

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 225704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2024
NAME OF PROVIDER OR SUPPLIER Life Care Center of West Bridgewater		STREET ADDRESS, CITY, STATE, ZIP CODE 765 West Center Street West Bridgewater, MA 02379	
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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** 48084</p> <p>Based on observation, interview, and record review, the facility failed to provide care and services consistent with accepted standards of clinical practice for two Residents (#91 and #282), out of a total sample of 26 residents. Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #91, to administer Eliquis (anticoagulant/blood thinner) and Tramadol (opioid narcotic for pain) per the physician's orders; and 2. For Resident #282, to follow orthopedic recommendations of touch down weight bearing (TDWB- weight-bearing status where a person's foot or toes can touch the ground to maintain balance, but they do not put any weight on the affected leg) for the left lower extremity (LLE). <p>Findings include:</p> <p>Review of the Massachusetts Board of Registration in Nursing Advisory Ruling #9324 titled Accepting, Transcribing and Implementing Prescriber Orders, dated as last revised 4/11/18, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Licensed Nurse accept, verify, transcribe, and implement orders from authorized prescribers. -The nurse is accountable for ensuring that any orders he or she implements are reasonable based on the nurse's knowledge of that particular patient's care needs at that time. -Standing orders/protocols are applicable to a specific patient or specific situation and directions remain consistent during implementation. <p>1. Review of the facility's policy titled Administration of Medications, dated as last reviewed 8/24/23, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility will ensure medications are administered safely and appropriately per physician order to address resident diagnosis and signs and symptoms. -Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration including the Right Time and Frequency and the Right Documentation. -High Alert medications include anticoagulants and opioids. <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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled Changes in Resident's Condition or Status, dated as last reviewed 8/9/23, indicated the facility will notify the physician when there is a need to alter treatment or to commence a new form of treatment.</p> <p>Resident #91 was admitted to the facility in August 2024 with diagnoses which included fracture around the internal prosthetic left hip joint, atrial fibrillation, and long term (current) use of anticoagulants.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 8/20/24, indicated he/she scored 14 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact. Additionally, he/she had a fracture, was taking scheduled pain medication for almost constant pain that interfered with activities, and was taking an anticoagulant.</p> <p>On 9/6/24 at 8:22 A.M., the surveyor observed Nurse #4 prepare the morning (8:00 A.M. and 9:00 A.M.) medications for Resident #91 as follows:</p> <ul style="list-style-type: none"> -Amiodarone 200 milligrams (mg) one tablet placed in medication cup (for heart failure) -Metoprolol Succinate Extended Release 100 mg one tablet placed in medication cup (for blood pressure) -Flomax 0.4 mg one capsule placed in medication cup (for enlarged prostate/help with urine flow) -Colace 100 mg one capsule placed in medication cup (stool softener) -Eliquis 2.5 mg twice daily was ordered and scheduled for 9:00 A.M., the medication was not in the medication cart and omitted. -Tramadol 50 mg every 12 hours was ordered and scheduled for 9:00 A.M., the medication was not in the medication cart and omitted. <p>Nurse #4 administered the four medications she had prepared and omitted the Eliquis and Tramadol.</p> <p>Nurse #4 failed to check the emergency medication supply for the Eliquis or Tramadol.</p> <p>During an interview on 9/6/24 at 8:22 A.M., Nurse #4 said the Eliquis and Tramadol were not available so she could not give them. She said both orders were new, and the medications had not been delivered from the pharmacy yet and then moved on to the next resident.</p> <p>Nurse #4 failed to call the pharmacy to check on the delivery status of the Eliquis or Tramadol.</p> <p>Review of the Physician/Nurse Practitioner progress note, dated 9/5/24, indicated Resident #91 had been having increased pain and he prescribed standing pain medication (Tramadol).</p> <p>Review of the MAR throughout the morning failed to indicate Nurse #4 had addressed and documented the omitted Eliquis and Tramadol.</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 - Few</p>	<p>Review of the nursing progress notes failed to indicate Nurse #4 had notified the physician the Eliquis and Tramadol were not available for the morning medication pass and to seek alternative treatment orders if applicable.</p> <p>Further review of the MAR on 9/6/24 at 1:25 P.M., failed to indicate Nurse #4 had addressed and documented the omitted Eliquis and Tramadol.</p> <p>During an interview on 9/6/24 at 1:42 P.M., Nurse #4 said the Eliquis had just been delivered from the pharmacy, but the Tramadol was still not in. She said usually they will call the pharmacy if a medication doesn't come on their shift because the pharmacy delivers three times a day, but she had not called yet. Nurse #4 said she had not given the Eliquis or Tramadol that were due at 9:00 A.M. yet and she could give it anytime into the afternoon as long as it did not conflict with his/her afternoon medications. She said she had not called the physician about the missed medications and was going to give the Eliquis now. Nurse #4 said the Tramadol was still not in, but hopefully it would be in tonight. Additionally, Nurse #4 said when a medication is not available sometimes the nurses can get it from the Pyxis machine (emergency medication supply) if it is a regular medication and not a narcotic. She said she did not know if the Eliquis was in the Pyxis machine because she had not looked. Additionally, she said sometimes they will also borrow from another resident if they have the same order, so they don't miss a dose. She said narcotics can't be borrowed so we have to wait for the pharmacy to deliver the medication.</p> <p>Review of the MAR indicated that after the surveyor and Nurse #4's interview concluded (at approximately 2:00 P.M.), the Eliquis ordered/scheduled for 9:00 A.M. was signed off as administered and the Tramadol order/scheduled for 9:00 A.M. was signed off as Other/See Progress Note.</p> <p>Review of the progress note, dated 9/6/24 at 2:04 P.M., linked to the Tramadol order indicated the nurse was waiting to receive the medication from the pharmacy. The note failed to indicate the physician had been notified of the missed dose.</p> <p>Nurse #4 failed to notify the physician and obtain an order to administer the Eliquis at 2:00 P.M. (five hours after it was scheduled to be administered). Additionally, the Eliquis was ordered twice a day and was due to be administered again at 9:00 P.M.</p> <p>During an interview on 9/6/24 at 2:31 P.M., the Director of Nurses (DON) and Regional Nurse #1 said medications could be administered one hour before or up to one hour after the ordered/scheduled time. They said if a medication is not available, the nurse should check the Pyxis machine to see if the medication is stocked in there. Neither the DON nor Regional Nurse #1 knew if Eliquis 2.5 mg was stocked in the Pyxis. Additionally, the DON said if the medication is not available, the nurse should call the provider and write a note. She said they should never borrow medications from another resident. The DON and Regional Nurse #1 were notified that the Eliquis had just been given (at approximately 2:00 P.M), it was ordered twice daily, and an order had not been obtained to administer the dose at 2:00 P.M. The DON said if a medication is outside the hour before or after, the physician should be notified and an order to administer at a different time should be written.</p> <p>Refer to F759</p> <p>41106</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 - Few</p>	<p>2. Review of the facility's policy titled Progressive Ambulation, dated September 2023, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility will provide progressive ambulation in accordance with professional standards of practice, as outlined by [NAME] through the procedure linked below. -The services provided or arranged by the facility as outlined by the comprehensive care plan, must- meet professional standards of quality. -The facility will utilize the Lippincott procedure: Ambulation, Progressive, Long-term care. <p>Review of [NAME](R) NURSING PROCEDURES - 9th Ed. (2023), indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Implementation- Check the patient's medical record for history, diagnosis, and therapeutic regimen. -If the patient is cooperative and can bear weight fully, have the patient place the feet flat on the floor and allow the patient to stand. Stand by for safety. Alternatively, if the patient is cooperative and can partially bear weight, apply a gait belt, and use another assistive device, as ordered, to assist with standing. <p>Review of the book titled Weight Bearing, published January 2024, indicated but was not limited to:</p> <ul style="list-style-type: none"> -Weight Bearing Grades: With touch down weight-bearing, the toes of the foot can touch the floor to maintain balance only. At no time should the individual place weight on the leg. <p>Resident #282 was admitted to the facility in September 2024 with diagnoses which included nondisplaced fracture of the inferior and superior pubic rami bone (front of the pelvis) and a fracture of the anterior wall acetabulum (socket of the hip joint).</p> <p>Review of the Hospital Discharge Summary, dated 9/3/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Patient was admitted post-fall at home which resulted in fracture of the pelvis. -Patient did complain of back pain with bilateral hip pain on 8/31/24- Cat scan ordered by night provider **Left pelvis fracture, nondisplaced, involving inferior and superior pubic rami bases and anterior wall acetabulum. -ORTHO CONSULT with recommendations- No surgical treatment indicated. Touch down weight bearing (TDWB) -Follow up in orthopedics clinic to assess stability of fracture. <p>Review of a nursing note, dated 9/4/24 at 10:39 P.M., with admitting diagnosis of pelvic fracture, remains weight bearing as tolerated (WBAT). No complaints of pain or discomfort. One assist with rolling Walker, for transfer, no breakthrough pain.</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 - Few</p>	<p>The nursing note, dated 9/4/24, failed to reflect the ortho recommendation in the hospital discharge summary of TDWB.</p> <p>On 9/5/24 at 8:10 A.M., from the doorway, the surveyor observed Resident #282 transferring from wheelchair to bed with a Certified Nursing Assistant (CNA). Resident #282 was observed standing on both legs with the CNA by his/her side. The Resident was holding onto the bed rail and twisting both lower legs as he/she moved to the bed. Resident #282 verbalized pain in their left leg and gave the CNA specific instructions on how to lift his/her leg onto the bed. The Resident again said their leg hurt. The surveyor did not observe Resident #282 use a walker to stand and did not observe the Resident maintain TDWB on the left lower extremity (LLE).</p> <p>During an interview on 9/6/24 at 9:45 A.M., Resident #282 said when he/she transfers back and forth from bed to wheelchair he/she does not use a walker with the nurses. Resident #282 said he/she stands on both legs, with most of the weight on the right foot because, of course, the left leg hurts. Resident #282 said he/she has a walker and pointed to the folded-up walker leaning against the wall. He/she said the walker is only used when he/she works with Rehab. Resident #282 said the pain in their left hip was currently a 1/10 (based on a pain scale of 1-10 with 10 being the worst pain), but if he/she stands on the leg, the pain goes to a 9/10.</p> <p>Review of the Physician's Orders indicated Resident #282's weight bearing status orders were written for TDWB to left LLE every shift, effective 9/6/24.</p> <p>Review of Resident #282's current Care Plan indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Resident expresses pain related to pelvic fracture; date initiated 9/4/24. -The resident will express pain relief through the review date. -Evaluate the effectiveness of pain interventions. -Pain medication as ordered. -No weight bearing status indicated. <p>Review of the Pain Evaluation Tool-V2, dated 9/8/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Patient complains of a sharp intermittent mid back pain that radiates to lower back down left hip/upper legs. -Most recent pain level: 6 dated 9/8/24 at 10:46 A.M. -What makes the pain worse? Movement from bed to chair/vice versa, ADLs, therapy. -What makes it better? Patient stated, laying in own bed with head of bed 30 degrees. -What is acceptable pain level: 4 <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 - Few</p>	<p>-Effects of Pain on Quality of Life: Sleep and rest, physical activity, and mobility.</p> <p>Review of Nurse Practitioner (NP) #1's progress note, dated 9/7/24, indicated but was not limited to the following:</p> <p>-Resident #282 was admitted from hospital. Here is a report from the hospital:</p> <p>Resident #282 was found to have a left pelvic fracture, non-displaced, involving the inferior and superior pubic Rami bases and anterior wall acetabulum.</p> <p>-Very pleasant man/woman lying in bed states, I am not having any pain while lying down but when I attempt to ambulate with therapy my pain goes up to 10.</p> <p>-Patient remains touchdown weight bearing left lower extremity.</p> <p>-Alert and oriented times 3</p> <p>-Complaining of left lower extremity pain with ambulation.</p> <p>During an interview on 9/6/24 at 3:10 P.M., Rehabilitation (Rehab) Staff #2 said Resident #282 is TDWB at minimal assist level with a walker. She said the nursing staff was educated on his/her transfer status and the Therapy Care Plan Communication Tool is in the medical record. Rehab Staff #2 said the form should have included the weight bearing status.</p> <p>Review of Therapy Care Plan Communication tool, dated 9/4/24, indicated but was not limited to the following:</p> <p>-Mobility/Transfer indicated stand/step transfers with rolling Walker, one person assist.</p> <p>-No weight bearing status indicated on the form.</p> <p>During an interview on 9/6/24 at 2:55 P.M., CNA #3 said she works with Resident #282, and he/she transfers in and out of bed standing without using the walker.</p> <p>During an interview on 9/6/24 at 3:00 P.M., Nurse #1 said Resident #282 is Weight bearing as tolerated (WBAT) with transfers from bed to wheelchair. She said he/she only uses the rolling walker with physical therapy. The surveyor and Nurse #1 reviewed the physician's orders and Nurse #1 said there are no orders for weight bearing for Resident #282.</p> <p>During an interview on 9/6/24 at 3:30 P.M., the Director of Nurses (DON) said she would expect a new admission would have weight bearing orders from the orthopedic physician and the staff to be following them.</p> <p>Refer to F697</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>41106</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate pain control for one Resident (#282), out of a sample of 26 residents. Specifically, the facility failed to adequately assess and provide pain control, resulting in a three-day delay of additional pain medications being ordered by the Nurse Practitioner (NP).</p> <p>Findings include:</p> <p>Review of the facility's policy titled Pain Assessment and Management, dated 9/8/2022, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Based on the comprehensive assessment of a resident, this facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. -All residents will be assessed for pain indicators upon admission/readmission, quarterly and with any change in condition. -An individualized pain management care plan will be developed and initiated when pain indicators are identified. The care will be reviewed and revised by the interdisciplinary team upon completion of each MDS assessment and as needed. -Based on the assessment of the facility, in collaboration with the attending physician/prescriber. Other health care professionals, and the resident and/or his/her representative, develop, implements, monitors, and revises as necessary interventions to prevent or manage each individual resident's pain, beginning at admission. -Monitoring appropriately for effectiveness and/or adverse consequences (e.g., constipation, sedation) including defining how and when to monitor the resident's symptoms and degree of pain relief: -Modifying the approaches, as necessary. <p>Resident #282 was admitted to the facility in September 2024 with diagnoses which included: nondisplaced fracture of the inferior and superior pubic rami bone (front of the pelvis) and a fracture of the anterior wall acetabulum (socket of the hip joint).</p> <p>Review of the Hospital Discharge Summary, dated 9/3/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Patient was admitted post-fall at home which resulted in fracture of the pelvis. -Patient did complain of back pain with bilateral hip pain on 8/31/24- Cat scan ordered by night provider **Left pelvis fracture, nondisplaced, involving inferior and superior pubic rami bases and anterior wall acetabulum. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-ORTHO CONSULT with recommendations- No surgical treatment indicated. Touch down weight bearing (TDWB-weight-bearing status where a person's foot or toes can touch the ground to maintain balance, but they do not put any weight on the affected leg).</p> <p>-Follow up in orthopedics clinic to assess stability of fracture.</p> <p>-Continue as needed (PRN) Tramadol (Opioid pain medication).</p> <p>Review of active medications (Hospital):</p> <p>-Acetaminophen 325 milligrams (mg)- 650 mg by mouth (PO) every six hours, PRN, mild pain 1-3.</p> <p>-Tramadol HCl 50 mg- 50 mg by PO every eight hours as needed for moderate pain 4-6. Last administered 9/3/24 at 10:46 AM.</p> <p>Review of Resident #282's Physical Therapy Evaluation, dated 9/4/2024, indicated but was not limited to the following:</p> <p>-Weight Bearing: left lower extremity Toe-Touch Weight Bearing (TDWB LLE).</p> <p>-Patient reports 8/10 (based on a pain scale of 1-10 with 10 being the worst pain) left pelvic pain during lower extremity (LE) range of motion and wheelchair propulsion with bilateral upper extremities/lower extremities, 9/10 left pelvic pain during transfers.</p> <p>Review of Resident #282's current Care Plan indicated but was not limited to the following:</p> <p>-Resident expresses pain related to pelvic fracture; date initiated 9/4/24.</p> <p>-The resident will express pain relief through the review date.</p> <p>-Evaluate the effectiveness of pain interventions.</p> <p>-Pain medication as ordered.</p> <p>On 9/05/24 at 8:10 A.M., from the doorway, the surveyor observed Resident #282 transferring from wheelchair to bed with a Certified Nursing Assistant (CNA). Resident #282 was observed standing on both legs with the CNA by his/her side. The Resident was holding onto the bed rail and twisting both lower legs as he/she moved to the bed. Resident #282 verbalized pain in his/her left leg and gave the CNA specific instructions on how to lift his/her leg onto the bed. Resident #282 again said their leg hurt. The surveyor did not observe Resident #282 use a walker to stand and did not observe the Resident maintain TDWB on the left lower extremity (LE).</p> <p>During an interview on 9/05/24 at 8:15 A.M., Resident #282 said his/her pain level was a 9/10 and they are not giving him/her enough pain medication. The Resident said he/she has asked for more pain medication every day and they only give him/her Tylenol which brings the pain down to an 8/10. The Resident said an acceptable pain level would be down to 4/10. Resident #282 said, The doctor must think I am a drug addict, which I am not; I am in pain.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/06/24 at 9:45 A.M., Resident #282 said when he/she transfers back and forth from bed to wheelchair he/she does not use a walker with the nurses. Resident #282 said he/she stands on both legs, with most of the weight on the right foot because, of course, the left leg hurts. Resident #282 said he/she has a walker and pointed to the folded-up walker leaning against the wall. He/she said the walker is only used when he/she works with Rehab. Resident #282 said the pain in his/her left hip was currently a 1/10, but if he/she stands on the leg, the pain goes to a 9/10. Resident #282 said he/she is still asking for more pain medication, but they have not given him/her any.</p> <p>Review of the Pain Evaluation Tool-V2, dated 9/8/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Patient complains of a sharp intermittent mid back pain that radiates to lower back down left hip/upper legs. -Most recent pain level: 6 dated 9/8/24 at 10:46 A.M. -What makes the pain worse? Movement from bed to chair/vice versa, ADLs, therapy. -What makes it better? Patient stated, laying in own bed with head of bed 30 degrees. -What is acceptable pain level: 4 -Effects of Pain on Quality of Life: Sleep and rest, physical activity, and mobility. -Pharmacological And Non-Pharmacological Treatment: PRN Oxycodone 5 mg every 4 hours as needed for pain 6-10. PRN Tramadol 50 mg every 4 hours as needed for pain 1-5. APAP (Tylenol) scheduled TID (three times a day). <p>Review of Nurse Practitioner (NP) #1's progress note, dated 9/7/24, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -Resident #282 was admitted from hospital. Here is a report from the hospital: <p>Resident #282 was found to have a left pelvic fracture, non-displaced, involving the inferior and superior pubic Rami bases and anterior wall acetabulum.</p> <ul style="list-style-type: none"> -Very pleasant man/woman lying in bed states, I am not having any pain while lying down but when I attempt to ambulate with therapy my pain goes up to 10. -New order for Tramadol 50 mg every four hours as needed. -Patient states he/she does not get good effect from that. He/she had that at the hospital. -Discussed with patient Oxycodone 5 mg. He/she would like to try Oxycodone for pain 6 to 10 prior to therapy. We will continue Tramadol for pain 1 to 5 and Oxycodone for pain 6 to 10. -Patient remains touchdown weight bearing left lower extremity. <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Alert and oriented times 3</p> <p>-Complaining of left lower extremity pain with ambulation.</p> <p>During an interview on 9/06/24 at 2:23 P.M., NP #1 said she has not seen Resident #282 yet and nobody has called her about Resident #282 having increased pain. NP #1 said if the Tylenol was not controlling his/her pain, she would expect the nursing staff to call her or the doctor and let them know. NP #1 said Resident #282 was receiving Tramadol in the hospital but was admitted to this facility only on Tylenol.</p> <p>During an interview on 9/06/24 at 3:30 P.M., the Director of Nurses (DON) said if a resident is having more pain, she would expect the nurses to notify the physician or nurse practitioner.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>48084</p> <p>Based on observation, interview, and record review, the facility failed to ensure it was free from a medication error rate of greater than five percent when one of two nurses made two errors out of 26 opportunities, totaling a medication error rate of 7.69%. These errors impacted one Resident (#91), out of four residents observed. Specifically, Eliquis (anticoagulant/blood thinner) and Tramadol (opioid narcotic for pain) were omitted during the medication pass.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Administration of Medications, dated as last reviewed 8/24/23, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility will ensure medications are administered safely and appropriately per physician order to address resident diagnosis and signs and symptoms. -Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration including the Right Time and Frequency and the Right Documentation. -High Alert medications include anticoagulants and opioids. <p>Review of the active Physician's Orders for Resident #91 included but was not limited to:</p> <ul style="list-style-type: none"> -Eliquis 2.5 milligrams (mg) twice daily was scheduled for 9:00 A.M. and 9:00 P.M. -Tramadol 50 mg every 12 hours was scheduled for 9:00 A.M and 9:00 P.M. <p>On 9/6/24 at 8:22 A.M., the surveyor observed Nurse #4 prepare and administer medications to Resident #91.</p> <p>Nurse #4 failed to administer the Eliquis and Tramadol as ordered, both of which could jeopardize the resident's health and safety and/or cause discomfort.</p> <p>During an interview on 9/6/24 at 8:22 A.M., Nurse #4 said the medications had not been delivered from the pharmacy yet and she moved on to the next resident.</p> <p>During an interview on 9/6/24 at 1:42 P.M., Nurse #4 said she had not administered the Eliquis or Tramadol ordered/scheduled for 9:00 A.M. and had not looked in the emergency medication supply (Pyxis machine) for the meds. Nurse #4 said the Eliquis had just been delivered from the pharmacy and she was going to give the Eliquis now.</p> <p>Review of the Medication Administration Record (MAR) indicated that after the surveyor and Nurse #4's interview concluded (at approximately 2:00 P.M.), the Eliquis ordered/scheduled for 9:00 A.M. was signed off as administered and the Tramadol order/scheduled for 9:00 A.M. was signed off as Other/See Progress Note.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the progress note, dated 9/6/24 at 2:04 P.M., linked to the Tramadol order indicated they were waiting to receive the medication from the pharmacy.</p> <p>During an interview on 9/6/24 at 2:31 P.M., the Director of Nurses (DON) said the expectation was for medication to be administered per physician's orders. She said medications should be administered one hour before or up to one hour after the ordered/scheduled time.</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>36542</p> <p>Based on observation, interview, and policy review, the facility failed to ensure all drugs and biologicals were stored in a safe and secure manner as required. Specifically, the facility failed for Resident #89, to ensure medications were not left unattended in the Resident's room.</p> <p>Findings include:</p> <p>Review of the facility's policy titled Storage of Medications, dated January 2023, indicated the following:</p> <ul style="list-style-type: none"> -Medications and biologicals are stored properly, following manufacturer's or provider pharmacy recommendations, to maintain their integrity and to support safe effective drug administration. -The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. <p>Review of the facility's policy titled Administration of Medications, dated 8/24/23, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> - The facility will ensure medications are administered safely and appropriately per physician order to address resident's diagnoses and signs and symptoms. -Medication administration is the responsibility of those individuals who through certification and licensure are authorized in their state to administer medications in a skilled nursing facility. <p>Resident #89 was admitted to the facility in April 2024.</p> <p>Review of the Minimum Data Set (MDS) assessment, dated 7/16/24, indicated Resident #89 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), indicating he/she was cognitively intact.</p> <p>During an observation with interview on 9/4/24 at 9:05 A.M., the surveyor observed an unlabeled medication cup on Resident #89's overbed table with two tablets and one chewable tablet. Resident #89 said the chewable tablet was calcium and he/she could not remember what the other two medications were. The Resident said he/she was given ProSource (a red liquid protein supplement observed on the overbed table) at the same time and taking medications with the liquid protein gives him/her an upset stomach. He/she said the nurses will leave the medications for the Resident to take later, adding they trust me.</p> <p>Review of the medical record for Resident #89 indicated the Resident had not been assessed for self-administering medications.</p> <p>Review of the medications indicated Resident #89 had orders for the following medications:</p> <p>(continued on next page)</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>-Metformin (antidiabetic) 500 mg (milligrams), twice per day (9:00 A.M. and 9:00 P.M.)</p> <p>-Calcium Carbonate (antacid) oral tablet 500 mg four times per day (9:00 A.M., 1:00 P.M., 5:00 P.M. and 9:00 P.M.)</p> <p>-Famotidine (acid reducer) 20 mg twice per day (7:30 A.M. and 4:30 P.M.)</p> <p>-ProSource oral liquid 30 ml (milliliter) twice per day (9:00 A.M. and 9:00 P.M.)</p> <p>During an interview on 9/4/24 at 9:20 A.M., Unit Manager #2 reviewed the medical record and said Resident #89 was not able to self-administer medications and the medications should not have been left with the Resident.</p> <p>During an interview on 9/6/24 at 9:00 A.M., Resident #89 said the nurses are no longer giving medications at the same time as the ProSource which was good because that was making him/her nauseous.</p> <p>During an interview on 9/6/24 at 2:30 P.M., the Director of Nurses (DON) said medications should not be left at a resident's bedside.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46862</p> <p>Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program to help prevent the development and potential transmission of communicable diseases and infections for three Residents (#112, #40, and #53). Specifically, the facility failed:</p> <ol style="list-style-type: none"> 1. For Resident #112, to ensure staff wore personal protective equipment (PPE) as required for Isolation/Droplet Precautions (infection control precautions used for residents who are infected with certain infectious agents including COVID-19 for which additional precautions are needed to prevent infection transmission) while entering the room and changing linen on the Resident's bed and transferring the Resident back to bed; 2. For Resident #40, to ensure staff wore PPE as required for Enhanced Barrier Precautions while entering the room and changing linen on the Resident's bed; and 3. For Resident #53, to ensure staff wore PPE as required for Contact Precautions while entering the room and providing physical therapy. <p>Findings include:</p> <p>Review of the facility's policy titled Transmission-Based Precautions and Isolation Procedures, dated as reviewed 6/3/2024, indicated but was not limited to the following:</p> <ul style="list-style-type: none"> -The facility will implement and utilize transmission-based precautions to ensure the mitigation of infection spread and to ensure standards of infection prevention and control are followed. -Transmission-based precautions must be used when a resident develops signs and symptoms of a transmissible infection, arrives at a nursing home with symptoms of an infection (pending laboratory confirmation), or had a laboratory confirmed infection and is at risk of transmitting the infection to other residents. -Standard precautions represent the infection prevention measures that apply to all resident care, regardless of suspected or confirmed infection status of the resident, in any setting where healthcare is being delivered. These evidence-based practices are designed to protect healthcare staff and residents by preventing the spread of infections among residents and ensuring staff do not carry infectious pathogens on their hands or via equipment during resident care. -Contact precautions are intended to prevent transmission of pathogens that are spread by direct (e.g., person-to-person) or indirect contact with the resident or environment, and require the use of appropriate PPE, including a gown and gloves before entering the room or cubicle. Prior to leaving the resident's room or cubicle, the PPE is removed, and hand hygiene is performed. -The use of droplet precautions applies when respiratory droplets contain pathogens which may be spread to another susceptible individual. Respiratory pathogens can enter the body via the nasal mucosa, conjunctivae and less frequently the mouth. <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 - Some</p>	<p>-Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown, and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.</p> <p>1. Resident #112 was admitted to the facility in April 2024 with diagnoses including hemiparesis following cerebral infarction, atrial fibrillation and osteomyelitis of right ankle and foot.</p> <p>Review of Physician's Orders included but was not limited to:</p> <p>-Isolation Contact and Droplet Precautions: COVID positive 9/4/24 every shift until 9/15/24, dated 9/4/24.</p> <p>On 9/4/24 at 11:00 A.M., the surveyor observed an Isolation Precaution sign hanging outside of Resident #112's room.</p> <p>The Precaution sign indicated the following:</p> <p>-In addition to standard precautions Staff and Providers must:</p> <ul style="list-style-type: none"> -Clean hands when entering and exiting -Gown change between each resident -N95 Respirator (Facemask acceptable if N95 not available; fit tested N95 or higher required for aerosol-generating procedures) -Eye protection (goggles or face shield) -Gloves change between each resident -Keep door closed (Unless safety concern or not on physically separate unit) -Use patient dedicated or disposable equipment -Clean and disinfect shared equipment <p>On 9/4/24 at 11:47 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 conversing with Resident #112 while changing linens on his/her bed. CNA #1 was wearing a surgical mask and gloves (not an N95, no gown, and no eye protection as indicated on the Isolation Precaution sign.) CNA #1 was then observed exiting the room and removed her surgical mask, folded it, and placed it in her pocket.</p> <p>During an interview on 9/4/24 at 11:50 A.M., the surveyor and CNA #1 reviewed the isolation sign posted at Resident #112's room. CNA #1 said she should have followed the sign and wore a gown, gloves, N95 and eye protection prior to entering the room. CNA #1 said she should have placed her surgical mask in the trash.</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 - Some</p>	<p>On 9/4/24 at 11:52 A.M., the surveyor observed CNA #1 wash her hands, put on a gown, gloves, and N95 mask. CNA #1 entered Resident #112's room and assisted Resident back to bed. CNA #1 did not put on eye protection.</p> <p>During an interview at 12:00 P.M., CNA #1 said she had forgotten to put on eye protection. CNA #1 said she should have followed the precaution sign and wore a gown, gloves, N95 and eye protection before entering the Resident's room.</p> <p>During an interview on 9/4/24 at 12:20 P.M., Unit Manager (UM) #1 said CNA #1 should have followed the posted isolation precaution sign for Resident #112. UM #1 said the expectation for any isolation room required staff to wear full PPE of gown, gloves, N95, and eye protection.</p> <p>2. Resident #40 was admitted to the facility in May 2018 with diagnoses including dementia, chronic obstructive pulmonary disease, and colostomy (an opening in the large intestine).</p> <p>Review of the Physician's Orders included but was not limited to:</p> <ul style="list-style-type: none"> -Enhanced barrier precautions secondary to colostomy, dated 5/9/23. <p>On 9/4/24 at 11:10 A.M., the surveyor observed an EBP sign hanging outside of Resident #40's room.</p> <p>The Precaution sign indicated the following:</p> <ul style="list-style-type: none"> -Everyone must: <ul style="list-style-type: none"> -Clean their hands, including before entering and when leaving the room. -Providers and staff must also: <ul style="list-style-type: none"> -Wear gloves and a gown for the following high-contact resident care activities. <ul style="list-style-type: none"> -Dressing -Bathing/showering -Transferring -Changing linens -Providing hygiene -Changing briefs or assisting with toileting -Device care or use: <ul style="list-style-type: none"> -Central line, urinary catheter, feeding tube, tracheostomy -Wound care: any skin opening requiring a dressing <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 - Some</p>	<p>-Do not wear the same gown and gloves for the care of more than one person.</p> <p>On 9/4/24 at 12:12 P.M., the surveyor observed CNA #2 changing linens on Resident #40's bed. CNA #2 was wearing gloves. CNA #2 was not wearing a gown.</p> <p>During an interview on 9/4/24 at 12:15 P.M., the surveyor and CNA #2 reviewed the EBP sign posted at Resident #40's room. CNA #2 said she should have followed the sign and wore a gown when making the Resident's bed.</p> <p>During an interview on 9/4/24 at 12:20 P.M., UM #1 said CNA #2 should have followed the posted EBP sign for Resident #40. UM #1 said the expectation was staff should be wearing a gown and gloves when changing linens in an EBP room.</p> <p>During an interview on 9/4/24 at 12:53 P.M., the Infection Control Preventionist (ICP) said the expectation was all staff should be reading and donning (putting on) the appropriate PPE as written on the posted precaution sign. The ICP said CNA #1 should have donned a gown, gloves, N95 and eye protection for Resident #112 upon entering his/her room. The ICP said CNA #2 should have donned a gown and gloves when changing linens on Resident #40's bed.</p> <p>49424</p> <p>3. Resident #53 was admitted to the facility in August 2024 with diagnoses which included enterocolitis due to clostridium difficile (a highly contagious bacterium that causes diarrhea and colitis also referred to as C-Diff).</p> <p>Review of Resident #53's Physician's Orders indicated a Contact Precautions Diagnosis: C-Diff every shift ordered 8/24/24 with no end date.</p> <p>On 9/4/24 at 9:10 A.M., the surveyor observed a contact plus precaution sign posted on the door frame of Resident #53's room which indicated for everyone entering/exiting the room to:</p> <ul style="list-style-type: none"> -Clean their hands, including before entering and when leaving the room. -Providers and Staff must also: <ul style="list-style-type: none"> -Put on gloves before room entry. Discard gloves before room exit. -Put on gown before room entry. Discard gown before room exit. -Do not wear the same gown and gloves for the care of more than one person. -Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. <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 - Some</p>	<p>During an observation with an interview on 9/4/24 at 9:11 A.M., the surveyor observed Rehabilitation Services Staff #1 inside the room sitting next to the Resident in a stationary chair instructing the Resident on leg exercises with no PPE donned. The Rehabilitation Services Staff said there was a Contact Precaution sign posted outside the door, but she said she did not have to wear any PPE because she was not encountering C-Diff. She said she would need to wear PPE if she was going to assist the Resident in the bathroom and would be exposed to stool.</p> <p>During an interview on 9/4/24 at 9:15 A.M., Nurse #4 said to enter the Resident's room PPE needed to be donned. She said this includes all the PPE on the sign (gown and gloves).</p> <p>During an interview on 9/4/24 at 9:17 A.M., Nurse # 3 said every employee needs to follow the sign posted outside of resident rooms. She said Rehabilitation Services Staff #1 should have been wearing PPE inside the room when working with the resident. She said she also should have completed hand hygiene when entering and exiting the room.</p> <p>During an interview on 9/4/24 at 9:20 A.M., the ICP said the Resident was on contact precautions for C-Diff and the purpose of wearing PPE was to prevent the spread of spores to employee's families and other residents. She said all staff have been educated on what the importance of proper PPE usage is and how to don and doff (remove) PPE.</p>		