permanent installation, he would install them.</p> <p>The MS said he was not aware of any specific monitoring checks of the bed rails but thought maybe one existed through the restorative department, although he was not aware of how often the restorative department checked the bed rails. The MS said it would be important to check the bed rails/assist bars for safety and to prevent injury or death from entrapment.</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47536</p> <p>Based on record review and staff interviews, the facility failed to develop and implement an antibiotic stewardship program which included antibiotic use protocols and a system to monitor antibiotic use for one (#21) of one resident out of 34 sample residents.</p> <p>Specifically, the facility failed to effectively track and monitor the use of long-term and short-term antibiotics prescribed for Resident #21.</p> <p>Findings include:</p> <p>I. Professional reference</p> <p>According to The Centers for Disease Control and Prevention (CDC) Antibiotic Prescribing and Usage in Hospitals and Long-term Care, (2019), retrieved on 6/5/24 from https://www.cdc.gov/antibiotic-use/hcp/core-elements/index.html,</p> <p>Implement policies that apply in all situations to support antibiotic prescribing, including specifying the dose, duration, and indication for all courses of antibiotics so that they are readily identifiable. Implement facility-specific treatment recommendations, based upon the national guidelines and local susceptibilities and formulary options that optimize antibiotic selections, duration, and common indications for the usage of community-acquired pneumonia, urinary tract infections, skin and soft tissue infections.</p> <p>Incomplete assessment and documentation of a resident's clinical status, physical exam or laboratory findings at the time a resident is evaluated for infection can lead to uncertainty about the rationale and appropriateness of an antibiotic. Ongoing audits of antibiotic prescriptions for completeness of documentation, regardless of whether the antibiotic was initiated in the nursing home or at a transferring facility, should verify that the antibiotic prescribing elements have been addressed and recorded.</p> <p>II. Facility policy</p> <p>The Antibiotic Stewardship policy, revised 11/6/23, was provided by the nursing home administrator (NHA) on 6/6/24 at approximately 10:24 a.m. It read in pertinent part,</p> <p>The facility's policy is to implement an antibiotic stewardship program as part of the overall infection prevention and control program. The program's purpose is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The program has the potential to limit antibiotic resistance in the post-acute setting and is aligned with the CDC Core Elements of antibiotic stewardship for nursing homes.</p> <p>The program includes antibiotic use protocols and a system to monitor antibiotic use.</p> <p>Antibiotic use protocols:</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Nursing staff shall assess residents suspected of infection and notify the physician. McGreer's criteria (criteria used to assess for true infections and provide guidelines for antibiotic initiation appropriateness) or other assessments should be completed to confirm the appropriateness of initiating an antibiotic.</p> <p>-The facility uses the Centers for Disease Control and Prevention and National Healthcare Safety Network surveillance definitions to define infections.</p> <p>All prescriptions for antibiotics shall specify the dose, duration and indication for use.</p> <p>-Empiric antibiotics (antibiotics given before the source of an infection is known) are reassessed after two to three days for appropriateness and necessity, factoring in the results of diagnostic tests, laboratory reports, and changes in the resident's clinical status.</p> <p>Monitoring antibiotic use</p> <p>-Antibiotic orders obtained by consulting, specialty, or emergency providers shall be reviewed for appropriateness.</p> <p>The interdisciplinary team, with a focus on antibiotic stewardship, will be established to be accountable for stewardship activities and to monitor for antibiotic resistance patterns.</p> <p>III. Resident #21</p> <p>A. Resident status</p> <p>Resident #21, age greater than 65, was admitted on [DATE]. According to the June 2024 computerized physician orders (CPO), diagnoses included Alzheimer's dementia, diabetes and a history of urinary tract infections (UTI).</p> <p>The 4/3/24 minimum data set (MDS) assessment revealed that Resident #21 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She required substantial/maximum assistance with bathing, toileting, and transfers and partial/moderate assistance with dressing and hygiene.</p> <p>The assessment documented Resident #21 was taking antibiotics and occasionally leaked urine from her bladder.</p> <p>B. Record review</p> <p>Review of Resident #21's June 2024 CPO revealed the following physician's order:</p> <p>Cephalexin 250 milligrams (mg). Give one capsule by mouth one time a day for urinary tract infection, ordered 10/12/22.</p> <p>-The physician's order for the Cephalexin failed to indicate the duration of the antibiotic.</p> <p>(continued on next page)</p>		

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-The record review revealed no documentation to indicate the facility's infection preventionist (IP) completed an antibiotic use assessment or documented the McGreer's criteria met to justify the Cephalexin prescription.</p> <p>A review of the IP infection surveillance documents revealed the facility identified facility residents with active infections and which residents were prescribed antibiotics.</p> <p>-The IP failed to document and monitor Resident #21's long-term use of Cephalexin on the surveillance documents.</p> <p>On 3/5/24, a nurse progress note revealed Resident #21 experienced symptoms of a UTI and a urinalysis test and culture of bacteria were ordered.</p> <p>On 3/8/24, the urine culture report documented the resident had a UTI with Escherichia coli (E. coli) bacteria in the urine. Lab testing and antibiotic sensitivity were completed, and it was determined a multi-drug-resistant strain of E. coli had been identified in Resident #21's urine sample.</p> <p>On 3/8/24, the physician ordered an antibiotic medication to treat the UTI.</p> <p>The order read, Bactrim DS 800-160 mg, give one tablet by mouth two times a day for UTI symptoms/positive urinalysis until 3/14/24 for complicated UTI.</p> <p>-The record review revealed no documentation to indicate the IP completed an antibiotic use assessment or documented the McGreer's criteria met to justify the Bactrim prescription.</p> <p>IV. Staff interviews</p> <p>The director of nursing (DON) was interviewed on 6/5/24 at 10:27 a.m. The DON said she had worked in the facility for several years in different positions and she was currently the certified IP. The DON said the previous IP had resigned the month before (May 2024) and she was in the process of learning all of the IP tasks.</p> <p>The DON said she was responsible for the antibiotic stewardship program at the facility. The DON said she shared and delegated IP tasks with two nursing supervisors and the facility pharmacy technician. The DON said she was unsure which residents taking antibiotics met McGreer's criteria or if an assessment for antibiotic treatment had been completed for residents who were on antibiotics.</p> <p>The DON said the previous IP did not include Resident #21 in the antibiotic surveillance documentation because Resident #21 was prescribed the Cephalexin antibiotic for UTI prevention and did not have an active infection.</p> <p>The DON said it was essential to identify and track all antibiotic usage to be aware of risks, such as a potential spread of multidrug-resistant organisms (MDRO) infections or ineffective antibiotic treatments.</p> <p>(continued on next page)</p>

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<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON said when a physician prescribed an antibiotic for a resident, the physician's order was entered into the electronic medical record (EMR) She said the pharmacist and the health care technician (HCT) reviewed the antibiotic orders for appropriateness but did not use an antibiotic assessment or McGreer's criteria.</p> <p>The DON said she was unaware if the previous IP completed an antibiotic assessment using McGreer's criteria or other assessments to review prescribed antibiotics for appropriateness.</p> <p>The DON said she would review the antibiotic stewardship program, antibiotic use assessments and McGreer's criteria to ensure an appropriate and thorough review was completed when antibiotics were prescribed. She said she would audit all residents who were prescribed antibiotics to ensure the orders included end dates for the antibiotics.</p> <p>V. Facility follow up</p> <p>On 6/6/24 (during the survey), the HCT contacted Resident #21's physician for order clarification of the resident's long-term Cephalexin antibiotic order. The physician requested the urologist evaluate the resident to determine whether the indefinite use of the Cephalexin antibiotic was appropriate.</p>