| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065420 | A. Building<br>B. Wing | 09/19/2024 |

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| Castle Peak Senior Life and Rehabilitation | 195 Freestone Rd<br>Eagle, CO 81631 |

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

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|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467<br><br>Based on record review and staff interviews, the facility failed to ensure one (#23) of three residents reviewed for abuse out of 23 sample residents was kept free from abuse.<br><br>Specifically, the facility failed to:<br><br>-Prevent Resident #22 from slapping Resident #23;<br><br>-Thoroughly investigate a resident to resident altercation between Resident #22 and Resident #23; and,<br><br>-Put interventions in place to prevent future resident to resident altercations between Resident #22 and Resident #23.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Vulnerable Adult policy, reviewed 10/20/23, was provided by the nursing home administrator (NHA) at 10:15 a.m. The policy documented in pertinent part, The resident has the right to be free from verbal, physical, sexual, or mental abuse, neglect, misappropriation of resident property, and exploitation as defined in this policy. This includes but is not limited to freedom from corporal punishment, and voluntary seclusion in any other physical or chemical restraint not required to treat resident symptoms.<br><br>Physical abuse includes hitting, slapping, pinching, and kicking.<br><br>Resident to resident altercations must be reported in accordance with regulations including willful actions resulting in physical injury, mental anguish, or pain.<br><br>All residents of the facility are considered vulnerable adults. Therefore, the interdisciplinary team evaluates the vulnerability of each resident and develops interventions as part of the resident plan of care.<br><br>(continued on next page) |

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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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The interdisciplinary team assesses, develops care plans, and monitors residents with needs and behaviors that might lead to abuse, conflict, or neglect, exploitation of residents. These residents' needs and behaviors may include communication disorders, those that require heavy nursing care and or totally dependent, a history of aggressive behavior, behaviors such as entering other residents' rooms, and/or self-injurious behavior.<br><br>The facility will initiate an investigation immediately upon identification of possible abuse, neglect, exploitation of residents, mistreatment, injuries of unknown source, resident to resident verbal or physical altercations, and or misappropriation of property.<br><br>All reports of suspected/alleged resident abuse, neglect, exploitation of residents, mistreatment, injuries of unknown source and/or misappropriation of resident property shall be properly and thoroughly investigated. All interviews related to the investigation shall be conducted in private.<br><br>The policy identified the procedure to investigate all suspected and allegations of resident abuse as the following:<br><br>-Collect data and document the investigation findings;<br><br>-Conduct a physical examination of the resident and the environment;<br><br>-Review documentation and the resident medical record for events leading up to the incident;<br><br>-Interview the person(s) reporting the incident;<br><br>-Interview the alleged victim;<br><br>-Interview any potential witnesses to the incident;<br><br>-Interview the alleged perpetrator;<br><br>-Interview other residents to whom the alleged perpetrator provides care or services; and,<br><br>-Review the completed documentation.<br><br>According to the policy, if witness reports were obtained, witnesses should sign and date such reports. Staff should analyze the incident/occurrence to determine what changes were needed, if any, to the policies and procedures to prevent further occurrences.<br><br>II. Resident to resident altercation between Resident #22 and Resident #23 on 9/9/24<br><br>The NHA provided the file containing the facility' s abuse investigation of the 9/9/24 incident between Resident #22 and Resident #23 on 9/17/24 at 5:41 p.m.<br><br>The investigation file included:<br><br>-The progress notes for both residents on the incident;<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Care plans for both residents;<br><br>-A summary of the situation;<br><br>-A witness statement from certified nurse aide (CNA) #3; and,<br><br>-An abuse reporting flow sheet.<br><br>The 9/9/24 nursing progress note for Resident #22 documented in pertinent part, This RN (registered nurse) was called to the dining room by CNA (certified nurse aide) stating that another resident got too close for this resident and this resident slapped the other resident (Resident #23) on the hand. This RN did have a conversation with this resident to tell her it was not okay to be mean to others just for being too close to them. If she is not comfortable with others that are close to her, then she needs to ask staff to move other residents away from her. It is determined that this resident due to her dementia, lacked willful intent and had no intention of causing harm. This RN will add the behavior to her care plan so we can continue to monitor.<br><br>The 9/9/24 nursing progress note for Resident #23 documented in pertinent part, This RN was called out to the dining room by CNA staff stating that another resident (Resident #22) slapped at this resident' s hand for being too close. Resident (#23) was assessed, but no injury or c/o (complaints of) pain to the area are noted. This resident is very active all over the MC (memory care) unit, and does tend to upset others by touching them or in this instance, by being too close to them. This incident lacked willful intent, as the other resident had no intention of hurting this resident. Will continue to monitor and report to the next shift to monitor for any bruising. No further issues or concerns at this time.<br><br>The 9/9/24 at 4:00 p.m. summary of the situation documented Resident #23 was standing near and possibly touching something of Resident #22' s. CNA #3 saw Resident #22 slap Resident #23' s hand. The CNA went over to the resident and guided Resident #23 away from Resident #22. The CNA then told Resident #22 not to hit the other residents. The unit manager was also asked to speak with Resident #22.<br><br>The summary read the behavior was known and care planned for Resident #22 and Resident #23. Resident #23 repeatedly picked up items. The summary documented due to the known behaviors of both residents, the staff monitored them.<br><br>According to the summary, it was determined Resident #22' s action was willful to stop Resident #23 from touching her belongings but not willfully to harm her. The summary documented there was no pain or physical injury and Resident #23 returned to her baseline behaviors, showing no signs of psychological or emotional harm. The incident would not be reported. The documentation was completed and the care plans were reviewed.<br><br>The witness statement for CNA #3 documented she saw Resident #22 slap Resident #23' s hand and told her to get away. Resident #23 stayed next to Resident #22 so the CNA intervened. She moved Resident #23 away from Resident #22. According to the statement, CNA #3 told Resident #22 to please not hit other residents and Resident #23 responded that the other resident needed to leave her stuff alone. CNA #3 told Resident #22 to let staff know if Resident #23 was touching her items and the staff would intervene.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -The investigation did not include interviews with Resident #22 and Resident #23 to determine if they felt safe.<br><br>-The investigation did not include interviews with other residents to ask if they felt safe and free from abuse.<br><br>-The investigation did not include interviews with other staff members on the memory care unit as part of the investigation process to determine abuse or ask if the staff had any concerns with abuse or insight of how to prevent future resident to resident altercations between Resident #23 and Resident #22.<br><br>-The investigation did not include what the residents were doing just before the altercation took place and if staff attempted to redirected the residents away from each prior to Resident #22 hitting resident #23.<br><br>III. Resident #22<br><br>A. Resident status<br><br>Resident #22, age greater than 65, was admitted on [DATE], with an initial admitted [DATE]. The resident resided in the secured memory care unit. According to the September 2024 computerized physician orders (CPO), diagnoses included unspecified dementia with unspecified severity without behavioral disturbances, major depressive disorder, anxiety disorder and unspecified convulsions.<br><br>The 7/10/24 minimum data set (MDS) assessment documented Resident #22 had severe cognitive deficits with a brief interview for mental status (BIMS) score of six out of 15. Resident #22 did not have upper or lower extremity limitations in range of motion and did not use a mobility device.<br><br>According the MDS assessment, Resident #22 had inattention thinking. She did not have physical or verbal behavioral symptoms directed at others or rejections of care. The resident did not have wandering behaviors.<br><br>B. Record review<br><br>The behavior care plan for Resident #22, initiated 8/1/23, documented Resident #22 called staff and residents derogatory names and was overprotective of her belongings and had caused a skin tear to another resident' s hand by yanking her phone from the resident.<br><br>According to the care plan, Resident #22 tended to slap at people' s hands or arms when she did not like what the person was doing or if someone got too close to her.<br><br>Resident #22' s care planned intervention added on 9/9/24,, after the resident to resident altercation, read Please move other residents away from me if I feel like they' re too close so that I do not hit or slap them.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The abuse prevention care plan for Resident #22, revised on 7/15/24, documented Resident #22 had no known history of abuse or neglect. She was at risk for abuse and neglect due to her vulnerable status living in a nursing facility. According to the care plan, Resident #22 was not alert and oriented and may not be able to report abuse/neglect. Her short term goal was to remain safe and free from abuse. The abuse prevention intervention was for staff to complete an abuse prevention observation per facility protocol.<br><br>The resident profile (a staff communication sheet) for Resident #22, initiated 9/9/24, was provided by the corporate consultant (CC) on 9/19/24 at 3:57 p.m. The resident profile directed staff to move other residents away from Resident #22 if Resident #22 felt they were too close so she did not hit or slap them.<br><br>IV. Resident #23<br><br>A. Resident status<br><br>Resident #23, age greater than 65, was readmitted on [DATE], with an initial admitted [DATE]. The resident resided in the secured memory care unit. According to the September 2024 computerized physician orders (CPO), diagnoses included unspecified dementia with unspecified severity with and without behavioral disturbances, major depressive disorder, vascular dementia with history of anxiety, and transient cerebral ischemic attack (reduced blood to the brain), unspecified.<br><br>The 7/8/24 minimum data set (MDS) assessment documented Resident #23' s cognition was severely impaired with a staff assessment for mental status.<br><br>According the MDS assessment, Resident #23 had short and long term memory problems. She had behaviors of inattention and disorganized thinking. Resident #23 did not have physical or verbal behavioral symptoms directed at others or rejections of care. Resident #23 did not have upper or lower extremity limitations in range of motion and did not use a mobility device.<br><br>Resident #23 did not have upper or lower extremity limitations in range of motion and did not use a mobility device.<br><br>The MDS assessment documented the resident wandered daily.<br><br>B. Record review<br><br>The abuse prevention care plan for Resident #23, revised on 7/8/24, documented Resident #23 had no known history of abuse or neglect. She was at risk for abuse and neglect due to her vulnerable status living in a nursing facility. According to the care plan, Resident #23 was not alert and oriented and may not be able to report abuse/neglect. Her short term goal was to remain safe and free from abuse. The abuse prevention intervention was for staff to complete an abuse prevention observation per facility protocol.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The skin integrity care plan intervention for Resident #23, initiated 8/4/23, documented Resident #23 liked to pick up other residents' and staff things such as a cell phone and walk around with the items. The intervention directed staff to keep items that she should not pick up out of the common area or put away. According to the care plan intervention, Resident #23 did not always agree to return the picked up items.<br><br>-Review of Resident #23' s care plan did not identify new care plan interventions put in place to prevent future resident to resident altercations after the 9/9/24 incident.<br><br>The abuse reporting flow sheet identified a resident to resident altercation must be reported if the action was a willful act such as hitting or slapping and resulted in physical injury, mental anguish or pain.<br><br>-The review of the investigation and Resident #23' s electronic medical record (EMR) did not identify concerns.<br><br>Review of Resident #23' s EMR and progress notes between 9/10/24 and 9/17/24 for Resident #23 did not document or identify behavior monitoring that was put in place after the 9/9/24 resident to resident altercation, such as monitoring for fearfulness to determine a component of potential abuse. On 9/18/24 and 9/19/24 (during the survey period), the progress notes documented the resident was not showing signs of fear, retreating or nervousness.<br><br>The resident profile for Resident #23, dated 9/19/24 (during the survey period and 10 days after the altercation), was provided by the CC on 9/19/24 at 4:35 p.m. The profile directed staff to give Resident #23 a piece of paper or other objects to keep in her hands so her hands were preoccupied in order to prevent her from touching other residents and their property.<br><br>-The resident profile intervention for Resident #23 was created during the survey period and 10 days after the altercation (see interviews below).<br><br>A 9/18/24 email to the nursing staff from the director of nursing (DON) was provided by the CC on 9/18/24 at 3:11 p.m. The email read This is a follow-up from the incident between Resident #23 and Resident 22 last week. Because trauma can appear at a later time, please monitor Resident #23 for emotional distress for 72 hours. CNAs please let the nurse know if you see any signs of distress such as fearfulness, retreating nervousness or any other behavioral change. nurses there' s an order to document this in the progress notes, thank you.<br><br>-The email was provided to the nursing staff during the survey period and nine days after the resident to resident altercation.<br><br>A 9/18/24 general order for Resident #23 was provided by the CC on 9/18/24 at 3:11 p.m. The order directed staff to document the resident' s behavior in progress notes every shift for three days and assess for any change in behavior such as fearfulness, retreating, nervousness or any other change in behavior.<br><br>-The order was created on 9/18/24 at 2:40 p.m., during the survey period, and nine days after the resident to resident altercation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | V. Staff interviews<br><br>The social service director (SSD) was interviewed on 9/18/24 at 8:55 a.m. The SSD said the facility wanted to keep the residents safe and put measures in place to help ensure the residents feel safe. He said the interdisciplinary team (IDT) would identify risk factors that lead to potential abuse. He said his role in an abuse investigation was to interview the residents. He said if an incident of abuse or potential abuse occurred in the memory care unit he would interview 10% of the residents in the memory care unit. The SSD said he would ask the residents basic questions to determine if they felt they were safe. He said most residents with memory problems could still say if they felt safe or not.<br><br>The SSD said the nursing management would interview the staff. He said behavior monitoring would be initiated by the nursing staff to help determine if there were changes in the behavior of a resident. He said if a resident was having cognitive or behavioral changes related to altercations, the facility would look at how their medications were affecting them, contact their physician and care plan accordingly. He said the facility may refer the concerns to a mental health specialist. The SSD said behavior monitoring was important because it could take time to process trauma and trauma could present differently for everyone.<br><br>The NHA was interviewed on 9/18/24 at 11:07 a.m. The NHA said the provided abuse investigation file for Resident #22 and Resident #23 was what was completed for the investigation. She said the director of nursing (DON) might have additional information.<br><br>The DON was interviewed on 9/18/24 at 1:24 p.m. The DON said she was the facility' s abuse coordinator. She said if there was an allegation or suspicion of potential abuse,, staff involved would be interviewed. She said staff who worked directly with the residents involved on both shifts would be interviewed. The DON said the staff would be asked if they were aware of any potential abuse, had seen abuse or had concerns for residents' safety. She said she would want to make sure staff were aware of the reporting protocol. She said the interviews would be documented and reviewed to help determine if there was abuse or suspicion of abuse. She said after the investigation she would write up an investigation summary. The DON said she would report an incident to the State Agency if abuse was determined.<br><br>The DON said pain would be monitored and documented in progress notes and on a weekly pain assessment. She said if there was pain reported, it would be on the pain log. She said the facility would watch for mood and behavior changes such as fearful reactions. The DON said the monitoring would be in progress notes for 72 hours for consistency. She said if monitoring residents after an incident was not in the progress notes, it probably was not documented. The DON reviewed the EMRs for Resident #22 and Resident #23 and said there was not 72 hour documentation of behavior monitoring after the 9/9/24 incident, but she said she said nothing was reported as a change.<br><br>The DON said she did not feel a more complete investigation was necessary because staff saw what happened. She said staff knew the way Resident #22 and Resident #23 were. The DON said it was normal behavior for both residents that resulted in the altercation. She said Resident #23 got in other residents' personal space and Resident #22 did not want others in her personal space. The DON said additional interviews were not completed because these were typical typical behaviors the residents exhibited. The DON said she did not feel there was more that could have been investigated.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said the facility ruled out the abuse concern because it was the residents' normal behavior and there was not a negative outcome and residents were separated at the time. She said the residents did not have pain, injury or psychological harm after the incident.<br><br>The DON said the incident was communicated in staff huddles that were not documented. She said the staff were reminded to supervise Resident #22 and Resident #23 related to the incident and their normal behaviors. She said there was no no new intervention put in place put in place for Resident #23 because it was it was her usual behavior to reach for things and it and it was already care planned. She said there had been no other problems on any other . She said there had been no other problems on any other days except for 9/9/24.<br><br>CNA #5 was interviewed on 9/18/24 at 2:05 p.m. CNA #5 said she had worked on the memory care unit for a few months. She said if there was a resident to resident altercation, she would redirect the residents away from each other and report the incident. She said she would tell the residents that the behavior was incorrect and encourage them to respond to each other in a more positive manner.<br><br>CNA #5 said Resident #23 could get agitated when staff tried to help her get dressed but she was not aware of any problems or incidents with other residents. She said Resident #22 liked to have her own personal space. She said if a resident tried to take her or her family member' s napkin, she would try to hit their hand. She said Resident #23 got into other residents' personal space so staff tried to tell her to move on when she was in another resident' s personal space. She said nothing had been reported to her about an incident between Resident #23 and Resident #22.<br><br>CNA #3 was interviewed on 9/18/24 at 2:13 p.m. CNA #3 said she witnessed Resident #22 hit the left hand of Resident #23. She said after the incident she redirected her not to get too close to Resident #22. She said she reminded Resident #22 that Resident #23 did not know what she was doing. She said she said she was not aware of other interventions other than talking to Resident #22 and reminding her that other residents were confused.<br><br>The activity director (AD) was interviewed on 9/19/24 at 9:30 a.m. The AD said when Resident #22 was in the common area, other residents should not get too close to her or or reach for her items. The AD said to help prevent any problems, she would try to sit with Resident #22 Resident #22 in an activity or take her to other activities outside of the memory care unit. The AD said Resident #23 should not be near Resident #22 because she did not have an understanding of personal space.<br><br>The AD said she was not aware of any resident to resident alterations between Resident #22 and Resident #23. She said usually found out about incidents in morning meetings and zoom communication. She said when there was an altercation, staff usually asked if activities staff were available to help redirect residents.<br><br>The CC was interviewed on 9/19/24 at 4:33 p.m. The CC said she spoke to the memory care staff on the afternoon of 9/19/24 and learned Resident #23 liked to hold pieces of paper. She said the staff was looking into independent activities the resident could do with her hands to help deter her from trying to reach for other resident' s items. The CC said the intervention would be added to the care plan and the resident' s profile.<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314<br><br>Based on record review and interviews, the facility failed to ensure one (#145) of 23 sample residents received treatment and care in accordance with professional standards of practice.<br><br>Specifically, the facility failed to ensure Resident #145's vital signs were taken after the resident sustained an unwitnessed fall in her room.<br><br>Findings include:<br><br>I. Professional reference<br><br>According to [NAME], P.A., [NAME], A.G., Fundamentals of Nursing, 10 ed. (2020), Elsevier, St. Louis Missouri, pp. 1780, retrieved on 9/23/24, : In the event of a fall, perform a post-fall assessment to identify possible causes. Monitor patients closely for 48 hours after a fall.<br><br>IV. Resident #145<br><br>A. Resident status<br><br>Resident #145, under the age of 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included hypertension (high blood pressure), renal insufficiency, and chronic obstructive pulmonary disease (COPD).<br><br>The 9/18/24 minimum data set (MDS) assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. She required supervision or touching assistance with car transfers and was independent with all other cares.<br><br>The assessment documented Resident #145 had no rejections of care.<br><br>B. Record review<br><br>The fall care plan, initiated on 9/5/24 and reviewed on 9/16/24. The plan of care documented nursing staff would check vital signs and assess Resident #145 for injuries if she should experience a fall. The plan of care included an intervention to document the circumstances and possible cause of the fall.<br><br>The fall incident report, dated 9/10/24, documented that Resident #145 experienced an unwitnessed fall on 9/9/24. The fall report documented the resident was found in her bathroom at 6:45 a.m. sitting on the floor with her legs crossed. The fall report documented Resident #145 experienced pain in her coccyx (tailbone). The fall report documented the nurse believed the resident may have become hypotensive (low blood pressure) as a reason for the fall. The fall event documentation included a prompt to attach all vital signs and a progress note that included a summary of the fall.<br><br>-The fall event documentation failed to include documentation indicating the resident's vital signs were obtained.<br><br>(continued on next page) |

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| | 065420 | A. Building<br>B. Wing | 09/19/2024 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Vital sign documentation was reviewed between 9/9/24 and 9/12/24.<br><br>-The facility failed to record vital signs after the resident experienced an unwitnessed fall on 9/9/24 until 8:18 a.m. on 9/11/24.<br><br>C. Resident interview<br><br>Resident #145 was interviewed on 9/16/24 at 3:02 p.m. Resident #145 said she fell in the bathroom about a week ago which caused her pain in her tailbone.<br><br>III. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on 9/18/24 at 10:18 a.m. LPN #1 said when a resident fell they must be assessed immediately. LPN #1 said vital signs and a full head-to-toe assessment should be completed to ensure the resident was not injured.<br><br>The director of rehabilitation (DOR) was interviewed on 9/19/24 at 10:39 a.m. The DOR said if a resident had an unwitnessed fall, she would get a nurse to assess the resident and obtain vital signs. The DOR said it was important to obtain a set of vital signs quickly to ensure the resident did not need additional care or services.<br><br>Certified nursing aide (CNA) #2 was interviewed on 9/19/24 at 10:49 a.m. CNA #2 said if a resident had an unwitnessed fall, she would get the nurse immediately to assess the resident while she obtained vital signs on the resident. CNA #2 said CNAs and nurses could obtain vital signs after a resident experiences a fall.<br><br>The director of nursing (DON) was interviewed on 9/19/24 at 1:41 p.m The DON said if a resident experienced an unwitnessed fall she would expect the nursing staff to assess the resident. The DON said the assessment included vital signs, a neurological assessment and a resident assessment to ensure there are no physical injuries from the fall.<br><br>The DON said it was important for the nursing staff to consider all possibilities of how the resident fell . The DON reviewed the fall report for Resident #145 documented on 9/10/24. The DON said that vital signs should have been taken when Resident #145 fell to ensure a low heart rate or a low blood pressure were not the cause of the fall. |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314<br><br>Based on observations, record review and interviews, the facility failed to ensure two (#10 and #35) of five residents out of 23 sample residents received the care and services necessary to meet their nutrition needs and to maintain their highest level of physical well-being.<br><br>Resident #10 was admitted to the facility for long-term care on 4/6/18 with diagnoses of dementia, stroke, and seizure disorder. Upon admission, the resident weighed 117 pounds (lbs).<br><br>On 7/30/24, Resident #10 weighed 145.6 lbs. On 9/3/24 the resident weighed 126 lbs. Resident #10 sustained a 18.6 lbs (12.8%) weight loss from 7/30/24 to 8/27/24 in one month, which was considered severe weight loss.<br><br>Due to the facility's failure to accurately assess and implement nutrition interventions timely the resident's weight continued to decline.<br><br>Additionally, Resident #35 admitted on [DATE] with a diagnosis of gastroesophageal reflux disease (GERD), arthritis and thyroid disorder. Upon admission, the resident weighed 107 lbs.<br><br>On 8/1/24 the facility discontinued the oral nutritional supplement that was prescribed to the resident, due to weight gain. However, the resident had lost 1.6 lbs from 7/23/24 to 7/30/24, in one week. The resident continued to have gradual weight loss and on 9/10/24 the resident weighed 106 lbs, which indicated the resident had lost eight pounds (7%) from 8/6/24 to 9/10/24, in one month, which was considered severe. After the resident sustained severe weight loss, the facility failed to implement person centered nutritional interventions to address the weight loss.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The weight measurement policy, reviewed 3/28/24, was provided by the nursing home administrator (NHA) on 9/19/24 at 1:12 p.m. It documented in pertinent part,<br><br>Weigh the resident at approximately the same time of day.<br><br>A re-weigh is needed in these circumstances: if the present weight of the resident is plus or minus five pounds from the previous weight, or if the resident weighs 100 pounds or less and the present weight is plus or minus three pounds from the previous weight.<br><br>Update the resident care plan with all changes of orders, goals, and interventions.<br><br>The hydration policy, reviewed 3/27/24, was provided by the NHA on 9/19/24 at 1:12 p.m. It read in pertinent part,<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The nutrition services professional, nursing staff, and physician will assess factors that may be contributing to inadequate intake. Orders for medications that may exacerbate dehydration ( diuretics) will be reviewed and held if medically appropriate.<br><br>Nursing will monitor fluid intake and the nutrition services professional will be kept informed of status. The interdisciplinary team will update the care plan and document resident response to interventions until the team agrees that fluid intake and related factors are resolved.<br><br>II. Resident #10<br><br>A. Resident status<br><br>Resident #10, over the age of 65, was admitted to the facility on [DATE] and readmitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included dementia, stroke, and seizure disorder.<br><br>The 9/3/24 minimum data set (MDS) assessment revealed the resident could not complete the brief interview for mental status (BIMS) score assessment because she was rarely or never understood. The resident was dependent on the nursing staff for all care. The assessment documented the resident had no signs or symptoms of swallowing disorders.<br><br>The assessment documented the resident was 62 inches (5 foot, 2 inches) tall.<br><br>The assessment documented the resident weighed 126 pounds. The assessment documented the resident had experienced 10% or more weight loss in the last six months. The assessment documented the resident was not on a physician-prescribed weight loss regimen.<br><br>B. Observations<br><br>During a continuous observation on 9/16/24, beginning at 11:58 a.m. and ending at 1:13 p.m. the following was observed:<br><br>At 11:58 a.m. Resident #10 was observed in a reclining chair in the living room area. The resident sat alone in the recliner chair until she was assisted one on one by an unidentified staff member which began at 12:21 p.m. The unidentified staff member assisted Resident #10 with eating lunch which included tomato soup with crackers, bread, and another unidentified food item that was covered with plastic wrap. Resident #10 ate 25-50% of her tomato soup and none of her bread during the lunch observation.<br><br>At 12:31 p.m. the unidentified staff member removed the lunch tray from Resident #10. The unidentified staff member did not offer the resident the bread or the unidentified food item. That food remained covered in plastic wrap.<br><br>-Resident #10 was not offered any alternate food option.<br><br>C. Record review<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The nutrition care plan was initiated on 4/6/18 and revised 9/5/24. The care plan documented a goal of maintaining Resident #10's weight and maintaining intakes greater than 50%, implemented on 6/5/24. Interventions included encouraging the resident to drink fluids and providing an easy to chew texture.<br><br>-A review of the comprehensive care plan revealed there were no new or revised interventions implemented after the resident sustained severe weight loss on 9/3/24.<br><br>Resident #10's weights were documented in the electronic medical record (EMR) as follows:<br><br>-On 7/30/24, the resident weighed 145.6 lbs;<br><br>-On 8/6/24, the resident weighed 140.4 lbs;<br><br>-On 8/13/24, the resident weighed 131.7 lbs;<br><br>-On 8/20/24, the resident weighed 139.4 lbs;<br><br>-On 8/27/24, the resident weighed 127 lbs; and,<br><br>-On 9/3/24, the resident weighed 126 lbs.<br><br>-The resident lost 18.6 lbs (12.8) from 7/30/24 to 8/27/24, in one month, which was considered severe.<br><br>The nutritional assessment, dated 9/4/24, documented the resident had not experienced weight loss or weight gain. The assessment documented the resident had not had a significant weight change due to a prescribed weight change regimen. The assessment documented Resident #10 had no food allergies and the resident's spouse preferred Glucerna protein shakes and evening snacks offered to the resident. The assessment documented Resident #10 was often assisted at mealtimes by her spouse. The assessment documented that Resident #10 required no new interventions at this time.<br><br>-However, Resident #10 sustained a 19.6 lbs (13.46%) from 7/30/24 to 9/3/24, which was considered severe.<br><br>-Review of the resident's EMR did not reveal a physician's prescribed weight loss regimen or indication of why the resident's weight loss was desired.<br><br>The nutritional quarterly progress note, dated 9/4/24, documented the resident lost 14 pounds in 30 days or less. The progress note documented no new interventions were necessary at this time, and the resident was receiving treatment for a urinary tract infection.<br><br>-The facility failed to implement a person centered nutritional intervention after Resident #10 sustained a 19. 6 lbs (13.46%) from 7/30/24 to 9/3/24, which was considered severe.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The care conference note, dated 9/12/24, documented Resident #10 had lost 16 pounds since the last care conference, which concerned the facility. The resident's spouse requested the facility explore potential supplements and the facility documented that the resident enjoyed protein drinks. It documented Resident #10 was falling asleep during meals.<br><br>-However, the facility failed to implement or trial oral nutritional supplements after the resident had sustained weight loss.<br><br>The nutrition at risk meeting note, dated 7/17/24, documented the resident had a BMI of 26.5, was eating 75-100% of all meals, required assistance at meals and the resident's spouse was often present at meals.<br><br>The nutrition at risk meeting note, dated 8/7/24, documented the resident had a BMI of 26.5, was consuming 75-100% of all meals, required assistance at meals and the resident's spouse was often present at meals.<br><br>-However, on 8/6/24 the weighed 140.4 pounds, which indicated the resident had a BMI of 25.7.<br><br>The nutrition at risk meeting note, dated 8/28/24, documented the resident had a BMI of 26.5, was consuming 75-100% of all meals, required assistance at meals and the resident's spouse was often present at meals.<br><br>-However, on 8/27/24 the resident weighed 127 pounds, which indicated the resident had a BMI of 23.2.<br><br>-The nutrition at risk meetings failed to identify that Resident #10 sustained a 18.6 lbs (12.8%) weight loss in one month, from 7/30/24 and 8/27/24, which was considered severe.<br><br>-The facility failed to implement person centered nutritional interventions to address the resident's weight loss.<br><br>The nutrition at risk meeting note, dated 9/18/24, documented the resident had a BMI of 23.1, was consuming 51-75% of all meals, required assistance at meals and the resident's spouse iwa often present at meals.<br><br>III. Resident #35<br><br>A. Resident status<br><br>Resident #35, over the age of 65, was admitted to the facility on [DATE]. According to the September 2024 CPO, diagnoses included GERD, arthritis and thyroid disorder.<br><br>The 7/26/24 MDS assessment revealed the resident had severe cognitive impairment with a BIMS score of four out of 15. The resident was independent with eating. The resident required supervision or touching assistance with bathing, dressing, personal hygiene and toileting.<br><br>The assessment documented the resident was 56 inches (4 foot, 8 inches) tall.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The assessment documented the resident weighed 118 pounds. The assessment documented the resident did not have a swallowing disorder. The assessment documented the resident had not experienced weight loss or weight gain in the last six months.<br><br>-However, the resident had sustained a 11.8 lbs (10.01%) weight loss in less than three months, which was considered severe weight loss.<br><br>B. Record review<br><br>The nutrition care plan, initiated on 4/24/24 and revised on 7/30/24, documented the resident was at a minimal nutritional risk with consistent food intake greater than 50%. The care plan documented the resident could eat independently and make her needs known. The interventions included maintaining the resident's weight, encouraging fluid intake, monitoring food and fluid intake at meals and providing snacks available daily.<br><br>-A review of the comprehensive care plan did not reveal documentation indicating interventions were reviewed or implemented to reduce or prevent weight loss after the resident sustained severe weight loss on 9/10/24.<br><br>Resident #35's weights were documented in the EMR as follows:<br><br>-On 6/12/24, the resident weighed 113.2 lbs;<br><br>-On 6/12/24, the resident weighed 113.2 lbs;<br><br>-On 5/28/24, the resident weighed 107 lbs;<br><br>-On 6/4/24, the resident weighed 112.8 lbs;<br><br>-On 6/11/24, the resident weighed 114.2 lbs;<br><br>-On 6/12/24, the resident weighed 113.2 lbs;<br><br>-On 6/25/24, the resident weighed 114.6 lbs;<br><br>-On 7/2/24, the resident weighed 113.6 lbs;<br><br>-On 7/9/24, the resident weighed 114.6 lbs;<br><br>-On 7/16/24, the resident weighed 115.6 lbs;<br><br>-On 7/23/24, the resident weighed 117.8 lbs;<br><br>-On 7/30/24, the resident weighed 116.2 lbs;<br><br>-On 8/6/24, the resident weighed 114 lbs;<br><br>-On 8/13/24, the resident weighed 111.4 lbs;<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | -On 8/20/24, the resident weighed 113 lbs;<br><br>-On 8/27/24, the resident weighed 112 lbs;<br><br>-On 9/3/24, the resident weighed 109 lbs; and,<br><br>-On 9/10/24, the resident weighed 106 lbs.<br><br>-The resident lost 8 lbs (7%) from 8/6/24 to 9/10/24, in one month, which was considered severe.<br><br>The nutritional assessment, dated 7/24/24 documented the resident had no food allergies and had not experienced weight loss. The assessment documented the resident was asleep during the assessment.<br><br>A physician's order, dated 8/1/25, documented the protein supplement (Ensure) was discontinued.<br><br>A physician's visit note, dated 8/1/24, documented Resident #35's protein supplement (Ensure) was discontinued because the resident had experienced weight gain.<br><br>-However, Resident #35 had lost 1.6 lbs from 7/23/24 to 7/30/24. Resident #35 had not experienced significant weight gain. The resident's weight fluctuated up and down a pound or two at each weigh-in (see the weight record above) and by 9/10/24 the resident had experienced a significant weight loss.<br><br>-A review of the resident's EMR did not reveal documentation indicating the resident was on a prescribed weight loss regimen.<br><br>IV. Staff interviews<br><br>Certified nursing aide (CNA) #1 was interviewed on 9/18/24 at 5:59 p.m. CNA #1 said Resident #35 did not regularly require assistance with eating. CNA #1 said Resident #35 usually ate what was in front of her as long as the staff helped her identify what the food items were because of her poor vision.<br><br>CNA #1 said Resident #10 was difficult to assist with eating because she often fell asleep during meals and it was a time consuming task for the nursing staff. CNA #1 said she knew Resident #10 had lost weight but could not say how much weight she had lost. CNA #1 said she did not know what the facility could do to prevent further weight loss for Resident #10.<br><br>The registered dietitian (RD) was interviewed on 9/19/24 at 11:16 a.m. The RD said she was in the building one day per week to assess resident nutritional needs. The RD said if she identified weight loss in a resident, she would perform a comprehensive assessment of the resident to identify the root cause for the weight loss.<br><br>The RD said if a resident experienced weight loss the resident would not always receive new interventions. The RD said she would have to look at the whole picture to determine if a resident needed a nutritional intervention. The RD said she did not expect the nutritional plan of care to be updated if a resident experienced weight loss. The RD said interventions such as nutritional supplements could be considered in residents with weight loss.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The RD said residents should be seated in the dining room for meals because the social aspect of meals helped the residents eat more. The RD said she did not know if additional food or supplements should be added or considered for residents experiencing consistent weight loss. The RD said she did not know if any interventions were added, reviewed, or changed for Resident #10 after she sustained severe weight loss between 7/30/24 and 9/3/24.<br><br>The RD said she did not have documentation indicated Resident #35 was on a weight loss regimen. The RD said she did not often manage weight loss regimens in the facility.<br><br>The RD said she thought Resident #35 had recently increased her prescribed dose of thyroid medication which was the cause of Resident #35's weight loss.<br><br>-However, review of Resident #35's EMR did not reveal documentation regarding the reasoning for Resident #35's weight loss.<br><br>The RD said she did not know if Resident #35 should receive protein supplements or not. The RD said she did not know if interventions were added, reviewed, or changed for Resident #35 to help reduce or prevent her severe weight loss between 7/30/24 and 9/3/24. The RD said Resident #35 was not reviewed in the nutrition at risk meeting.<br><br>The director of nursing (DON) was interviewed on 9/19/24 at 1:41 p.m. The DON said if a resident was experiencing weight loss, the facility worked to identify why the resident was losing weight and how the facility could prevent it. The DON said all residents experiencing weight loss were reviewed in the nutrition at risk committee. The DON said she reviewed the nutrition at risk committee meeting notes between 7/17/24 and 9/18/24 for Resident #10. The DON said the weights documented for Resident #10 on the nutrition at risk committee meeting notes did not match documented weights in the EMR. The DON said the facility could have done more to help reduce or prevent Resident #10's severe weight loss, such as considering supplements, diet changes, or working with the nursing staff to improve her intake.<br><br>The DON said Resident #35 was not identified as at risk in the nutrition at risk committee. The DON said Resident #35 should have been discussed in the nutritional at risk committee because she experienced significant weight loss. The DON said the facility could have done more to help reduce or prevent Resident #35's severe weight loss if she had been identified in the committee. The DON said she was concerned about the accuracy of the information being brought to the nutrition at risk committee because of documentation inaccuracies seen in Resident #10. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50314<br><br>Based on record review and interviews, the facility failed to ensure two (#14 and #37) of five residents reviewed were free from unnecessary psychotropic medications out of 23 sample residents.<br><br>Specifically, the facility failed to ensure as-needed psychotropic medications for Resident #14 and Resident #37 had an identified end date from the prescriber.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Psychotropic Medication Monitoring policy, reviewed 3/4/24, was received from the nursing home administrator (NHA) on 9/19/24 at 11:09 a.m. It read in pertinent part,Residents who use psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.<br><br>II. Resident #14<br><br>A. Resident status<br><br>Resident #14, age greater than 65, was admitted on [DATE]. According to the September 2024 computerized physician orders (CPO), diagnoses included hypertension (high blood pressure), stroke and respiratory failure.<br><br>The 8/5/24 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview of mental status (BIMS) assessment score of nine out of 15. She was dependent on staff for eating, oral care, bathing, toileting, dressing and personal hygiene.<br><br>B. Record review<br><br>A review of the September 2024 CPO revealed the resident had a physician's order for Haloperidol (antipsychotic medication) 1 milligram (mg) per 0.5 milliliter (mL) oral syrup every six hours as needed, ordered on 7/25/24.<br><br>-The antipsychotic medication was ordered by the medical director (MD) and did not have a a stop date.<br><br>-The antipsychotic medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.<br><br>III. Resident #37<br><br>(continued on next page) |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A. Resident status<br><br>Resident #37, over the age of 65, was admitted on [DATE]. According to the September 2024 CPO, diagnoses included non-traumatic brain dysfunction, anxiety disorder, and Alzheimer's disease.<br><br>The 8/30/24 MDS assessment revealed the resident had severe cognitive impairments with a BIMS assessment score of zero out of 15. She required moderate assistance with bathing, dressing, and personal hygiene. She required supervision or touching assistance with eating and oral hygiene.<br><br>B. Record review<br><br>A review of the September 2024 CPO revealed the resident had a physician's order for Haloperidol (antipsychotic medication) concentrate 2 milligrams (mg) per milliliter (mL), administer one mL every six hours as needed for agitation, ordered on 8/16/24.<br><br>-The antipsychotic medication was prescribed by the MD without a stop date.<br><br>-The antipsychotic medication was prescribed for over 14 days on an as needed basis. A review of the resident's EMR did not reveal documentation from a physician indicating the medication needed to be prescribed as needed for over 14 days.<br><br>IV. Staff interviews<br><br>The medical director (MD) was interviewed on 9/19/24 at 9:59 a.m. The MD said that as-needed psychotropic medications have a maximum prescribing time of 14 days for the order. The MD reviewed the September 2024 CPO for Resident #14 and Resident #37. The MD said Resident #14's Haloperidol should have had a stop date and it was incorrect to order the medication without one. The MD said Resident #37's ordered Haloperidol did not have a stop date either, which was also incorrect. The MD said it was important to have stop dates for as-needed psychotropic medications to ensure we are using psychotropic medications only when necessary. The MD said it was the responsibility of the MD to ensure as-needed psychotropic medications are prescribed appropriately. The MD said it should not be the responsibility of the nursing staff to ensure psychotropic medications are prescribed correctly in the CPO. The MD said she would address the incorrect psychotropic medication orders on 9/19/24.<br><br>The director of nursing (DON) was interviewed on 9/19/24 at 1:41 p.m. The DON said as-needed psychotropic medications cannot be ordered for more than 14 days. |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40467<br><br>Based on record review and interviews, the facility failed to ensure one resident (#5) out of five residents reviewed were free from significant medication errors out of 23 sample residents.<br><br>Specifically, the facility failed to ensure, for Resident #5:<br><br>-Antibiotics were started as ordered;<br><br>-The correct antibiotic was given as ordered;<br><br>-The physician was notified when the antibiotics were not available; and,<br><br>-Timely identification and notification of a significant medication error.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Medication Administration policy, last reviewed [DATE], was provided by the nursing home administrator (NHA) on [DATE] at 1:14 p.m. The policy read in pertinent part, Medications will be administered to residents as prescribed by the primary MD (medical doctor)/NP (nurse practitioner)/PA (physician assistant).<br><br>Staff will follow the six rights of medication administration. Right resident, right medication, right dose, right dosage form, right frequency and right route.<br><br>Medications will be given one hour before or one hour after scheduled medication unless there is a specific order or indication otherwise.<br><br>Expired or discontinued medications will be promptly removed from the medication cart and disposed of per medication disposition policy.<br><br>The Notification of Physician and Resident Representative policy, last reviewed [DATE], was provided by the NHA on [DATE] at 1:14 p.m. The policy read in pertinent part, Primary physicians, residents, and the resident representative, consistent with their authority, will be updated with resident condition changes as soon as possible. The names of those contacted will be documented in the progress notes.<br><br>The policy identified the physician needed to be contacted as soon as possible when:<br><br>A need to alter treatment significantly, for example need to discontinue or change existing form or treatment due to adverse consequences, or to begin a new form of treatment.<br><br>A significant medication error.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | II. Resident #5<br><br>A. Resident status<br><br>Resident #5, age greater than 65, was admitted on [DATE] and readmitted on [DATE] According to the [DATE] computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (COPD), unspecified otitis externa (inflammation of the ear canal), right ear and unspecified otitis externa.<br><br>The [DATE] minimum data set (MDS) assessment revealed the resident had moderate cognitive impairments with a brief interview for mental status (BIMS) of 10 out of 15. The resident did not exhibit disoriented thinking or inattention.<br><br>-The MDS assessment indicated the resident was on an antibiotic during the lookback period.<br><br>B. Resident interview<br><br>Resident #5 was interviewed on [DATE] at 3:29 p.m. He said he had an ear ache since [DATE]. He said he was supposed to get ear drops for it on [DATE] but was told the ear drops were coming from an out of town pharmacy and would not arrive until tonight ([DATE]).<br><br>Resident #5 was interviewed a second time on [DATE] at 2:59 p.m. He said he was now getting the ear drops for his ear ache but his ear was hurting over the weekend and had to ask for tramadol (a synthetic opioid pain reliever).<br><br>C. Record review<br><br>The [DATE] physician progress note identified Resident #5 was seen by the medical director (MD) on [DATE] at 3:15 p.m. The resident had right ear pain that was described as deep. According to the note, the resident had a diagnosis of otitis externa to the right ear which was recurrent and improved with treatment. The MD prescribed cortisporin (antibiotic ear drops).<br><br>The [DATE] medication administration record (MAR) revealed Resident #5 had physician's orders for the antibiotic treatment of neomycin-polymyxin-HC (ear) drops three times a day, ordered on [DATE] and discontinued on [DATE].<br><br>-According to [DATE] MAR, Resident #5 received the ordered antibiotic until the discontinue date of [DATE].<br><br>The [DATE] MAR revealed Resident #5 had a physician's order for for cortisporin-TC (neomycin-colist-hc-thonzonium) ear drops to be given twice a day for seven days, ordered on [DATE] and ending on [DATE].<br><br>According to the [DATE] MAR, Resident #5 did not receive the cortisporin antibiotic ear drops for both scheduled doses on [DATE] and [DATE] and one scheduled dose on [DATE].<br><br>-The missed doses were documented as unavailable, not administered and waiting for delivery from the pharmacy.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -However, the cortisporin was documented on [DATE] as administered by registered nurse (RN) #2 between the hours of 7:00 a.m. and 10:00 a.m. (see interviews below).<br><br>-Review of Resident #5's electronic medical record (EMR) did not reveal documentation indicating the resident's physician was notified of the missed doses on [DATE], [DATE] and [DATE].<br><br>A [DATE] email between the director of nursing (DON) and the nursing staff was provided by corporate consultant (CC) on [DATE] at 3:50 p.m. The email was created on [DATE] (during survey period). The email read in pertinent part, When a medication order is received that the resident should start right away such as an antibiotic or narcotic, check the stat safe list and use that until the medication arrives. when you fax in order to the pharmacy, please enter the time the order was faxed on the physician order sheet. Please communicate on report any medications that should be arriving. night shift, during your chart check, please be the second set of eyes and know any medications that should be arriving. compare this to the medications that come in. If a medication does not arrive as expected, please document in the progress notes:' X medication order was faxed to the pharmacy at X time. Medication did not arrive in tonight's shipment. Will pass on to the next shift to contact the pharmacy and the provider.' Pass this on to the day nurse. The day nurse will be responsible for calling the pharmacy and checking on this. you will document in the progress notes the status of the medication as well as any follow-up that is needed. The day nurse will contact the provider to see if the provider would like to order a different medication. The information will be passed on to the next shift. This will continue until the medication is received.<br><br>The DON directed the staff to document each step of the process.<br><br>D. Staff interviews<br><br>Licensed practical nurse (LPN) #1 was interviewed on [DATE] at 12:37 p.m. LPN #1 said the MD ordered the cortisporin ear drops for Resident #5's ear infection on Friday [DATE] for a start date on [DATE]. LPN #1 said the pharmacy was notified of the order on [DATE]. He said the antibiotics were ordered from a pharmacy that was out of town and it was common for a medication not to arrive till the following Monday when it was ordered late on a Friday. LPN #1 said the antibiotic did not arrive until Monday night ([DATE]). He said Resident #5 received his first dose of the cortisporin antibiotic on Tuesday morning ([DATE]).<br><br>The infection preventionist (IP) was interviewed on [DATE] at 1:01 p.m. The IP reviewed Resident #5's MAR and said the antibiotic was scheduled twice a day starting on [DATE] but the MAR was not clear when the resident received it and she would need to refer to the DON for clarification.<br><br>The DON was interviewed on [DATE] at 1:11 p.m. The DON reviewed Resident #5's MAR. She said the resident should have received the antibiotic starting on [DATE] but according to the notes on the MAR, the antibiotic was not available to give. The [DATE] administration of the antibiotic must have been marked as received in error because the antibiotic did not arrive until [DATE]. She said she would contact RN #2 to find out what happened and provide education to her.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said she was not sure why the medication did not arrive until [DATE]. She said she was not made aware of a concern. The DON reviewed Resident #5's progress notes and said she did not know if the pharmacy was contacted to determine why the late delivery. She said she had not been informed that it was common for a medication ordered on Friday not to arrive until monday. She said the physician's orders needed to be given to the pharmacy by 3:00 p.m. to receive the following day but no one complained to her that the medication would not arrive the following day. She said she did not know if the MD was notified that the antibiotic was not given on [DATE] as ordered and he did not have his first dose until [DATE]. The DON said it could be more difficult to reach the MD if the concern was not urgent but she should have been contacted. The DON said she did not see any notes identifying the resident complained of pain related to his ear.<br><br>The CC was interviewed on [DATE] at 3:11 p.m. The CC said the facility was in process of notifying the MD to inform her of the delay in antibiotics for Resident #5. She said RN #2 would be educated on the charting error and the pharmacy would be contacted. The CC said the DON was still in process of trying to identify why the antibiotic was marked as administered when it was not available.<br><br>The MD was interviewed on [DATE] at 3:13 p.m. The MD said she was informed today ([DATE]) that there was a delay over the weekend to give Resident #5's the antibiotic ear drops. She said she put in a PRN (as needed) order for the drops on [DATE] once she heard the risk of not getting the medication over the weekend so that they would be available to him if it happens again. She said she was not contacted until [DATE] and would have preferred to be contacted if the resident did not receive his medication, especially if the resident was experiencing discomfort. She said she could have ordered through the local pharmacy for an easy pickup.<br><br>The DON was interviewed again on [DATE] at 5:47 p.m. The DON said she sent out an email to nursing staff on documentation and what to do when a medication was not available as ordered. She said she was trying to figure out how the medication error occurred. She said once she learned what happened she would know what her next steps were.<br><br>The DON was interviewed again on [DATE] at 12:31 p.m. The DON said she spoke to RN #2. She said RN #2 remembered giving Resident #5 his antibiotics on [DATE]. The DON said RN #2 named off a discontinued antibiotic (neomycin-polymyxin administered three times a day). She said the discontinued antibiotic was also ear drops but it was discontinued on [DATE]. She said the cortisporin (neomycin-colist-hc-thonzonium administered twice a day) was ordered on [DATE] and was the ear drop RN #2 should have been administered. She said the discontinued antibiotics were not removed for the nursing medication cart and RN #2 gave Resident #5 the wrong antibiotic. She said the discontinued antibiotic was later removed by a night nurse on [DATE] but after the discontinued antibiotic was given on [DATE].<br><br>The DON said she was concerned with RN #2 accuracy of medication administration. She said RN #2 did not review the orders close enough to ensure the resident did not receive an discontinued antibiotic and that was giving him the correct antibiotic. The DON said education would be provided to RN #2. She said the education would include the rights of medication administration (see above in policy) and online training. She said he education would be completed prior to RN #2 administering medications. The DON said RN #2 would then be monitored during medication pass to ensure accuracy.<br><br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON said she was concerned that the staff did not inform her of delays with receiving medications over the weekends. She said the nurses should have communicated to her. She said after speaking with the staff it was identified as a long standing concern. The DON said she would discuss her concerns with the NHA and the pharmacy. She said it was not appropriate for a medication to be ordered on a Friday and not able to start till its next scheduled dose on a Tuesday morning. The DON said the pharmacy concern would also be discussed in the quality assurance and performance improvement (QAPI) meeting. The DON said she would speak to the MD with an immediate plan to mitigate the receival of weekend medications ordered on a Friday. |