

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 106153	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER Legacy Pointe at Ucf		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 Hestia Loop Oviedo, FL 32765	

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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on interview, and record review, the facility failed to follow their grievance process for 2 of 2 residents reviewed for grievances, of a total sample of 26 residents, (#21 and #443).</p> <p>Findings:</p> <p>1. Review of resident #21's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, atrial fibrillation, and osteoarthritis.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment with Assessment Reference Date (ARD) of 10/14/24 revealed resident #21 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated she was cognitively intact.</p> <p>On 1/21/25 at 1:48 PM, resident #21 shared she could not find some lotion and a gait belt she had in her room. She stated staff helped her look for the items, but no one had found them. Resident #21 stated while getting care from her aide about a day or two ago, a healed wound had reopened. She said she wished to no longer have that aide provide care to her. She explained the Certified Nursing Assistant (CNA) grabbed her by her hips instead of under her arms when transferring from the toilet to her wheelchair. She indicated she received care for the wound and it was now healing but staff should learn the basics because not all of them knew how to transfer or pivot in the bathroom. She indicated the day after the incident, she shared with staff the details of what occurred and had not seen that girl again.</p> <p>Review of the Grievance Log from November 2024 through 1/21/25 did not include any grievances from resident #21.</p> <p>On 1/23/25 at 1:17 PM, CNA D recalled resident #21 reporting a missing item which she reported to the nurse. She was unsure who the nurse was or when exactly it occurred. CNA D stated she had handed blank grievance forms to resident #21 in the past. She explained resident #21 had completed at least two grievance forms because she received them and dropped them off under the Social Services Director's office door. She stated the last grievance was about a month ago which concerned her medications and the other grievance referred to a caregiver not knowing how to transfer her. She indicated resident #21 completed both forms and left them in the Social Service office, under her door.</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 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/24/25 at 10:50 AM, the Social Services Director confirmed she was the Grievance Officer and explained she had a box in the copy room where staff placed grievance forms. She indicated she also had found forms on her office floor when she came in. The Social Services Director shared resident #21 had not expressed many concerns, but the last one concerned the cost of medication which she had mentioned on the care plan meeting held on 1/22/25. The Social Services Director indicated resident #21's concerns did not escalate to a grievance since it was about medication prices and the bill. The Social Services Director shared that during the care plan meeting, resident #21 showed her a copy of the grievance form which she had completed in regard to the cost of getting medication from an outside provider. She indicated she had the Nurse Practitioner address resident #21's concerns the same day. The Social Services Director mentioned she told resident #21 to hold onto the grievance form. The Social Services Director stated she did not get a copy of the grievance but should have. She indicated she figured the issue was addressed at that time and the form was not needed. She explained the grievance forms ensured residents concerns were addressed timely and showed the facility's response. The Social Services Director later provided a copy of grievance resident #21 completed on 12/29/24.</p> <p>Review of Resident/Family Concern/Grievance Form dated 12/29/24 was not completely legible. The form included, Eliquis Request Earlier for (not legible) this is the 2nd med. [medication] Miscommunication on blood work. Dr [physician] requested 2 types. Report return with 2 but only was what I requested. Notified nurse of error and nothing done even of drs [physician] office resubmitted. No meds[medications] until dr [physician] sees blood work. A second page mentioned needing help as cost of medication was \$1200.00 and issue started by nurse delayed, getting her late to a doctor's appointment.</p> <p>2. Review of resident #443's medical record revealed he was admitted to the facility on [DATE] with diagnoses including sepsis due to enterococcus, chronic obstructive pulmonary disease, type 2 diabetes, and sensorineural bilateral hearing loss.</p> <p>Review of the MDS admission assessment with ARD of 1/10/25 revealed resident #443 had a BIMS score of 15 out of 15 which indicated he was cognitively intact.</p> <p>On 1/21/25 at 11:18 AM, resident #443 stated he was hard of hearing, had hearing aids which did not work properly and requested the surveyor speak with his wife. Later at 12:08 PM, resident #443's wife explained her husband was admitted approximately two weeks ago to receive intravenous (IV) antibiotics which were completed on Sunday. She indicated she requested to speak with his physician and for him to be discharged today and his foley to be removed. She shared last Friday they attended a care plan meeting with four staff who were not familiar with her husband's discharge plans and were rushing to get to another meeting. She indicated they were unable to find out what the physician's plan was, and she asked to speak with the physician. She stated his hearing was challenged, and anything discussed with him was lost and confusing. She shared the night he was admitted to the facility was a disaster because the facility did not have the medications, and the contract nurses were not familiar with the facility's operations. She indicated the antibiotics were given every four to six hours at the hospital but the facility was giving it continuously. She indicated her daughter in law came in and spoke with the Director of Nursing (DON) to help sort things out. She mentioned the staff was not cleaning or charging resident #443's hearing aids, she had to clean them, and she requested the batteries to be charged at night. She shared she was worried about him because the facility, seemed ill-prepared for his admission.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Grievance Log for January 2025 revealed one grievance on 1/21/25 for resident #443. The grievance was filed by resident #443's wife. The brief description in the grievance section read, request discharge.</p> <p>Review of resident #443's medical records revealed a Progress Note dated 1/04/25 entered by a nurse which read, Notified stepdaughter [name] of meds that were able to be given to PT (patient). Addressed her other concerns with medication, pharmacy was notified and meds will be delivered to facility ASAP (as soon as possible).</p> <p>On 1/24/25 at 10:34 AM, the Social Services Director indicated she had two grievances for resident #443 although only one showed on the Grievance Log. She explained during the care plan meeting on Friday, resident #443's wife did not go into details about her concerns but was upset about the discharge and they had to cut the meeting short because of other meetings staff had to attend. The Social Services Director indicated she returned to resident #443's room after the other meetings to obtain more details about the concerns mentioned in the care plan meeting. The Social Services Director indicated resident #443's wife mentioned she instead had addressed her concerns with the Nursing Home Administrator (NHA). She stated she did not log in the first grievance in the Grievance Log because she attached it to the grievance dated 1/21/25 as it related to the same issue.</p> <p>On 1/24/25 at 5:37 PM, the NHA stated he spoke with resident #443's wife the day after his admission. He explained she was upset about the medications because they were not the same as at his last place. The NHA mentioned he did not file a grievance form because she was upset about the sending facility, not them, for not letting her know about the new medications. He did not reply when asked about one of the antibiotics which was incorrectly entered and given to resident #443, which would have been reflected in the list of medications she reviewed the day after his admission.</p> <p>Review of the facility's Right to Voice Grievances and Have Grievances Resolved policy dated 4/01/23 read, The community has an identified grievance official who is responsible for tracking grievances, investigation of grievance, overseeing the grievance process and communication to all individuals involved. The facility will maintain evidence demonstrating the results of all grievance for at least 3 years.</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on interview, and record review, the facility failed to provide written Notification of Transfer or Discharge forms to the residents or their representative and the Ombudsman for 4 of 4 residents reviewed for hospitalization s, of a total sample of 26 residents, (#10, #25, #31 and #38).</p> <p>Findings:</p> <p>1. Review of resident #25's medical record revealed she was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. Her diagnoses included myocardial infarction, type 2 diabetes, congestive heart failure, and fracture of right ileum.</p> <p>Review of the Minimum Data Set (MDS) discharge assessment with Assessment Reference Date (ARD) of 8/12/24 revealed resident #25 had an unplanned transfer to a short-term acute care hospital. The record showed additional MDS discharge assessments were completed for unplanned transfers to the hospital on 9/11/24, 11/12/24 and 12/11/24.</p> <p>Review of resident #25's medical record revealed she was transferred to the hospital on 9/11/24 due to low oxygen, on 11/12/24 due to shortness of breath (SOB) and wheezing and on 12/11/24 due to SOB.</p> <p>Review of resident #25's medical record did not contain the Notification of Transfer or Discharge forms for any of the hospitalization s.</p> <p>In interviews on 1/21/25 at 11:28 AM, and on 1/22/25 at 11:52 AM, resident #25 was alert and oriented to person, place, and time. She did not express any concerns with being allowed to return to the facility from her previous hospitalization s for her respiratory issues.</p> <p>45646</p> <p>2. Resident #10 was admitted to the facility on [DATE] with diagnoses including chronic systolic congestive heart failure, immunodeficiency, umbilical hernia, hypertension, hypotension and chronic atrial fibrillation.</p> <p>Review of resident #10's medical record revealed he was hospitalized on [DATE] due to low hemoglobin and blood transfusion; on 11/24/24 due to altered level of consciousness and respiratory distress; and on 12/12/24 due to altered mental status and complaint of pain. The medical record did not contain Notification of Transfer or Discharge forms for the hospitalization s. The resident did not return to the facility due to his death at the hospital on 12/15/24.</p> <p>(continued on next page)</p>		

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<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. Resident #31 was admitted to the facility on [DATE] with diagnoses including cerebral atherosclerosis, Parkinson's disease, acute embolism and thrombosis, vascular dementia with mood disturbance and Alzheimer's Disease. Review of resident #31's medical record revealed he was hospitalized on [DATE] due to fall with complaint of pain and on and 10/31/24 to rule out deep vein thrombosis due to right lower extremity edema. He returned to the facility from his latest hospitalization on [DATE] where he currently remained.</p> <p>The medical record did not contain Notification of Transfer or Discharge forms for the hospitalization s.</p> <p>4. Resident #38 was admitted to the facility on [DATE] with diagnoses including vascular dementia, type 2 diabetes, hypertension, hyperlipidemia, unspecified convulsions, depression and anxiety disorder.</p> <p>Review of resident #38's medical record revealed he was hospitalized on [DATE] due to lethargy and hypoglycemia. The medical record did not contain Notification of Transfer or Discharge forms for the hospitalization . Resident #38 returned to the facility on [DATE] where he currently remained.</p> <p>On 1/23/25 at 10:25 AM, the Assistant Director of Nursing (ADON) stated the nurse completed the Notice of Transfer or Discharge form when a resident went to the hospital. She explained she was unaware of who provided the form to the resident or their representative or who notified the Ombudsman office of the transfer.</p> <p>On 1/24/25 at 1:46 PM, the Social Services Director she stated she notified the Ombudsman and completed the Notice of Transfer or Discharge forms for residents who discharged to the community, but not for residents who transferred to the hospital. She was able to provide the log and form for those community discharged resident. She explained she was aware the forms needed to be completed and sent to the Ombudsman but was not aware of who completed the Notice of Transfer or Discharge forms for residents who went to the hospital.</p> <p>On 1/24/25 at 2:38 PM, the Director of Nursing (DON) confirmed nurses were responsible for completing the Notification of Transfer or Discharge form when a resident transferred to the hospital. She acknowledged they were not being completed and she was not able to provide any documentation of them for residents #10, #25, #31 or #38. The DON stated she was not aware of any being completed since she began in December 2024.</p> <p>On 1/24/25 at 2:58 PM, the Administrator stated the DON made him aware of the concern with the Notification of Transfer or Discharge forms. He explained the nurses were supposed to complete the form and Social Services should have sent a log to the Long-Term Care Ombudsman office. The Administrator acknowledged the forms were not being provided to the residents or their representatives or sent to the Ombudsman office upon hospital transfer. He explained they have had a couple of changes in staff and the process fell through the cracks.</p> <p>The facility's policy and procedure for Transfer and Discharge, Voluntary - Notification of State Long-Term Care (LTC) Ombudsman indicated the facility would provide written notification to the State Long-Term Care Ombudsman when a resident has a transfer/emergency admission to the hospital.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43192</p> <p>Based on observation, interview, and record review, the facility failed to ensure nursing staff had the appropriate competencies and skill sets required to meet residents' needs for medication administration and storage per nursing standards of care for 3 of 3 nurses reviewed for medication administration and storage.</p> <p>Findings:</p> <p>1. Review of resident #443's medical record revealed he was originally admitted to the facility on [DATE] and readmitted on [DATE] from an acute care hospital. His diagnoses included sepsis due to enterococcus (bacteria), type 2 diabetes, congestive heart failure and chronic obstructive pulmonary disease.</p> <p>Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency, (retrieved from www.cdc.gov on 1/29/25).</p> <p>On 1/21/25 at 12:08 PM, resident #443's wife shared the night he was admitted was a disaster. She indicated the only reason her husband was here was for the Intravenous (IV) antibiotics and the facility did not have them. She stated the weekend nurses were contracted staff and not familiar with the facility's operations. She stated her daughter-in-law spoke with the Director of Nursing (DON) to help sort things out. She indicated one medication which was administered every 4 to 6 hours was changed in the facility to continuous. She stated the facility seemed ill-prepared for his admission.</p> <p>Review of a hospital progress notes from the Infectious Disease (ID) physician dated 12/31/24 revealed resident #443 was to continue receiving Ampicillin 12 gram (GM) IV continuously over 24 hours, every 24 hours, and Ceftriaxone 2 GM IV every 12 hours both until 1/19/25.</p> <p>Review of resident #443's physician orders revealed the following two antibiotics orders were entered on 1/04/25: Ceftazidime 2-GM IV one time a day for sepsis until 1/19/25 and Ampicillin 12-GM IV one time a day for sepsis until 1/19/25. These antibiotics were discontinued on 1/06/25 and new orders entered on 1/06/25 for Ampicillin 12-GM IV one time a day for sepsis until 1/19/25 and Ceftriaxone 2-GM IV one time a day for sepsis until 1/19/25. The orders were discontinued again on 1/08/25 and reentered on the same day to Ampicillin 12 GM IV every shift for sepsis until 1/19/25 in Sodium Chloride 0.9% 500 milliliters (ml) infusion, 21 ml/hr (per hour) over 24 hours. Pause to give Ceftriaxone then flush line with normal saline and resume Ampicillin. Ceftriaxone 2-GM IV one time a day for Sepsis, infuse via IV access 2 gm/100 ml normal saline over 30 minutes.</p> <p>Review of resident #443's Medication Administration Record (MAR) revealed Ceftazidime 2 GM IV was scheduled for administration on 1/04/25 at 9:00 AM and 1/05/25 at 4:30 PM and was documented as given both days. The MAR showed Ceftriaxone 2 GM was given once per day from 1/06 to 1/19/25 at 2:00 PM, except on 1/15/25 and 1/16/25 because resident #443 was in the hospital.</p> <p>Review of the progress notes in the medical record showed the following entries:</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/03/25 a Physician note read, . the nurse consulted [on call group] to assess the patient, to review discharge medications and orders and to ensure safe transition of care. Review of available paperwork and consultation with patient/nurse was completed to identify and manage high risk conditions and medications while awaiting evaluation by primary team . Resident discharged to complete course of Ceftriaxone 2 GM IV QD (every day) and Ampicillin 12 GM QD until January 19, 2025 with weekly labs .</p> <p>On 1/03/25 and Admission Note by Licensed Practical Nurse (LPN) B indicated, . All medications reviewed with on call NP (Nurse Practitioner) through [company name] and sent to pharmacy. Awaiting medication delivery from pharmacy.</p> <p>On 1/04/25 at 11:38 AM, by LPN E documented in the medical record, Notified stepdaughter [name] of meds (medications) that were able to be given to PT (patient). Address her other concerns with medication pharmacy was notified and meds will be delivered to facility ASAP (as soon as possible).</p> <p>On 1/04/25 at 11:40 AM, by LPN E documented, Nurse reached out to ID (Infectious Disease) to verify Ampicillin order< tried to leave a message for a return call operator by the name [name] stated that would not be possible that we would have to reach out Monday.</p> <p>On 1/04/25 [name of on call group] note indicated that LPN E reported patient missed his 2:00 AM dose of IV antibiotics as they were not received by the pharmacy at the time. The nurse wanted to make sure it was ok to give them now. Ceftriaxone IV once a day and Ampicillin 12 GM once a day. The note documented they gave the nurse an okay to give the IV antibiotics now that medications were available.</p> <p>On 1/04/25 at 10:19 PM, a progress note documented by LPN F revealed, Resident continues on IV ABT (antibiotic), Ceftriaxone 2 GM qd (every day) and Ampicillin 12 GM in 500 cc (milliliters) NS (normal saline) administered over 24 hours for sepsis.</p> <p>On 1/06/25 at 9:29 PM, an Incident Note documented by LPN B revealed, This nurse incorrectly put in order for medication Ceftriaxone Sodium Injection Solution Reconstituted 2 GM (Ceftriaxone Sodium). Medication order error corrected before pharmacy dispense or before medication administration to resident. Nurse educated on error, this nurse understands error and how to correct and not reoccur. Resident notified. MD (physician) notified. All safety measures in place.</p> <p>On 1/08/25 at 8:56 AM a progress note by the Assistant Director of Nursing (ADON) revealed, Received call from ID regarding clarification of IV antibiotics. Ampicillin to run at 21/hr continuously with a pause to administer Ceftriaxone daily over 30 minutes then resume Ampicillin.</p> <p>Review of the Packing Slip form from the pharmacy showed 3 bags of Ceftazidime 2 GM/100 ml NS and 2 bags of Ampicillin 12 GM/500 ml NS were delivered to the facility on [DATE].</p> <p>Review of a Fill History report from the pharmacy showed 3 bags of Ceftriaxone 2 GM/100 ml NS were dispensed on 1/06/25, 4 bags on 1/09/25 and another 3 bags on 1/13/25 for a total of 10 bags.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/22/25 at 4:10 PM, LPN B stated she had been working in the facility for a few weeks, received 3 days of training before being allowed to work on her own. She explained she did not have an admission during orientation. LPN B recalled she admitted resident #443 with the assistance of another nurse who completed some of the required assessments and contacted the physician to review the medications. She stated she entered the orders for antibiotics at around 2:00 AM in the medical record. She indicated she faxed the order to the pharmacy and called for confirmation they received it and left for the day. She explained she received a phone call on Monday 1/06/25 around noon asking her to come 45 to 60 minutes early before starting her shift for an in-service. She explained she spoke with the DON and learned she entered one of the antibiotics incorrectly. She stated she was not sure what happened that weekend, and she was under the impression the medications were not delivered until Monday morning. She indicated the medication error was not caught until Monday. She explained she entered Ceftazidime 2 GM instead of Ceftriaxone. She pointed out the incorrect order she created on 1/04/25 at 2:29 AM. She explained the Ampicillin was to run for 24 hours. She indicated when she asked the former ADON for help to clarify the order, her response was she was not a pharmacist or a doctor and did not offer any help. She indicated another nurse offered assistance when she called the pharmacist to clarify how to run the Ampicillin and was told for 23 1/2 hours then pause for 30 minutes to administer the Ceftriaxone. She indicated based on the documentation in the medical record, Ceftazidime was administered on 1/04/25 at 9:00 AM by LPN E and on 1/05/24 at 1:00 PM by LPN G .</p> <p>On 1/24/25 at 1:00 PM, the Director of Nursing (DON) indicated during their morning clinical meeting on 1/06/25 they discovered one of the antibiotics listed on the active orders for resident #443 did not match the discharge orders from the hospital. She explained Ceftazidime was entered instead of Ceftriaxone. The DON stated they notified the physician and family, corrected the order, completed a risk manager report, and monitored the resident for adverse effects. Later at 1:34 PM, the DON explained LPN B completed a Medication Error report on 1/06/25. The DON stated she reviewed the report which indicated the medication had not been administered to resident #443. She mentioned she did not review the medical record and did not know Ceftazidime was documented in the MAR as given on 1/04/25 and 1/05/25. She indicated resident #443 was informed of the error but not his family because he was his own person. She indicated resident #443's physician was notified on 1/06/25 and he saw the resident on 1/07/25. She explained only the primary physician was notified of the error, and not the ID Specialist, even though ID ordered the antibiotics. She indicated after the order was corrected and education was provided to the nurses on transcribing medications, nothing else was reviewed. Later at 3:47 PM, the DON corroborated the LPNs needed to be IV certified to administer and handle IV antibiotics and lines. She stated she was waiting on the agency to provide the IV certificate for LPN E. The DON validated LPN B administered the IV medication but she was not IV certified. She reviewed the MAR and stated LPN B administered the IV antibiotics 8 times for resident #443. The DON stated their former ADON was responsible for education of nursing staff and competencies, but was not able to locate any evidence.</p> <p>On 1/24/25 at 4:16 PM, during a telephone interview, the physician validated he was the primary care physician for resident #443 and had seen him during his rounds. He indicated he was not aware of the medication error for resident #443. He explained the antibiotic orders came from the hospital and he questioned the continuous infusion for Ampicillin, so he requested that the facility clarify the order with the ID Specialist. He explained the medications were in the same classification and he could see where someone could commit a clerical error because of the auto-population feature for words when typing the name. He indicated he expected the facility performed good antibiotic stewardship and gave the correct medication. He repeated the medication error, Was never brought to my attention until this very moment.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/24/25 at 4:27 PM, during a telephone interview, the Pharmacist Consultant stated he was not aware Ceftazidime was entered incorrectly and administered for resident #443. He confirmed Ceftazidime was included on the original orders sent to the pharmacy and they sent three bags on 1/04/25 to the facility. He shared he was in the facility the previous Friday and last Tuesday but was not made aware of the transcription error on the order. He indicated the one thing that helped avoid an adverse outcome were both antibiotics were in the same class. He indicated he expected the nurses to enter the correct medications as ordered by the physician.</p> <p>Review of the Infectious Disease Consultant progress note dated 1/14/25 read, The patient has been treated with IV Ampicillin q(every) 24 hours and IV Ceftriaxone q 12 hours . Review of the Infectious Disease Consultant Homecare IV Infusion Worksheet showed an entry on 1/14/25 for Diflucan 200 mg (milligram) daily for 7 days. There was no evidence in resident #443's medical record Diflucan was ever given.</p> <p>On 1/24/25 at 5:00 PM, the DON stated she did not have the IV certification for LPN E and could find no competencies for medication administration for the nurses. She indicated she did not find evidence in the medical record the Diflucan (antifungal) order was entered or given to resident #443. She validated the Ceftriaxone was supposed to be administered once daily.</p> <p>2. On 1/22/25 at 8:51 AM, Registered Nurse (RN) A was observed preparing resident #35's 9:00 AM medications. RN A poured 15 ml of Potassium chloride (KCl) in a medication cup and placed 6 pills including Amlodipine 10 mg, Clopidogrel 75 mg, Furosemide 20 mg, Gabapentin 100 mg, Iferex Nu-Iron 150 mg, and Vitamin C 500 mg in another medication cup. The instructions on the label of the KCL bottle read, dilute in 4 oz (ounces) of cold water and take 15 ml by mouth twice a day. Take with food. In addition to the label attached to the bottle, the bottle included instructions to dilute prior to administration. RN A did not dilute KCl in water. At 9:04 AM, resident #35 drank the KCl and said, Oh God, that stuff is awful. At 9:06 AM, RN A stated she was familiar with resident #35 and said she liked to take the KCl like that. RN A indicated resident #35 did not like the KCl to be mixed with anything, or diluted. She stated she had previously mentioned it to the physician but could not find evidence of her notification in the medical record.</p> <p>KCl for oral solution, May cause gastrointestinal irritation, (retrieved from www.fda.gov on 1/29/25).</p> <p>3. Review of resident #9's medical record revealed she was readmitted to the facility on [DATE] with diagnoses including cellulitis of the chest wall, type 2 diabetes, heart disease, and cerebrovascular disease.</p> <p>On 1/22/25 at 8:40 AM, during a tour on the Blue Unit, a cup with seven pills was observed unattended on top of the medication cart. A minute later, RN A returned to the medication cart and stated she thought she had locked the medication cup when she left to attend an emergency. RN A counted the pills and stated there were seven pills in the medication cup. RN A validated she was not supposed to leave the pills unattended and unsecured.</p> <p>Review of resident #9's physician orders revealed 10 oral medications were scheduled for 9:00 AM. The medications included Aricept 10 mg, Aspirin 81 mg, Effexor 75 mg, Isosorbide 30 mg, Lisinopril 20 mg, Nifedipine 30 mg, Sertraline 50 mg, Augmentin 500-125 mg, Carvedilol 6.25 mg, and Lactobacillus. Review of the MAR for January 2025 showed the 10 medications were administered by RN A at 9:00 AM.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 1/23/25 at 9:24 AM, RN A explained the day before (1/22/25) resident #9 did not have all her morning medications available in the medication cart and she requested the missing ones from pharmacy. She mentioned Lisinopril, Nifedipine, and Lactobacillus were not available in the medication cart when she prepared the medications. She stated she was going to give them all later when she received them from the pharmacy. She indicated she received the medications later during her shift and gave them to the resident. She clarified Lactobacillus was an over-the-counter medication that was available in the facility. As requested, she showed the Lisinopril and Nifedipine blister packs which contained all 30 pills and none yet used. She looked at the MAR and confirmed all 9:00 AM medications were documented as given incorrectly. She stated she received Lisinopril and Nifedipine after 2:00 PM and, She was not going to lie, that she should have entered code 11 this morning which meant the medication was not available. She reiterated she was not going to lie, and mentioned she was supposed to contact the physician, but did not do it. She said, Yesterday was a hectic day, and after the situation with resident #35 where she did not dilute the KCl she contacted the physician to address that and forgot to mention three medications for resident #9 were not given. She validated she documented she gave all the medications when she did not.</p> <p>On 1/23/25 at 3:16 PM, the Assistant Director of Nursing (ADON) stated it was her and the DONs responsibility to ensure staff were competent to perform their job duties such as medication administration. She stated the previous DON did medication administration competencies on all nurses such as herself. She said she was unable to locate the staff that received competencies on medication administration at this time. She stated the staff nurses trained the new hires on medication administration with the third day of training consisting of the new hire nurses passing medications with supervision. She explained if the new hires did not feel comfortable with being on their own yet and needed more training, it would be offered until they felt comfortable in their role. She indicated she only completed one medication administration competency on one nurse since in her role as ADON.</p> <p>On 1/23/25 at 3:31 PM, the DON stated the nurses received medication administration training with the floor nurses for three days and would receive more training if needed prior to passing medications on their own. She stated they were working on implementing a competency skills fair for the nurses and Certified Nursing Assistants upon hire and annually. The Interim DON indicated she was unable to locate the nurses' competencies prior to her employment in this role. She noted she reviewed the documentation and orders every morning in the stand-up meetings and explained nurses must be IV certified to administer IV medications. She acknowledged she did not complete medication administration competencies for any facility nurses since being the facility's Interim DON.</p> <p>On 01/24/25 at 12:35 PM, the ADON and DON stated they were able to locate the medication administration competencies dated November and December of 2023 for five nurses but were unable to locate any medication administration competencies for 2024. They stated they did not know if the nurses had received medication administration competencies for 2024 and acknowledged the nurses should have received this education annually. They stated they were in the process of completing nursing competencies on medication administration for 2025. The Interim DON acknowledged it was important to validate competencies for nurses annually on medication administration to ensure the residents received the correct medications and were not harmed. The ADON acknowledged the importance for annual medication administration competencies for nurses to ensure they followed evidence-based practice when administering medications for the safety of their residents.</p> <p>Review of the facility's policy, Medication Administration undated, revealed a purpose to, Safely and accurately administer physician-ordered medication to each resident.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy, Medication Errors and Drug Reactions undated read, All medication errors and drug reactions must be promptly reported to the Director of Nursing, attending physician, pharmacist, resident and/or resident representative.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>43192</p> <p>Based on observation, and interview, the facility failed to ensure medications were inaccessible to non-authorized staff and residents in 1 of 1 medication carts on the Blue Unit.</p> <p>Findings:</p> <p>During a tour of the Blue Unit on 1/22/25 at 8:40 AM, a medication cup with seven pills was left unattended on top of a medication cart. The medication cart was locked.</p> <p>On 1/22/25 at 8:41 AM, Registered Nurse (RN) A stated she left to attend an emergency. She explained a staff member asked her to go to a resident's room and she thought she placed the cup in the medication cart's drawer before stepping away. She indicated the medication cart itself was locked. She stated she knew this was not safe because, any patient or family can grab it, it is a hazard, definitely not supposed to leave [the medicine] outside, unlocked.</p> <p>On 1/22/25 at 10:43 AM, the Assistant Director of Nursing (ADON) explained nurses received computer and hands-on training during orientation, but competencies were not completed. She indicated if a nurse was called away due to an emergency while preparing medications, the expectation was for them to discard the medication in the medication room using a chemical to safely dispose of it, then attend to the emergency. She stated the nurse would have to start getting medications ready again when finished with the emergency since they would not know how long that could take. The ADON indicated medications should not be left unattended, whatsoever because anyone including a resident could come by and take those medications, and it was, not the correct protocol.</p> <p>Review of the facility's policy, Storage of Medications not dated, revealed a purpose to, Ensure that medications are stored in a safe, secure, and orderly manner. The procedure included, Compartments containing medications are locked when not in use. Trays or carts used to transport such items are not to be left unattended .</p>		

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<p>F 0847</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse.</p> <p>45646</p> <p>Based on interview, and record review, the facility failed to ensure that the binding arbitration agreement explicitly granted the resident or their representative the right to rescind the agreement within 30 calendar days of signing it.</p> <p>Findings:</p> <p>Review of the facility's Nursing Admission and Care Agreement revealed an Arbitration Provision in Section I of the agreement. The document contained language stating that agreeing to resolve disputes as set forth herein was not a precondition for receiving medical treatment or for admission. The document language further revealed, (the resident) did also acknowledge that he or she has had the right and opportunity to consult with an attorney prior to signing the Admission and Care Agreement and to seek any explanation or clarification desired. The signature line followed a statement which read, The undersigned acknowledge that each of them has read this entire admission and care agreement and understands that by signing this agreement each has waived his/her right to a trial, before a judge or jury, and that each of them voluntarily consents to all of the terms of the agreement. The signature line followed Section A through K. There was no separate section or signature to accept or decline the Arbitration Provision separately from the entire admission and care agreement. The agreement did not contain a statement to inform the resident or resident representative of their right to rescind the agreement within 30 calendar days of signing the agreement.</p> <p>On 1/24/25 at 11:32 AM, the Skilled Nursing Facility Admission Coordinator stated she was responsible for meeting with residents or their representatives to get the admission agreement signed. She verified the admission agreement was required to be signed for admission. The admission coordinator stated she informed the resident or representative that the arbitration meant they could not go to court. She acknowledged there was not a specific signature line for the resident or representative to decline the arbitration provision. She stated if they wanted to decline, they could write, declined on that page or draw a line through the provision and initial the page. She acknowledged the arbitration provision did not specify the amount of time the resident or representative had to rescind the document after signing. The Admission Coordinator reported that none of the 42 current residents had declined the arbitration provision.</p> <p>On 1/24/25 at 12:00 PM, the Administrator reviewed the arbitration provision and acknowledged it appeared to be part of the required admission agreement. He stated the provision should have a separate signature line as an indicator of whether or not the resident or representative agreed to the arbitration provision. The Administrator acknowledged the wording of the provision did not explicitly grant the resident or resident representative 30 days from the date of signing to rescind the agreement.</p>		

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<p>F 0848</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide a neutral and fair arbitration process and agree to arbitrator and venue.</p> <p>45646</p> <p>Based on interview, and record review, the facility failed to ensure that the binding arbitration agreement provided for the selection of a neutral arbitrator agreed upon by both parties and provided for the selection of a venue that was convenient to both parties.</p> <p>Findings:</p> <p>Review of the facility's Nursing Admission and Care Agreement revealed an Arbitration Provision in Section I of the agreement. The document contained language stating the arbitration would be referred to, conducted by and resolved in accordance with the American Arbitration Association's rules and parameters at a formal arbitration hearing. The provision did not contain a statement which provided for the selection of a neutral arbitrator agreed upon by both parties or the selection of a venue that was convenient to both parties.</p> <p>On 1/24/25 at 11:32 AM, the Skilled Nursing Facility Admission Coordinator stated she was responsible for meeting with residents or their representatives to get the admission agreement signed. The Admission Coordinator stated she informed the resident or representative that the arbitration meant they would settle outside of a court setting. She acknowledged there was no statement to provide for the selection of a neutral arbitrator or the selection of a venue convenient to both parties. She was unaware of what the rules and parameters were for the American Arbitration Association. The Admission Coordinator reported that none of the 42 current residents had declined the arbitration provision.</p> <p>On 1/24/25 at 12:00 PM, the Administrator reviewed the arbitration provision and verified there was no language to inform the resident or representative of their right to choose a neutral arbitrator or for the selection of a venue convenient to them and the facility. He acknowledged the provision should contain all the required details to ensure residents were informed of their rights when signing the arbitration agreement.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>43192</p> <p>Based on interview, and record review of facility documentation, the facility failed to ensure implementation of policies to the extent of including thorough monitoring of previously identified areas of concern and adequately tracking performance to ensure the facility had competent nursing staff and infection prevention control measures implemented.</p> <p>Findings:</p> <p>Review of the facility's Quality Assessment and Assurance (QAA) policy not dated revealed the objective was, To provide an ongoing program to monitor quality of care and quality of life for the residents. The document disclosed the responsibility was the Nursing Home Administrator (NHA), the Director of Nursing (DON) and the Medical Director and Designee. The document included the QAA committee would meet at least quarterly or more frequent as necessary, to coordinate and evaluate activities under the QAPI (Quality Assurance and Performance Improvement) program . The committee will develop and implement appropriate plans of action to correct identified quality deficiencies.</p> <p>The facility had deficiencies of F726-Competent Nursing Staff and F880-Infection Prevention and Control during the certification survey of 11/16/23.</p> <p>In the course of the present survey, F726 and F880 were again identified as concerns. As a result of these repeat citations, it was identified there was insufficient auditing and oversight of the previously mentioned citations.</p> <p>During an interview with the NHA and DON on 1/24/25 at 5:37 PM, the NHA explained departments conducted monthly or quarterly audits to identify trends or concerns that were brought in to the QAPI meetings and addressed. He indicated they created Performance Improvement Plans (PIP) after conducting a root cause analysis and implemented actions accordingly. He indicated staff competency was discussed this past December and they planned to introduce admission orders in their QAPI meeting this week but the meeting was not held on Tuesday as planned. He presented a Problem Identification Tools for Staff Competencies form which showed the root cause was the lack of monitoring, change of the orientation process, change of DON and Assistant DON. He explained after they followed the plan of correction from the last survey, it did not stay in place. He shared they monitored for several months, but obviously it did not continue. The DON stated she was not aware of the last survey findings. The NHA indicated the QAPI system did not work, and as a result they they had a lot of work to do and were trying to get the right people in place.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>43192</p> <p>Based on observation, interview, and record review, the facility failed to adhere to proper infection control practices related to hand hygiene and disinfection of equipment during medication administration on 1 of 2 units, (Orange Wing).</p> <p>Findings:</p> <p>During a medication administration pass observation on 1/22/25 at 2:15 PM, Licensed Practical Nurse (LPN) C retrieved a mobile vital signs device from the hallway across from her assigned residents and brought into resident #495's room but did not disinfect the device before using it. Outside resident #495's room a sign was on the door which indicated the resident was on enhanced barrier precautions. Prior to entering the room, she donned a gown and gloves but did not perform hand hygiene. After LPN C obtained resident #495's vital signs, she removed the gown and gloves and exited the room with the mobile vital signs device, which she placed next to the medication cart. She did not perform hand hygiene. LPN C unlocked the medication cart, pulled 2 blister packs which contained medications for resident #495 and poured them in a medication cup. She then crushed the pills and mixed them with applesauce in the medication cup. Later at 2:27 PM, she donned the gown she had previously used which was left ?? by resident #495's door, entered the room and grabbed a pair of gloves. She did not perform hand hygiene and instead donned the gloves and administered the medications.</p> <p>On 1/22/25 at 2:29 PM, LPN C explained she was running late to administer the medication because she had dining room duty. She indicated they had one mobile vital signs device on the unit and it was supposed to be cleaned in between each resident's use. She stated the cleaning consisted of wiping down the blood pressure cuff using bleach wipes. She indicated resident #495 was on enhanced barrier precautions and it was preferable to wipe the equipment after use. She shared she assumed the nurse who used the mobile vital signs device before her had disinfected it. She validated she should have cleaned the device before using it but she did not. LPN C read the sign located on resident #495's door and explained the sign instructed everyone to perform hand hygiene before and after care. She indicated she was an agency nurse and has not received in-service about infection control in the facility.</p> <p>In interviews on 1/22/25 at 10:43 AM, and 1/24/25 at 9:06 AM, the Infection Preventionist (IP) stated nurses' orientation included computer and hands-on training but there were no records of competency forms completed. The IP indicated nurses were expected to perform hand hygiene to avoid cross contamination. The IP shared her responsibilities included ensuring clinical staff were competent with hand hygiene, sanitizing equipment, correctly donning/doffing personal protective equipment, and correct isolation procedures.</p> <p>Review of the facility's policy titled Infection Prevention and control program (IPCP) not dated revealed the facility would establish and maintain an IPCP to provide a safe, sanitary, and comfortable environment and to help prevent the development of communicable diseases and infections. The IPCP included a section for Hand Hygiene which read, The single most important measure to prevent infection is hand hygiene and continues to be the cornerstone of infection preventions activities. The document revealed All Staff will be trained and competent on performing hand hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the undated policy, Medication Administration revealed general guidelines for medication administration/pass to include washing hands before administering medication to any resident and between contact with other residents or duties.</p>