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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195621 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/09/2024 |
| NAME OF PROVIDER OR SUPPLIER Sage Rehabilitation Hospital Snf | | STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Summa Avenue Baton Rouge, LA 70809 | |

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) |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590</p> <p>Based on record reviews and interviews, the facility failed to ensure alleged violations involving sexual abuse were reported to the state survey agency within 2 hours after the allegations were made for 1 (#1) of 2 (#1 and #2) residents reviewed for abuse.</p> <p>Findings:</p> <p>Review of the facility's Compliance with Reporting Allegations of Abuse, Neglect, Exploitation policy, revised 08/2022, revealed, in part, the following:</p> <p>Policy:</p> <p>It is the policy of the facility to report all allegations of abuse to other appropriate agencies in accordance with current state and federal regulations within prescribed timeframes.</p> <p>Compliance Guidelines:</p> <p>4. Identification:</p> <p>b. Abuse:</p> <p>ii. Sexual Abuse is the non-consensual sexual contact of any type with a resident.</p> <p>8. Reporting/Response: The facility will report all alleged violations . to the state agency .</p> <p>Procedure for Response and Reporting Allegations of Abuse:</p> <p>2. The Administrator or Designee will:</p> <p>a. Notify the appropriate agencies immediately .</p> <p>Resident #1</p> <p>Review of Resident #1's Clinical Record revealed she was admitted to the facility on [DATE]. Further review revealed Resident #1 was discharged from the facility on 08/23/2024.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #1's Discharge MDS, with an ARD of 08/23/2024, indicated the resident had a BIMS of 15, which indicated the resident was cognitively intact.</p> <p>Review of the facility's Grievance Log, dated 08/01/2024 through 10/08/2024, revealed, in part, the following:</p> <p>08/12/2024 - Resident #1 reported to S4NP she was raped overnight.</p> <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S4NP. S4NP confirmed she was familiar Resident #1 and Resident #1 was cognitive. S4NP confirmed during her morning rounds on 08/11/2024, Resident #1 reported she was raped overnight on 08/10/2024 by S5LPN during a catheter procedure and S6CNA was present. S4NP confirmed she immediately left Resident #1's room and verbally made S1ADM and S2DON aware of Resident #1's allegation of rape by a staff member.</p> <p>Review of the facility's Report Submission to the state agency regarding Resident #1's allegation of sexual abuse revealed, in part, the following:</p> <p>Date/Time Incident reported to State Office: 08/23/2024 at 6:10 p.m.</p> <p>Date/Time Staff first became aware of the Incident: 08/12/2024 at 9:00 a.m.</p> <p>Allegation Type: Sexual Abuse</p> <p>Alleged Victim: Resident #1</p> <p>Alleged Perpetrator: S5LPN</p> <p>An interview was conducted on 10/09/2024 at 4:20 p.m. with S3ADON. S3ADON confirmed S2DON was on extended medical leave and unavailable by telephone. S3ADON confirmed S2DON and S1ADM handled the reporting and investigation of the rape allegations made by Resident #1. S3ADON confirmed Resident #1's allegation of rape would be considered an allegation of sexual abuse and should have been reported to the state agency within the required 2 hour timeframe.</p> <p>An interview was conducted on 10/09/2024 at 4:00 p.m. with S1ADM. S1ADM confirmed he was responsible for submitting required reports to the state agency. S1ADM confirmed an allegation of rape would be considered an allegation of sexual abuse and should be reported to the state agency within 2 hours of the allegation being made. S1ADM confirmed Resident #1's allegation of rape was originally made on 08/11/2024 and not reported to state office until 08/23/2024. S1ADM confirmed the allegation of sexual abuse was not reported within the required 2 hour timeframe and should have been.</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50093</p> <p>Based on record reviews and interviews, the facility failed to ensure services were provided by the facility to meet professional standards of quality for 1 (#4) of 2 (#4 and #5) sampled residents reviewed for diabetes in the facility. The facility failed to notify the nurse practitioner of the resident's refusal of blood sugar checks and diabetic medications. This deficient practice had the potential to affect all 20 residents currently residing in the facility.</p> <p>Findings:</p> <p>Review of Resident #4's Clinical Record revealed he was admitted to the facility on [DATE] with diagnoses, which included Diabetes Mellitus.</p> <p>Review of Resident #4's current Physician's Orders revealed the following:</p> <p>(Start date: 10/02/2024) Fingerstick Blood Sugar, before meals and at bedtime;</p> <p>(Start date: 10/02/2024) Glimepiride 2 mg, give 4 mg by mouth twice daily; and,</p> <p>(Start date: 10/02/2024) Insulin Lantus, inject 25 units subcutaneously at bedtime.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Fingerstick Blood Sugar checks were not administered at 7:30 a.m. on 10/06/2024 through 10/08/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Fingerstick Blood Sugar checks were not administered at 11:30 a.m. on 10/04/2024 through 10/08/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Fingerstick Blood Sugar checks were not administered at 4:30 p.m. on 10/03/2024 through 10/06/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Fingerstick Blood Sugar checks were not administered at 9:00 p.m. on 10/04/2024 through 10/06/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Glimepiride was not administered at 7:00 a.m. on 10/07/2024 and 10/08/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Glimepiride was not administered at 7:00 p.m. on 10/04/2024 through 10/06/2024.</p> <p>Review of Resident #4's MAR for October 2024 revealed Resident #4's Insulin Lantus was not administered on 10/03/2024 through 10/09/2024.</p> <p>Further review of Resident #4's detailed Medication Administration Record revealed documentation of Resident #1's Fingerstick Blood Sugar checks, Glimepiride, and Insulin not being administered on all of the above dates and times due to being refused by Resident #4.</p> <p>(continued on next page)</p> | | |

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| <p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of Resident #4's Nurses' Notes revealed no documentation of Resident #4's nurse practitioner being notified of Resident #4's refusal of blood sugar checks, Glimperide, and insulin on the above dates.</p> <p>An interview was conducted on 10/09/2024 at 10:45 a.m. with S4NP. S4NP confirmed she had not been notified of Resident #4's above documented refusals and should have been.</p> <p>An interview was conducted on 10/09/2024 at 10:50 a.m. with S5NP. S5NP confirmed she had not been notified of Resident #4's above documented refusals and should have been.</p> <p>An interview was conducted on 10/09/2024 at 11:16 a.m. with S15LPN. S15LPN confirmed she provided care to Resident #4 on 10/03/2024. She confirmed Resident #4 refused a Fingerstick Blood Sugar check and insulin on 10/03/2024 at 9:00 p.m. S15LPN confirmed she did not notify S4NP or S5NP of Resident #4's refusals and should have.</p> <p>An interview was conducted on 10/09/2024 at 11:52 a.m. with S14LPN. S14LPN confirmed she provided care to Resident #4 on 10/04/2024, 10/05/2024, and 10/06/2024. She confirmed Resident #4 refused Fingerstick Blood Sugar checks and diabetic medications at 7:00 p.m. and 9:00 p.m. on those dates. S14LPN confirmed she did not notify S4NP or S5NP of Resident #4's refusals and should have.</p> <p>An interview was conducted on 10/09/2024 at 12:05 p.m. with S8LPN. S8LPN confirmed he provided care to Resident #4 on 10/08/2024. S8LPN confirmed Resident #4 refused Fingerstick Blood Sugar Checks and diabetes medication on 10/08/2024 at 7:00 a.m., 7:30 a.m., 11:30 a.m. and 4:30 p.m. S8LPN confirmed he did not notify S4NP or S5NP of Resident #4's refusals and should have.</p> <p>An interview was conducted on 10/09/2024 at 2:47 p.m. with S16LPN. S16LPN confirmed she provided care to Resident #4 on 10/07/2024. She confirmed Resident #4 refused insulin at 9:00 p.m. on 10/07/2024. S16LPN confirmed she did not notify S4NP or S5NP of Resident #4's refusal and should have.</p> <p>An interview was conducted on 10/09/2024 at 5:39 p.m. with S2DON. S2DON confirmed S4NP or S5NP should have been notified of Resident #4's refusals of blood sugar checks and diabetic medications.</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590</p> <p>Based on record reviews and interviews, the facility failed to provide pharmaceutical services that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals to meet the needs of each resident. The facility failed to ensure prescribed medications were available for administration for 2 (#3 and #6) of 5 (#2, #3, #4, #5, and #6) residents reviewed for medication availability.</p> <p>Findings:</p> <p>Review of the facility's Unavailable Medications policy, revised 07/2022, revealed, in part, the following:</p> <p>Policy:</p> <p>The facility shall use uniform guidelines for unavailable medications.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. The facility maintains a contract with a pharmacy provider to supply the facility with routine . medications.</p> <p>Resident #3</p> <p>Review of Resident #3's Clinical Record revealed the resident was admitted to the facility on [DATE] with diagnoses including Stage 4 Pressure Ulcer of Sacral Region; Sepsis; and Methicillin-Resistant Staphylococcus Aureus (MRSA). Further review revealed Resident #3 was discharged from the facility on 08/26/2024.</p> <p>Review of the facility's Incident Log, dated 08/01/2024 through 10/08/2024, revealed, in part, the following:</p> <p>08/21/2024 - Resident #3; Medication Error - Missed Dose.</p> <p>08/22/2024 - Resident #3; Medication Error - Missed Dose.</p> <p>Review of the facility's above Incident Reports involving Resident #3 revealed, in part the following:</p> <p>Date of Incident: 08/21/2024</p> <p>Involved Person: Resident #3</p> <p>Reported by: S11LPN</p> <p>(continued on next page)</p> |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Overview of Incident: Medication not administered.</p> <p>Date of Incident: 08/22/2024</p> <p>Involved Person: Resident #3</p> <p>Reported by: S11LPN</p> <p>Overview of Incident: Patient made aware medication is still unavailable.</p> <p>Review of Resident #3's Physician Orders, dated 07/31/2024 through 08/26/2024, revealed, in part, the following:</p> <p>Order Date: 07/31/2024. Zyvox 600mg/300mL IVPB. Infuse over 1 hour IVPB every 12 hours. Duration: 23 days. Start Date: 07/31/2024. Stop Date: 08/23/2024.</p> <p>Review of Resident #3's MAR, dated 08/20/2024 through 08/23/2024, revealed, in part, the following:</p> <p>08/21/2024 9:22 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not given. Medication unavailable.</p> <p>08/22/2024 9:00 a.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not listed on MAR.</p> <p>08/22/2024 8:22 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not given. Medication unavailable.</p> <p>08/23/2024 9:00 a.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Given by S12LPN.</p> <p>08/23/2024 9:00 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Given by S11LPN.</p> <p>Review of Resident #3's Nurses Notes, dated 08/20/2024 through 08/23/2024, revealed, in part, the following:</p> <p>08/21/2024 9:06 p.m. - S11LPN - Pharmacy contacted at approximately 9:00 p.m. regarding missing antibiotic.</p> <p>08/24/2024 4:43 a.m. - S11LPN - Night dose of Zyvox for 08/23/2024 not received with medication delivery.</p> <p>Review of Resident #3's Physician's Notes, dated 07/31/2024 through 08/26/2024, revealed, in part, the following:</p> <p>08/01/2024 - Assessment/Plan: Sacral Decubitus Stage IV Ulcer. Zyvox 600mg IV every 12 hours x28 days. End of Treatment: 08/23/2024.</p> <p>08/24/2024 - Pharmacy did not deliver IVPB Zyvox. Missed doses.</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview was conducted on 10/09/2024 at 2:15 p.m. with the facility's pharmacist. She stated the pharmacy sent a total of 41 doses to cover up to the last dose on 08/20/2024 at 9:00 p.m. She confirmed the facility would not have had medication on hand to administer Resident #3's Zyvox on 08/21/2024, 08/22/2024, or 08/23/2024.</p> <p>An interview was conducted on 10/09/2024 at 2:45 p.m. with S11LPN. S11LPN confirmed Resident #3's antibiotics were not present in the facility and she missed doses of the medication. S11LPN stated if she wrote a note on 08/24/2024 stating Resident #3's medication still had not been received, it would mean the medication was still not available to be administered at that time and she must have inadvertently misdocumented on the MAR.</p> <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S5NP. S5NP confirmed if an order was written for a patient to receive a medication, she would expect the medication to be available for administration as ordered. S5NP confirmed Resident #3's last dose of Zyvox should have been on 08/23/2024 at 9:00 p.m. S5NP confirmed Resident #3 missed doses of her antibiotic on 08/21/2024, 08/22/2024, and 08/23/2024 and should not have.</p> <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S4NP. S4NP confirmed the missed doses caused Resident #3 to remain inpatient an additional 2 days after her planned discharge date in order to complete her full course of antibiotics.</p> <p>An interview was conducted on 10/09/2024 at 4:20 p.m. with S3ADON. S3ADON confirmed Resident #3 missed 4 consecutive doses of an antibiotic because it was not available for administration and should not have.</p> <p>Resident #6</p> <p>Review of Resident #6's Clinical Record revealed the resident was admitted to the facility on [DATE]. Further review revealed Resident #6 was discharged from the facility on 09/04/2024.</p> <p>Review of the facility's Incident Log, dated 08/01/2024 through 10/08/2024, revealed, in part, the following:</p> <p>08/18/2024 - Resident #6; Medication Error - Missed Doses.</p> <p>Review of the facility's above Incident Reports involving Resident #6 revealed, in part the following:</p> <p>Date of Incident Report: 08/18/2024</p> <p>Date of Incident: 08/17/2024</p> <p>Involved Person: Resident #6</p> <p>Reported by: S17LPN</p> <p>(continued on next page)</p> | | |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Overview of Incident: At least 2 missed doses of Esomeprazole 40mg. Order present for home medications to be used. Family provided staff with medication on 08/13/2024. Staff have been unable to locate medication for administration.</p> <p>Review of Resident #6's Physician Orders, dated 08/10/2024 through 09/04/2024, revealed, in part, the following:</p> <p>08/14/2024 - Omeprazole 40mg. 1 capsule PO daily. Ok to use home medication.</p> <p>Review of Resident #6's MAR, dated 08/20/2024 through 08/23/2024, revealed, in part, the following:</p> <p>08/18/2024 7:00 a.m. - Omeprazole 40mg. Give 1 capsule daily. - Not given. Medication unavailable.</p> <p>08/19/2024 7:00 a.m. - Omeprazole 40mg. Give 1 capsule daily. - Not given. Medication unavailable.</p> <p>Review of Resident #6's Physician's Notes, dated 08/10/2024 through 09/04/2024, revealed, in part, the following:</p> <p>08/17/2024 - Resident #6 complaining of acid reflux. Daughter stated home doses of Omeprazole were given to staff at the facility but it can't be found.</p> <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S4NP. S4NP stated she wrote an order to approve the use of Resident #6's home medication. S4NP stated Resident #6's daughter gave the medication to her and she immediately gave it to the floor nurse. S4NP stated several days later, Resident #6 reported still not receiving her home medication because staff told her they could not locate it. S4NP confirmed if an order was written for a patient to receive a medication, she would expect the medication to be available for administration as ordered. S4NP confirmed when staff misplaced Resident #6's medication it caused her to miss multiple doses and should not have.</p> <p>An interview was conducted on 10/09/2024 at 4:20 p.m. with S3ADON. S3ADON confirmed Resident #6 missed multiple doses of medication because it was not available for administration and should not have.</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44590</p> <p>Based on record reviews and interviews, the facility failed to ensure residents were free of any significant medication errors for 1 (#3) of 2 (#3 and #6) residents reviewed for medication errors.</p> <p>Findings:</p> <p>Review of the facility's Medication Administration and Documentation policy, revised 08/2024, revealed, in part, the following:</p> <p>Policy:</p> <p>Drugs shall be prepared and administered in accordance with the orders of the physicians or licensed independent practitioners responsible for the patient's care and accepted standards of practice.</p> <p>B. Patient's Personal Drugs</p> <p>The patient's personal medication, once approved, will be kept in a locked medication storage.</p> <p>C. Medication Administration Record (MAR)</p> <p>Use the MAR as a guide for medication administration.</p> <p>F. Medication Administration Recording</p> <p>An entry of drugs administered . and omitted doses shall be properly documented in the patient's medical record as follows:</p> <p>If the patient for any reason does not receive a dose of medication as prescribed, . explain, in nurses' notes, the reason for each . omitted dose .</p> <p>Review of the facility's Unavailable Medications policy, revised 07/2022, revealed, in part, the following:</p> <p>Policy:</p> <p>The facility shall use uniform guidelines for unavailable medications.</p> <p>Policy Explanation and Compliance Guidelines:</p> <p>1. The facility maintains a contract with a pharmacy provider to supply the facility with routine . medications.</p> <p>3. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable:</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>a. Determine reason for unavailability, length of time medication is unavailable and what efforts have been attempted by the facility or pharmacy provider to obtain the medication.</p> <p>b. Notify the physician of inability to obtain medication upon notification or awareness medication is not available. Obtain alternate treatment orders and/or specific orders for monitoring patient while medication is on hold.</p> <p>4. If a patient misses a scheduled dose of the medication, staff shall follow procedures for medications errors, including physician/family notification, completion of a medication error report via the facility's incident reporting process/form and monitoring the patient for adverse reactions to omission of the medication.</p> <p>Review of the facility's Medication Errors policy, revised 03/2019, revealed, in part, the following:</p> <p>Policy:</p> <p>Medication administration errors shall be reported immediately to the practitioner who ordered the drug in accordance with written procedures. If the practitioner who orders the drug is unavailable, the error shall be reported to the attending practitioner or another responsible practitioner.</p> <p>The medication . omitted shall be properly recorded in the patient's medical record. Notification of the ordering practitioner must be documented in the medical record.</p> <p>Definition of Medication Administration Errors:</p> <p>This policy applies only to medication . doses omitted.</p> <p>Medication administration errors need not necessarily have caused harm to the patient. Written reports shall also be made of minor error that result in no harm to the patient but have a potential adverse affect on patient care.</p> <p>Examples of medication administration errors include, but are not limited to:</p> <p>Omission of a dose.</p> <p>Review of the facility's Staff Training conducted on 08/13/2024 revealed, in part, the following:</p> <p>Nursing:</p> <p>2. Medication</p> <p>b. If medication is unavailable, call pharmacy. Let the provider know. Document provider was notified and when. Notify Charge Nurse and S1DON. Complete an incident report.</p> <p>Resident #3</p> <p>(continued on next page)</p> | | |

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| NAME OF PROVIDER OR SUPPLIER Sage Rehabilitation Hospital Snf | | STREET ADDRESS, CITY, STATE, ZIP CODE 8000 Summa Avenue Baton Rouge, LA 70809 | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident #3's Clinical Record revealed an admitted [DATE] with diagnoses including Stage 4 Pressure Ulcer of Sacral Region; Sepsis; and Methicillin-Resistant Staphylococcus Aureus (MRSA). Further review revealed Resident #3 was discharged from the facility on 08/26/2024.</p> <p>Review of the facility's Incident Log, dated 08/01/2024 through 10/08/2024, revealed, in part, the following:</p> <p>08/21/2024 - Resident #3; Medication Error - Missed Dose.</p> <p>08/22/2024 - Resident #3; Medication Error - Missed Dose.</p> <p>Review of the facility's above Incident Reports involving Resident #3 revealed, in part the following:</p> <p>Date of Incident: 08/21/2024</p> <p>Involved Person: Resident #3</p> <p>Reported by: S11LPN</p> <p>Overview of Incident: Medication not administered. Pharmacy contacted and reported the order they received for the medication discontinued on 08/20/2024. On-call NP notified and looking into it.</p> <p>Date of Incident: 08/22/2024</p> <p>Involved Person: Resident #3</p> <p>Reported by: S11LPN</p> <p>Overview of Incident: Provider already notified on 08/21/2024 of missing antibiotic. Pharmacy already contacted on 08/21/2024. Patient made aware medication is still unavailable.</p> <p>Review of Resident #3's Physician Orders, dated 07/31/2024 through 08/26/2024, revealed, in part, the following:</p> <p>07/31/2024 - Linezolid (Zyvox) 600mg/300mL IVPB. Infuse over 1 hour IVPB every 12 hours. Indication MRSA. Duration: 23 days. Start Date: 07/31/2024. Stop Date: 08/23/2024.</p> <p>Review of Resident #3's MAR, dated 08/20/2024 through 08/23/2024, revealed, in part, the following:</p> <p>08/21/2024 9:22 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not given. Medication unavailable.</p> <p>08/22/2024 9:00 a.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not listed on MAR.</p> <p>08/22/2024 8:22 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Not given. Medication unavailable.</p> <p>08/23/2024 9:00 a.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Given by S12LPN.</p> <p>(continued on next page)</p> |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>08/23/2024 9:00 p.m. - Zyvox 600mg/300mL IVPB every 12 hours. - Given by S11LPN.</p> <p>Review of Resident #3's Nurses Notes, dated 08/20/2024 through 08/23/2024, revealed, in part, the following:</p> <p>08/21/2024 9:06 p.m. - S11LPN - Pharmacy contacted at approximately 9:00 p.m. regarding missing antibiotic. Pharmacist stated he received a discontinue date of 08/20/2024. NP contacted to verify stop date. NP looking into it.</p> <p>08/24/2024 4:43 a.m. - S11LPN - 08/23/2024 night dose of Zyvox not received with medication delivery. On-call NP notified of incident. Pharmacy contacted.</p> <p>Review of Resident #3's Physician's Notes, dated 07/31/2024 through 08/26/2024, revealed, in part, the following:</p> <p>08/01/2024 - Assessment/Plan: Sacral Decubitus Stage IV Ulcer. Zyvox 600mg IV every 12 hours. End of Antibiotic: 08/23/2024. Final report: MRSA. Contact Precautions: MRSA.</p> <p>08/24/2024 - Pharmacy did not deliver IVPB Zyvox. Missed doses.</p> <p>An interview was conducted on 10/09/2024 at 2:15 p.m. with the facility's pharmacist. She reviewed Resident #3's file for the preparation and shipments of Zyvox to the facility. She stated when the original order was received by the pharmacy on 07/31/2024, the pharmacy sent a total of 41 doses for the last dose to be given on 08/20/2024 at the 9:00 p.m. dose. She stated the pharmacy then received an additional order for 3 more doses on 08/23/2024 and those 3 doses were not sent out for delivery until 08/24/2024. She confirmed the facility would not have had medication on hand to administer Resident #3's morning or night time doses of Zyvox on 08/21/2024, 08/22/2024, or 08/23/2024. She stated she reviewed the original order and whomever entered the order put it in with a stop date of 08/20/2024. She stated given the original stop date, the facility would have only received enough doses through the 2nd dose on 08/20/2024. She confirmed the pharmacy did not send additional doses until they were contacted by the facility's provider on 08/24/2024 with a new order for 3 additional doses. She stated the facility's provider informed them the stop date had been entered incorrectly and should have been 08/23/2024 not 08/20/2024.</p> <p>An interview was conducted on 10/09/2024 at 2:45 p.m. with S11LPN. S11LPN confirmed she was familiar with Resident #3 and had been her nurse when she was in the facility. S11LPN confirmed she recalled a few days when she did not have Resident #3's antibiotics available at the facility to administer. S11LPN stated she could not be certain of the exact number of doses she missed, but she knew it was at least 2. S11LPN stated if she wrote a note on 08/24/2024 stating Resident #3's medication still had not been received, it would mean the medication was not available to be administered and she must have documented incorrectly by accident on the MAR. S11LPN confirmed multiple consecutive missed doses of an antibiotic for a resident admitted to receive antibiotics would be considered a significant medication error and should not happen.</p> <p>An interview was conducted on 10/09/2024 at 2:48 p.m. with S13RN. S13RN confirmed 4 consecutive missed doses of an antibiotic a resident was admitted to receive would be considered a significant medication error and should never happen.</p> <p>(continued on next page)</p> | | |

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| <p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S5NP. S5NP confirmed if an order was written for a patient to receive a medication, she would expect the medication to be given as ordered. S5NP confirmed various problems could occur from missed doses of antibiotics. S5NP confirmed Resident #3 was admitted to the facility from an acute care hospital in order to complete her full course of IVPB antibiotics due to an infected sacral wound. S5NP reviewed Resident #3's medical record and confirmed she was supposed to receive a dose of IVPB antibiotic every 12 hours through the 2nd dose on 08/23/2024. S5NP confirmed she and S4NP were not aware of Resident #3's missing doses of medication until 08/24/2024. S5NP stated a call was placed by the facility to the on-call NP after the first missed dose but the floor nurses never made her or S4NP aware during rounds. S5NP stated if she or S4NP had been made aware, the situation would have been resolved promptly thus preventing any additional significant medication errors from occurring. S5NP stated once additional doses of Resident #3's antibiotic arrived to the facility on [DATE], the resident had to remain in the facility an additional 2 days to complete her full course of treatment.</p> <p>An interview was conducted on 10/09/2024 at 10:40 a.m. with S4NP. S4NP confirmed 4 consecutive missed doses of an antibiotic a resident was admitted to receive would be considered a significant medication error and should never happen. S4NP confirmed the significant medication error caused Resident #3 to remain inpatient an additional 2 days after her planned discharge in order to complete her full course of antibiotics.</p> <p>An interview was conducted on 10/09/2024 at 4:20 p.m. with S3ADON. S3ADON confirmed S1DON was on extended medical leave and unavailable by telephone. S3ADON confirmed S1DON handled the investigation into Resident #3's medication errors so she could not speak directly to the situation. S3ADON confirmed multiple consecutive missed doses of an antibiotic causing a resident to remain inpatient in the facility an additional 2 days past their planned discharge date would be considered a significant medication error and should not happen.</p> | | |

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| <p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.</p> <p>50093</p> <p>Based on record reviews and interview, the facility failed to ensure required trainings were completed for 7 of 7 (S1ADM, S2DON, S6LPN, S7CNA, S8LPN, S9RT, and S10LD) personnel files reviewed. The facility failed to ensure:</p> <ol style="list-style-type: none"> S8LPN and S9RT completed the required abuse, neglect, and dementia training; and S1ADM, S2DON, S6LPN, S7CNA, and S10LD completed the required dementia training. <p>Findings:</p> <p>Review of the facility's Abuse, Neglect, Exploitation policy, last revised 08/2022, revealed, in part, the following:</p> <p>II. Employee Training</p> <p>A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation.</p> <p>B. Existing staff will receive annual education through planned in-services and as needed.</p> <p>S1ADM</p> <p>Review of S1ADM's personnel file revealed a hire date of 03/05/2023. Further review revealed no documentation of completion of dementia training.</p> <p>S2DON</p> <p>Review of S2DON's personnel file revealed a hire date of 11/06/2022. Further review revealed no documentation of completion of dementia training.</p> <p>S6LPN</p> <p>Review of S6LPN's personnel file revealed a hire date of 08/18/2023. Further review revealed no documentation of completion of dementia training.</p> <p>S7CNA</p> <p>Review of S7CNA's personnel file revealed a hire date of 04/17/2024. Further review revealed no documentation of completion of dementia training.</p> <p>S8LPN</p> <p>(continued on next page)</p> | | |

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| <p>F 0943</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Review of S8LPN's personnel file revealed a hire date of 05/19/2024. Further review revealed no documentation of completion of abuse, neglect, and dementia training.</p> <p>S9RT</p> <p>Review of S9RT's personnel file revealed a hire date of 05/09/2024. Further review revealed no documentation of completion of abuse, neglect, and dementia training.</p> <p>S10LD</p> <p>Review of S10LD's personnel file revealed a hire date of 06/13/2022. Further review revealed no documentation of completion of dementia training.</p> <p>An interview was conducted on 10/09/2024 at 6:01 p.m. with S1ADM. S1ADM confirmed the facility did not have documentation of completion of abuse and neglect training and dementia training for the aforementioned staff and should have.</p> | | |