| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 235074 | A. Building<br>B. Wing | 08/14/2024 |

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| Marlette Comm Hosp Ltcu | 2770 Main St<br>Marlette, MI 48453 |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978<br><br>Based on observation, interview and record review, the facility failed to appropriately monitor for a change in condition per professional standards of practice for one resident (Resident #30) of one resident reviewed for hospitalization s, resulting in the potential for delayed treatment and a further deterioration of condition.<br><br>Findings include:<br><br>Resident #30 (R30):<br><br>Review of R30's Minimum Data Set (MDS) assessment, dated 6/10/2024, revealed R30 was admitted to the facility on [DATE] and had diagnoses including hypertensive heart disease with heart failure, aortic valve stenosis, peripheral vascular disease, hypertension and dementia. Further review revealed R30 scored five out of 15 (5/15) on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.<br><br>An observation on 8/12/2024 at 1:27 a.m. revealed R30 seated in a wheelchair in her room. R30 was observed to be receiving three liters per minute of oxygen via nasal cannula from a portable oxygen tank housed on the back of the wheelchair. When asked if she required continuous use of the oxygen, R30 reported I do now. R30 was unable to state when or why she began using supplemental oxygen.<br><br>Review of R30's electronic medical record (EMR) revealed R30 was transferred to the emergency department (ED) and subsequently hospitalized on [DATE] for an exacerbation of congestive heart failure and acute pulmonary edema [excess fluid in the lungs]. R30 returned to the facility on [DATE].<br><br>Review of R30's ED Note, dated and signed 5/21/2024 at 7:53 a.m., revealed the following, in part: . from [facility] for evaluation of acute difficulty in breathing . the patient's respiratory symptoms were of rapid onset several hours ago and have since worsened in severity. She is reported to have a history of CHF [congestive heart failure] with chronic diuretic therapy. She is claimed to have experienced similar respiratory symptoms to a lesser extent of severity on 5/11/2024 . Pulmonary: Diffuse rhonchi and rales [abnormal lung sounds indicating air flow obstruction in the lungs]. Tachypnea [rapid respirations] with profound accessory muscle usage. No wheezes . Lab results . BNP [blood test used to detect heart failure, normal range less than 100] 1174 HIGH . Historical Results: 5/13/2024, 996 HIGH .<br><br>Further review of R30's EMR prior to transfer to the ED on 5/21/2024 revealed the following:<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5/11/2024 at 7:17 a.m. Patient states SOB [shortness of breath] with no chest pain. Right lower lobe crackles [rales] noted. VS [vital signs] 95% @ 3L via NC [95% oxygen saturation on three liters of oxygen per minute via nasal cannula], HR [heart rate] 95, Temp 97.2, RR [respiratory rate] 30, BP 166/79. [Provider] called and informed. Ordered labs and chest x-ray for patient.<br><br>5/11/2024 at 12:32 p.m. [Provider] called due to results of labs and chest x-ray. Chest x-ray showed atelectasis [collapse of lung or partial lung due to decreased air flow] bilaterally. Lasix [medication used to remove excess fluid from the body] dose changed to 40 mg [milligrams] BID [twice daily] . Patient is a daily weight .<br><br>5/12/2024 at 3:33 a.m. Administration Note: guaifenesin [medication used to relieve chest congestion] oral syrup 100 mg/mL [milligrams per milliliter] . Give 5 mL by mouth every 4 hours as needed for cough.<br><br>5/12/2024 at 5:25 a.m. Administration Note: guaifenesin [medication used to relieve chest congestion] oral syrup 100 mg/mL [milligrams per milliliter] . Give 5 mL by mouth every 4 hours as needed for cough. PRN [unscheduled, as needed] administration was effective.<br><br>5/13/2024 at 2:01 p.m. [R30] had laboratory tests and [chest x-ray] done over the weekend and it appeared that she has mild CHF with haziness in the perihilar [central region of lungs] area . and an elevated BNP . says she is somewhat short of breath . Diagnostic studies from 5-11-24: elevated BNP 1068 . CXR [chest x-ray] with perihilar haziness, pleural effusion [buildup of fluid in lungs] . Impression: dyspnea [shortness of breath] with CHF .<br><br>5/13/2024 at 5:40 p.m. BNP results remain high at 996 .<br><br>5/21/2024 at 3:46 a.m. Resident called for help, reported pain in her back, head, chest and everywhere . VS obtained [BP] 212/87, [RR] 27, O2 89% 2L, [HR] 110 and her congestion/lungs . wet and audible. Called cardio [cardiopulmonary therapy] for a [as needed] breathing treatment and when he came down, he assessed her and stated she was filled with fluid and so provider called and gave order to send out to [ED] .<br><br>Review of R30's EMR, including progress notes, assessments and the May 2024 medication administration record [MAR], revealed no documentation of a respiratory assessment to correspond with the PRN dose of guaifenesin 100mg/mL administered on 5/12/2024 at 3:33 a.m. Further review revealed no respiratory assessments were documented for R30, apart from the nurses' note on 5/13/2024 at 2:01 p.m., from the time of R30's change in condition on 5/11/2024 until 5/21/2024 at 3:46 a.m., when R30 called out for help and was found to be in respiratory distress.<br><br>On 8/13/2024 at 09:29 a.m., the Director of Nursing (DON) reported she searched R30's EMR and cardiopulmonary therapy documentation and did not find any respiratory assessments for R30 from 5/11/2024 to 5/13/2024 and from 5/14/2024 until the date of R30's transfer to the ED on 5/21/2024. The DON reported R30's vital signs were monitored daily, and her oxygen saturation was documented as monitored every shift (three times daily) but only one result was documented daily. The DON stated she would expect a full respiratory assessment, including resident appearance and assessment of lung sounds to be documented during episodes of acute change in condition until the resident returned to baseline. The DON also stated a respiratory assessment should have been documented to correspond with the administration of the PRN guaifenesin 100mg/mL on 5/12/2024. |

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| F 0696<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care/assistance for a resident with a prosthesis.<br><br>40383<br><br>Based on observation, interview, and record review, the facility failed to provide care and assistance to wear and be able to use a prosthetic device for one resident (Resident #20) of one resident reviewed for activities of daily living with a prosthesis.<br><br>Findings include:<br><br>Resident #20 (R20):<br><br>On 8/13/24 at 9:06 AM, Resident #20 (R20) was observed in the hallway sitting in his wheelchair. He explained he had lost most of his right arm in an accident many years ago. He stated he had a prosthesis, but on observation he was not wearing .the bottom portion of the prosthesis.<br><br>On 8/13/24 at 11:43 AM, R20 was observed and was not wearing the bottom portion of his right arm prosthesis. R20 stated Some of them (Certified Nurse Aids or CNA's) put it on, and some can't get it on. R20 said he did not put it on himself.<br><br>During an interview on 8/13/24 at 1:24 PM, CNA F and CNA G were asked about the right arm prosthesis. CNA G said she had not put the prosthesis on. CNA F stated R20's prosthesis was broken and could not be worn. CNA F said, It is in his room, and we are waiting for the orthotist to fix it (the prosthesis).<br><br>During an interview on 8/13/24 at 1:32 PM, the Director of Nursing (DON) was unaware R20's prosthesis needed adjustment.<br><br>During an interview on 8/13/24 at 2:40 PM, Physical Therapist I said she remembered CNA F bringing the broken prosthetic to her a few weeks ago but she had not taken action at that time and it fell through the cracks.<br><br>On 8/14/24 at 9:33 AM, R20 was observed in restorative therapy riding the therapy bike and joking with staff. R20 was not wearing the bottom portion of his right arm prosthesis. CNA G said she believed the prosthesis was noted to be broken on approximately 7/29/24.<br><br>During an interview on 8/14/24 at 10:18 AM, Social Services Staff E stated she was aware of R20 not wearing his prosthesis because it needed to be repaired. She said this had not been documented and the orthotist had not been made aware.<br><br>(continued on next page) |

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| F 0696<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The electronic medical record (EMR) for R20 had diagnoses including acquired absence of right upper limb below the elbow and presence of artificial right arm. The physician orders included: 2/23/23 OT (Occupational Therapy) recommendations: Resident to wear orthotic arm as desired, at least 2 or more hours/day for 6-7 days/week. R20's care plan included a care plan with a focus of: (R20) has an ADL (Activity of Daily Living) self-care performance deficit r/t (related to) CVA (cerebral vascular accident - stroke) with right Hemiplegia, below elbow amputation right arm. Has prosthesis for right lower arm/hand . The care plan interventions included: Assist resident with placement of prosthesis right lower arm/hand. Alert OT if problems with RT (right) prosthetic arm occurs. Resident to wear prosthesis as desired at least 2 hr./day, 6-7 days/week. Date Initiated: 08/20/2022<br><br>The facility policy titled: Rehabilitation Procedures and Modalities and dated as last approved 01/2023 read in part:<br><br>Purpose: To ensure safe, competent and proficient performance of treatment procedures is necessary for the optimal outcome of treatment and to avoid injury to the patient .<br><br>Procedure: All treatment procedures will be performed in a manner that takes into account the patient's medical and therapy conditions, cognitive status, and any precautions/contraindications. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>49310<br><br>Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% based on five medication errors of 34 medication administration opportunities. This deficient practice resulted in a medication error rate of 14.7%.<br><br>Findings include:<br><br>Registered Nurse (RN) A was observed administering medications on 8/13/24 at 10:15 a.m. RN A said she was passing the morning medications on the west hall.<br><br>RN A prepared medications for Resident #31 (R31) consisting of 11 medications. The medications for R31 were ordered to be administered at 9:00 a.m. RN A documented the medications as administered at 10:19 a.m. on 8/13/24.<br><br>RN A prepared medications for Resident #25 (R25) consisting of 17 medications. When the medications were prepared, RN A handed the medications to another nurse, RN B, to administer to R25 while RN A continued with preparing medications at the medication cart. The medications for R25 were ordered to be administered at 9:00 a.m. RN A documented the medications as administered at 10:28 a.m. on 8/13/24 despite not having administered the medications to R25 or having observed R25 taking the medications.<br><br>RN A prepared medications for Resident #3 (R3) consisting of 20 medications. The medications for R3 were ordered to be administered at 9:00 a.m. RN A documented the medications as administered at 11:29 a.m. and 10:41 a.m. on 8/13/24. The medications due at 9:00 a.m. were administered during two separate medication administrations.<br><br>On 8/13/24 at 12:04 p.m., RN B obtained Morphine Sulfate (MSO4) from the controlled substance box. RN B documented the MSO4 on a proof of use form at the medication cart but did not fill out the time on the proof of use form. When asked why the time wasn't documented on the proof of use form, RN B said she does not fill out the time the MSO4 was removed from the medication cart on the proof of use form. RN B said she documents the time on the proof of use form after the resident takes the medication.<br><br>On 8/14/24 at 7:51 a.m., RN C prepared medications for Resident #23 (R23). RN C said R23 was administered medications crushed in applesauce. RN C opened a medication crushing pouch and placed her bare, ungloved finger inside the pouch to open the pouch wider for the placement of medication. R23 used bare, ungloved fingers to open a medication capsule to pour the content into a medication cup.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The Director of Nursing (DON) was interviewed on 8/14/24 at 8:45 a.m. The DON said medication is expected to be administered within one hour before to one hour after the scheduled administration time. The DON provided the example, If a med is scheduled at 8:00 a.m., the nurse has to give the med between 7:00 a.m. to 9:00 a.m. The DON said nurses should perform hand hygiene and put on gloves to open medication capsules or place medications into a crushing pouch. The DON said the nurse who prepares a medication should be the nurse who administers that medication and observes the resident safely swallows the medication. The DON agreed RN A should not have signed out medications that were administered by RN B. When asked if she had a policy, the DON replied, No, that's a standard of practice. The DON said RN B should have filled out the proof of use sheet completely when the MSO4 was taken from the medication cart, including the time the medication was taken from the inventory, not after the medication was administered.<br><br>The policy [Name of facility] Medication Administration dated 7/2024 read, in part: .4. Adhere to the 5 Rights (Resident, Dose, Route, Time and Drug) in preparing medications .9. Administer medications within sixty (60) minutes of time indicated .Infection Control Guidelines will be followed with medication administration . Narcotics: .5. A licensed nurse will document in the narcotic record at the time of removal of any narcotics. Documentation is to include: medication, dose, time of removal . |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>49310<br><br>Based on observation, interview, and record review, the facility failed to properly store and dispose of medications and ensure insulin pens and eye drops were labeled with dates when opened in two medication carts of two medication carts reviewed for medication storage and labeling.<br><br>Findings include:<br><br>On 8/13/24 at 10:35 a.m., Registered Nurse (RN) A attempted to administer medications to Resident #3 (R3). R3 told RN A she did not want the medications because she was on the phone. RN A returned to the medication cart with the medications and obtained a marking pen. RN A wrote R3's initials on the cup containing the medications and pulled open the top drawer of the medication cart. The Director of Nursing (DON) approached and asked RN A what she was doing. RN A told the DON R3 did not want her medications at that time. The DON told RN A to dispose of the medications in the medication cup and obtain new medications when R3 was ready to take the medications. RN A emptied the medications into a Sharps container (a wasted container for sharp medical instruments).<br><br>The South Hall medication cart was reviewed with RN B on 8/13/24 at 12:04 p.m. The cart was observed with four insulin pens that were opened and undated. Three of the insulin pens were prescribed for the same resident.<br><br>The [NAME] Hall medication cart was reviewed with RN C on 8/14/24 at 7:51 a.m. The cart was observed with two prescription eye drops and two insulin pens opened and undated. The cart also contained a drawer with non-medication items stored with oral medications. Pens, pencils, markers were in the same drawer and same compartment as medications for residents.<br><br>The DON was interviewed on 8/14/24 at 8:45 a.m. When asked about RN A writing R3's initials on the medication cup, the DON said, I'm well aware of what she was going to do - she was going to place the cup in the cart and give them later. The DON said nurses should never label a medication cup and place the cup containing medications back into the medication cart. When asked about disposal of medications, the DON said her expectation is for nurses to use [a brand name solution for medication disposal that dissolves medications on contact] to dispose of medications, and not dispose of medications in a Sharps container. The DON confirmed that insulin pens should be dated when opened, and nurses should date eye drops when opened if the eye drops are not over the counter.<br><br>The policy Storage and Expiration Dating of Medications and Biological's dated 8/1/24 read, in part: .Facility should ensure that resident medication and biological storage areas are locked and do not contain non-medication/biological items .<br><br>The policy [Name of facility] Medication Administration dated 7/2024 read, in part: .Multi Dose Medication 1. Will be dated month, day, year on the bottle when opened .6. All insulin vials will be dated with date of opening and expiration date when opened .All eye drops will be dated with date of opening and expiration date when opened . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>39083<br><br>Based on observation, interview, and record review, the facility failed to date mark potentially hazardous foods, maintain sanitary equipment, and maintain proper glove use and handwashing, resulting in an increased risk of foodborne illness, affecting all residents that consume food from the kitchen.<br><br>Findings include:<br><br>On 8/12/24 at 11:40 AM, during a kitchen inspection, assisted by Certified Dietary Manager (CDM) H, an opened bag of hard boiled eggs was observed to not be provided with a date mark to identify the discard date.<br><br>On 8/12/24 at 11:45 AM, a chicken wrap, located in the reach-in deli cooler, was observed to not be provided with a date mark. At this time, CDM H stated the wrap was left over from the day before.<br><br>According to the 2017 FDA Food Code Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. Pf<br><br>On 8/12/24 at 11:51 AM, encrusted food debris was observed on the commercial mixer. At this time, CDM H immediately wiped down the commercial mixer.<br><br>According to the 2017 FDA Food Code Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.<br><br>On 8/12/24 at 12:06 PM, during an observation of lunch service, Dietary Staff J was observed to drop silverware on the ground. Dietary Staff J proceeded to pick up the silverware with gloved hands, set the dirty silverware to the side, then proceeded to assemble clean silverware on resident trays. Dietary Staff J did not change gloves and wash hands until prompted by the surveyor. Dietary Staff J confirmed that they could contaminate the silverware by not changing gloves.<br><br>On 8/12/24 at 12:22 PM, during an observation of lunch service, Dietary Staff K was observed to be serving food onto trays with gloved hands. Dietary Staff K was observed to lightly shred the pork entree every couple of trays and was observed on three occasions touching/adjusting their glasses with gloved hands. Dietary Staff K did not change gloves and wash hands after contaminating hands.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | According to the 2017 FDA Food Code Section 3-304.15 Gloves, Use Limitation. (A) If used, SINGLE-USE gloves shall be used for only one task such as working with READY-TO-EAT FOOD or with raw animal FOOD, used for no other purpose, and discarded when damaged or soiled, or when interruptions occur in the operation. P<br><br>According to the 2017 FDA Food Code Section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. P |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41978<br><br>Based on interview and record review, the facility failed to implement tracking of Covid-19 (a highly contagious respiratory disease) immunizations to ensure appropriate education was offered and vaccinations administered or declined for four residents (R13, R17, R30 and R35) of five residents reviewed for immunization, resulting in the potential for residents and resident representatives to be uninformed of the benefits and potential side effects of Covid-19 vaccination and the potential for eligible residents to remain unvaccinated, increasing the risk of disease.<br><br>Findings include:<br><br>Resident #13 (R13):<br><br>Review of R13's Minimum Data Set (MDS) assessment, dated 6/24/2024, revealed R13 was admitted to the facility on [DATE].<br><br>Review of R13's immunization history obtained from his electronic medical record (EMR) revealed the date of R13's most recent Covid-19 vaccination was documented as 5/04/2022. It was noted in review of the immunization history there was no documentation of R13 being offered an up to date 2023-2024 formula Covid-19 vaccination. Further review of R13's EMR revealed no signed declination for the vaccination or proof of education provided related to the risk and benefits regarding immunization.<br><br>During an interview on 8/14/2024 at 9:50 a.m., the facility's Infection Preventionist, Registered Nurse (RN) A, reported all immunizations offered to residents were recorded in the immunization history section of the EMR. RN A stated education is provided related to the benefits of the vaccination being offered and a screening form indicating acceptance or declination is completed and signed by the resident or the resident's representative. During review of R13's EMR, RN A confirmed there was no record of R13 being offered, administered or declining the updated Covid-19 vaccination. RN A stated she would search through the EMR and the previous Infection Preventionist's documents for the missing documentation. A request was made at that time to include documentation for R17, R30 and R35 in the search.<br><br>Resident #17 (R17):<br><br>Review of R17's MDS assessment, dated 6/03/2024, revealed R17 was admitted to the facility on [DATE]. Review of R17's EMR revealed her most recent Covid-19 vaccination was 10/18/2022. Further review of R17's EMR revealed no signed declination for the vaccination or proof of education provided related to the risk and benefits regarding immunization.<br><br>Resident #30 (R30):<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235074 | A. Building<br>B. Wing | 08/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Marlette Comm Hosp Ltcu | 2770 Main St<br>Marlette, MI 48453 |

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) |
|---|---|
| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of R30's MDS assessment, dated 6/10/2024, revealed R30 was admitted to the facility on [DATE]. Review of R30's EMR revealed her most recent Covid-19 vaccination was 2/04/2021. Further review of R30's EMR revealed no signed declination for the vaccination or proof of education provided related to the risk and benefits regarding immunization.<br><br>Resident #35 (R35):<br><br>Review of R35's MDS assessment, dated 6/06/2024, revealed R35 was admitted to the facility on [DATE]. Review of R35's EMR revealed no documented immunization for Covid-19. Further review of R35's EMR revealed no signed declination for the vaccination or proof of education provided related to the risk and benefits regarding immunization.<br><br>On 8/14/2024 at 11:15 a.m., the Director of Nursing (DON) reported she and RN A reviewed the EMR and paper charts for R13, R17, R30 and R35, and could not provide documentation of the residents being offered, administered or declining the updated 2023-24 Covid-19 vaccination.<br><br>Review of the facility policy titled, Vaccinations for LTC [Long-Term Care] Resident, dated 7/2024, revealed the following, in part: The Covid-19 vaccine is recommended for all residents in LTC [Long-Term Care]. Before offering Covid-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects . On admission the screening form . will serve as documentation and consent to administer vaccines including yearly influenza vaccine. This form will also indicate any vaccines refusal . Documentation in the resident's chart will include the following: Education provided to resident/legal representative .Reason for non-vaccination such as, resident/legal representative refusal, medical contraindication, vaccine unavailability . previous vaccination, or precautions necessitating need for delay (acute illness) .<br><br>Review of the Centers for Disease Control and Prevention (CDC) guidance titled, Updated (2023-2024 Formula) Covid-19 Vaccine, dated 4/03/2024, revealed the following, in part: [AGE] years and Older: Covid-19 Vaccination History: Unvaccinated (0 doses) .2023-24 Vaccine Schedule: Give now; Covid-19 Vaccination History: Any number of previous doses of Covid-19 vaccine, not including at least 1 dose of 2023-24 vaccine . 2023-24 Vaccine Schedule: Give one dose at least 8 weeks (two months) after the last dose . |