STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	425419	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Veteran Village	1200 E National Cemetery Rd Florence, SC 29506

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28734 Based on observation, interview, record review, and facility policy review, the facility failed to implement a comprehensive person-centered care plan for two (2) of 19 sampled residents by failing to: 1) Assess the placement of a gastrostomy (g-tube) tube prior to the administration of medications for one (1) of 19 sampled residents (Resident (R)36) and 2) Develop and implement interventions for episodes of hypoglycemia for residents with Diabetes for one (1) of five (5) residents reviewed for unnecessary medications from a total of 19 sampled residents. (R2) Findings include: 1. Review of the facility policy titled, Care Plan (Comprehensive) dated 6/2019 revealed, Purpose: To develop an interdisciplinary resident centered comprehensive care plan to meet the individual needs of each resident. Procedure: . 2. The comprehensive care plan has been designed to: a. Identify care needs that include resident's strengths, history, and preferences . d. Include individualized approaches to meet resident's goals. Review of R36's the most recent History and Physical dated 09/26/23 revealed the resident had the following diagnoses: Chronic Obstructive Pulmonary Disease (COPD),severe Protein-Calorie Malnutrition, Gastro-Esophageal Reflux Disease (GERD) without Esophagitis, Aphasia, Acute Respiratory Distress Syndrome, Dysphagia and Unspecified Systolic Congestive Heart Failure. During an observation on 10/09/24 at 2:00 PM, of Licensed Practical Nurse (LPN)A, as he/she administered medications to R36 in his/her room, revealed the LPN to have prepared the contents of two (2) Gabapentin (medication given to control seizures, and also used to control pain) capsules 300 milligrams (MG) in a medication cup that also contained approximately 15 milliliters (ML) of water, and the nurse also crushed a Reglan (medication used to treat GERD, and/or gastroparesis in residents with Diabetes) five (5) MG tablet and placed it in a separate medication cup filled with approximately 15 MLs of water. The nurse was observed to administer the medications separately into the resident's g-tube without having checked for any residual amounts of gastric contents in the resident's stomach. Continued observation revealed the LPN did not assess for the correct placement of the g-tube by the instillation of air and auscultation via stethoscope to hear the air enter the stomach. The LPN did not flush the g-tube between the two (2) administered medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R36's Care Plan, revised on 10/08/24, stated, Focus - [R36] is at risk for altered nutrition and complications related to Tube Feeding. At risk for weight loss. [He/She] is NPO [nothing by mouth] .Goal - Resident will tolerate TF [Tube Feeding] .Interventions . Check placement and residual per facility protocol, Date Initiated: 06/04/2024. Continued review of the Care Plan revised 8/5/24 revealed, Focus -At risk for complications related to feeding tube. Goal - Will not have complications r/t [related to] feeding tube through next review date . Interventions - Check placement and residual per MD [Medical Doctor] order & [and] facility protocol . Revision on: 08/28/2024. During an interview on 10/10/24 at 1:54 PM, LPNA revealed the LPN realized he/she had not checked R36's g-tube for placement or residuals prior to having administered the resident's medications. The LPN stated normally, he/she would have checked placement of a g-tube by pushing air into the tube and auscultating with a stethoscope for a gurgling sound in the stomach area. LPNA further revealed medications administered via g-tube without a placement check could possibly end up in other cavities of the resident or could possibly cause an abscess. LPNA concluded that they had been trained to give medications via g-tube separately. During an interview on 10/11/24 at 1:55 PM, the Director of Nursing (DON) revealed each department was responsible for developing their own Plan of Care for each resident. The DON further stated that he/she expected staff to follow the Care Plan because it provided interventions on how to care for each resident, and what staff should be doing for them. The DON revealed Care Plans were updated quarterly, and as needed. During an interview on 10/11/24 at 2:35 PM, the Administrator revealed it was his/her expectation that all staff were here to care for and provide for these residents and follow their Plans of Care. 42070 2. Review of R2's medical record revealed an initial admitted [DATE]. R2's primary medical diagnosis was Chronic Systolic Heart Failure. His/her secondary medical diagnoses included Diabetes Type II. Review of an Annual Minimum Data Set (MDS) dated [DATE] revealed that R2 received insulin injections. Review of R2's Physician's Orders revealed an order dated 06/03/24, for Insulin Lispro sliding scale insulin before meals and at bedtime. The order did not specify directions for nursing staff to respond to episodes of hypoglycemia. A second order dated 09/13/24, was noted for Lantus insulin 30 units injected subcutaneously at bedtime. The order did not specify directions for nursing staff to respond to episodes of hypoglycemia. Review of a form titled Physicians Services Group Standing Orders revealed an order directing staff to contact the Medical Provider for blood glucose results less than 70. Additionally, for residents who were symptomatic, the orders directed staff to hold any existing insulin and give GVoke (Glucagon Injection) 1 milligram (mg) subcutaneously and to repeat in 15 minutes. Lastly, the order directed staff to initiate blood glucose checks every 15 minutes until the resident's blood sugar was stable. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A preliminary review of R2's Plan of Care revealed a focus area for hypo/hyperglycemia risk due to a diagnosis of Diabetes. The Plan of Care included an intervention directing staff to observe R2 for signs and symptoms of hypo/hyperglycemia but did not include interventions to respond to either condition. A review of R2's blood glucose flow records revealed a blood glucose result of 66 on 10/09/24 at 6:54 AM. There were no corresponding progress notes indicating R2 was assessed for symptoms, that the Medical Provider was notified, that any actions were taken to increase the resident's blood glucose, or that the blood glucose was rechecked. Continued review of R2's blood glucose flow records revealed a blood glucose result of 68 on 10/07/24 at 6:41 AM. There were no corresponding progress notes indicating R2 was assessed for symptoms, that the Medical Provider was notified, that any actions were taken to increase the resident's blood glucose, or that the blood glucose was rechecked. Continued review of R2's blood glucose flow records revealed a blood glucose result of 60 on 10/06/24 at 6:34 AM. There were no corresponding progress notes indicating R2 was assessed for symptoms, that the Medical Provider was notified, that any actions were taken to increase the resident's blood glucose, or that the blood glucose was rechecked. During an interview on 10/10/24 at 3:22 PM, Licensed Practical Nurse (LPN)5 stated that, generally, he/she would provide orange juice and recheck the blood sugar in about thirty minutes. When asked how he/she would respond to a resident that would be unable to take anything by mouth, LPN5 stated, I would probably just send them to the hospital. When asked whether he/she was familiar with any policies or procedures the facility had for responding to episodes of hypoglycemia, LPN5 stated, Not that I know of. During an interview on 10/11/24 at 1:45 PM, the Director of Nursing (DON) was asked to supply a copy of the facility's policies governing nursing staffs' response to residents experiencing episodes of hypoglycemia. The DON explained that the facility had not developed a policy for this condition, but that standing orders had been developed. The DON then provided a copy of that form.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on observations, interviews, and record reviews, the facility failed to prevent the significant worsening of a pressure area and the development of a Stage III (3) pressure area for one (1) Resident (R21) out of 19 sampled residents, who developed in house pressure areas. R21's mattress malfunctioned which led to the increase in size in one (1) pressure ulcer and the development of another. Finding include: Review of the facility policy titled, Wound Intervention and Prevention, dated ,d+[DATE], documented, The following is meant to be a guideline and is intended to assist in the decision-making process when determining appropriate treatment and prevention according to the underlying etiology of the alteration in skin integrity, the condition of the wound, and the overall condition of the entire resident. Prevention and Intervention: General Guidelines: 1. Identify residents being At Risk for alterations in skin integrity . 2. Assure proper Tissue Load Management. a. Reposition resident when in bed or in the chair, avoiding sheer and friction, if resident is unable to reposition independently. b. Use pressure redistribution surfaces in the bed and chair as indicated for residents identified at risk for alteration in skin integrity. c. Use proper technique and positioning device when positioning resident for maximum pressure relief effort. 3. Encourage maximum Functional Mobility of Resident . 4. Manage Moisture . 5. Manage Nutrition . 6. Documentation . 7. Pain Management a. Assess the resident for pain indicators and medicate per physician order. [sic] Review of the facility policy titled, Accident/Incident Report, dated [DATE], documented Purpose: To document the events of an incident/accident Procedure: 1. Complete report when unusual event(s) occur(s). 2. Fill out report completely. 3. Physician and family must be notified and documented. 4. The QA (Quality Assurance)/Risk Manager RN will review the investigation, update the incident report, and then close the report. 5. Examples of unusual event(s), but not limited to: . b. Skin Tears/Abrasions/Lacerations . f. Injury of Unknown Origin. 6. The Director of Nursing, Administrator, and Medical Director will review incidents during the QAPI [Quality Assurance/Performance Improvement] meetings. [sic] Review of R21's medical record revealed R21 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus with Diabetic Arthropathy, Peripheral Autonomic Neuropathy, and Morbid Obesity. Review of R2's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The MDS identified displayed behaviors, such as little interest in doing things and he/she felt down. They were also coded as occasionally rejecting care. The MDS further revealed the resident was at risk for skin breakdown and had a Stage II (two) pressure area. Treatments documented included: pressure relieving device to chair and bed, turning/repositioning program, nutrition/hydration interventions, pressure ulcer care, and applications of ointments. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R2's Physician Orders revealed an order dated [DATE], which indicated to cleanse the area of the right buttock with normal saline, apply calcium arginate with silver to wound bed and cover with silicone border dressing once daily. Diagnosis of a Stage III (three) pressure ulcer. The order stated to use Dakins (, d+[DATE] strength) external solution .124% (sodium Hypochlorite) and to monitor the sacrum for signs and symptoms of infections and placement every shift. Review of R2's Care Plan, dated [DATE], documented under Focus, deep tissue injury to right buttock, Goals were Pressure injury will improve without complications through next review date. Interventions listed were to assess and record wound measurements routinely, complete Braden scale per protocol, diet as ordered, labs as ordered, observe signs and symptoms of infection, observe signs and symptoms of pain and intervene appropriately, positioning devices as indicated. Also listed on the Care Plan under Focus was [R21] is at risk for skin breakdown r/t [related to] incontinence, impaired mobility, weakness, PVD [peripheral vascular disease], morbid obesity, diabetes with neuropathy & angiopathy, venous insufficiency and edema, & refuses care & repositioning. PRD mattress and cushion in place. Protective ointment used QS [every shift] & PRN [as needed]. [He/She] uses a sling lift for transfers and uses ,d+[DATE] SRs [side rails] to enable bed mobility and positioning. [DATE] refuses turning & repositioning. [DATE] Air mattress overlay to bed. [DATE] Air mattress, heel protector boots as tolerated in bed. [DATE] alternating pressure mattress. Listed under Goals: Resident will have no skin breakdown through next review date. Interventions listed were: ,d+[DATE] SRs to enable bed mobility. [DATE] DC [discontinue] - [DATE] Air mattress, [DATE] Air mattress overlay to bed. [DATE] discontinued. [DATE] heel protector boots as tolerated in bed, Assist with turning and repositioning per facility protocol and prn., Braden scale completed per protocol., Diet as ordered., Incontinent care as needed to keep skin clean and dry, Notify physician as needed., Observe standard precautions., Pressure relieving device to bed and chair as ordered., Preventative skin care as ordered/indicated, Routine body audit, Supplements as ordered. In addition, listed under Focus, Pressure injury to sacrum, Goals were listed as pressure injury will heal without complications by next review, Interventions listed were, [DATE] alternating mattress, assess and record wound measurements, complete Braden scale, diet as ordered, labs as ordered, notify responsible party, observe enhanced barrier precautions, observe for signs and symptoms of infection, observe for signs/symptoms of pain and intervene appropriately, positioning devices as indicated. Review of R2's Nursing Progress Notes dated [DATE], indicated the resident had a new wound to his/her coccyx, unstageable pressure (2x1), order in place and wound doctor to evaluate on next round [DATE]. The Wound Physicians weekly notes were as follows: [DATE] - Patient has a wound on his sacrum. Stage three (3) 2.5x3.5x.2 cm. Surface area 8.75, moderate serous exudate, 90% slough, 10% granulation. The treatment plan was to apply alginate calcium once daily, apply foam silicone border three (3) times per week, and use house barrier cream daily. Recommendations were to offload the wound, reposition per facility protocol, and use a group 2 mattress. A debridement was done to remove necrotic tissue. [DATE] - Patient has a wound on his sacrum. Stage three (3) pressure wound on sacrum full thickness 4.0x 3.5x .2cm, 14 cm surface area with moderate serous exudate, 90% slough, 10% granulation tissue. The dressing treatment plan and recommendations were the same as above. A debridement was done to remove the necrotic tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	[DATE] - Patient has a wound on his sacrum. Stage three (3) pressure wound on sacrum full thickness, 4. 1x3.7x.2 cm, surface area 15.17 cm, 90% slough, 10% granulation. The dressing treatment plan and recommendations remained the same. A debridement was done to remove necrotic tissue. [DATE] - Patient has wounds on his/her sacrum and right buttocks. Stage three (3) pressure wound on sacrum full thickness, 4.8x4x.2 cm, surface area 19.20 cm, exudate moderate serous, thick adherent devitalized necrotic tissue 100%. Listed under Additional Wound Detail, Not offloading wound Wound progress: Exacerbated due to patient noncompliance with wound care. Unstageable DTI [deep tissue injury] of the right buttock undetermined thickness, 4x4x not measurable cm, surface area 16.00 cm. Skin intact with purple/maroon discoloration. Additional Wound Detail: Air mattress broke and deflated. Dressing: Skin prep apply once daily for 30 days. Recommendation: limit sitting to 30 minutes, reposition per facility protocol, off-load wound: turn to side in bed every one to two (,d+[DATE]) hours if able. [DATE] - Patient has wounds on sacrum and right buttock. Stage four (4) pressure wound to sacrum full thickness, 4.5x4x1 cm, surface area 18.00 cm, exudate moderate serous, thick adherent devitalized necrotic tissue 50%, slough 50%, wound progress not at goal. Additional Wound Detail: Patient reported significant pain, had trouble tolerating. Consider debridement in OR [operating room]. The dressing treatment plan was Dakin's, apply twice daily, wet gauze with Dakin's, foam silicone solution boarder apply three (3) times per week, house barrier cream daily, recommendations: Off-Load wound, reposition per facility protocol, group 2 mattress. Stage three (3) pressure of the right buttock full thickness 4x3.3x.1 cm, surface area 13.2 cm, cluster wound open ulceration area of 1.32 cm, exudate moderate serous, slough 10%, skin intact normal color 90%, wound improved evidenced by decreased surface area. Dressing- skin prep apply daily: alginate calcium w/silver apply once daily, gauze island w/border daily, recommendations: limit sitting to 30 minutes, reposition per facility protocol, off-load wound, turn side to side in bed every one to two (,d+[DATE]) hours. Debridement was done to remove necrotic tissue. [DATE] - Patient has wounds on sacrum and right buttock. Stage four (4) pressure wound sacrum full thickness, 5.3x4.4x2cm, surface area 23.32 cm exudate moderate serous, thick adherent devitalized necrotic tissue 50%, slough 50%, wound progress not at goal. The treatment plan remained the same along with recommendations. Debridement was done to remove necrotic tissue. Stage three (3) pressure wound of the right buttock, full thickness, measured 3.8x3.5x.1cm surface area 13.3 cm, exudate moderate serous, slough 50%, granulation tissue 50%. The treatment and recommendations remained the same. Debridement was done to remove necrotic tissue. Wound progress - at goal. [DATE] - Patient has wounds on sacrum and right buttocks. Stage four (4) wound sacrum full thickness. 5. 1x4.4x2cm surface area 22.44 cm. undermining 2cm at 12 o'clock exudate moderate serous, thick adherent devitalized necrotic tissue: 40%, slough:20%, granulation tissue 40%, wound progress: improved. Additional wound detail revealed now has type 2 (two) mattress, treatment remained the same. Debridement of necrotic tissue. Stage three (3) pressure wound of right buttock full thickness 3.5x3.1x.01 cm surface area 10.85, exudate moderate serous, slough 50%, granulation tissue 50%, wound progress; improved evidenced by decreased surface area. The dressing treatment and recommendations remained the same. The wound was debrided to remove necrotic tissue. Review of the Nursing Notes, [DATE] through [DATE], revealed that there was no specific documentation addressing the resident's refusal to be turned or repositioned. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:30 PM, the Wound Physician, when asked how the wound occurred on [DATE] and how the sacral wound increased in size, stated there was a malfunction in the mattress the resident was using at the time, the mattress went flat. The Wound Physician stated that within four (4) hours a pressure area could occur. The Wound Physician thought that contributed to the sacral wound getting larger and the development of the right buttock ulcer. The Wound Physician also stated that the resident doesn't always cooperate with care or turning. He/She stated the resident doesn't like to turn by him/herself either. He/She stated that when the mattress malfunctioned it was like the resident was sitting on a bunch of rocks for a few hours. During an interview on [DATE] at an unspecified time, the Wound Care Nurse (WCN) stated the area on the sacrum was discovered as an unstageable pressure injury on [DATE]. The WCN stated the Wound Physician saw it on [DATE] at a stage three (3). The WCN stated that a malfunction of the mattress happened during the night and when discovered, the mattress was plugged in again. The WCN thought this contributed to the sacral wound getting larger and the development of the right buttock area wound. The WCN stated the resident now has a new mattress as of three (3) weeks ago. The area is looking better, he/she stated. Prior to the new mattress, the resident had a wedge in place, a turning schedule, heel protectors, and nutritional supplements. During an interview on [DATE] at 3:00 PM, R21 stated he/she didn't remember the incident with the mattress. R21 also stated he/she didn't mind being turned and repositioned; R21 didn't recall refusing turning and repositioning. During an interview on [DATE] at 11:00 AM, the Director of Nursing (DON) stated they didn't do an Incident Report on the mattress malfunction. The DON stated that the staff had R21 up and fixed the mattress as soon as it was discovered. The DON didn't know how long the mattress had been deflated and mentioned that they checked the mattress every shift. During an observation and interview on [DATE] at 11:15 AM, of wound care conducted for R21, with the WCN revealed, upon entering the room, R21 was being repositioned onto his/her right side with the assistance of two (2) staff members. A sacral pressure injury was observed to R21's sacrum which was packed with gauze. There was no secondary dressing covering the wound. A silicone border dressing was observed to R21's right buttock. The WCN removed the gauze packing from R21's sacral pressure injury revealing a Stage IV, full-thickness injury. There was a moderate amount of serosanguineous exudate noted to the gauze. The visible aspects of the wound bed consisted of approximately 25% red granulation tissue with three (3) scattered islands of slough noted throughout. There was approximately 75% red/pink connective tissue observed. When asked whether there was any tunneling or undermining, the WCN explained there was undermining from the ,d+[DATE] o'clock margins to a depth of approximately 3 centimeters. The wound edges appeared callused and were not attached to the wound bed. The immediate peri wound skin was noted to be flaky, dry, and pink in color. There were no obvious indicators of infection at the time of the observation. Following care for the sacral injury, the WCN removed the border dressing from R21's right buttock revealing a partial-thickness pressure injury. There was a scant amount of serous exudate noted to the dressing. The wound bed consisted primarily of pink epithelial tissue. The wound margins were clearly demarcated. The immediate peri wound skin was noted to be flaky and dry and was deep pink in color. There were no obvious indicators of infection at the time of the observation. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28734 Based on observation, interview, record review and facility policy review, the facility failed to provide the appropriate treatment and services to prevent potential complications of enteral feeding for one (1) of one (1) sampled resident. Resident (R)36 received medications through a gastrostomy tube (g-tube), however, the g-tube was not aspirated for residual contents, or verified by auscultation for the proper placement prior to administration of the medications. Findings include: Review of the facility policy, dated 6/2024, and titled, Gastrostomy Tube Medication Administration, stated, Purpose: To provide medications via gastrostomy tube. Procedure: . 2. Prepare ordered medications . b. Crush pills and mix with 10-30cc [centimeters] water in one (1) medication cup . 4. Clean the bell of stethoscope with an alcohol wipe . 14. Auscultate for bowel sounds in all 4 [four] quadrants via stethoscope. 15. Check placement by placing stethoscope to abdomen and inject 10-15cc air in tubing 16. Aspirate residual (Do not hold residual-may gently push contents back into the stomach.) [sic] Review of R36's most recent History and Physical dated 09/26/23, revealed diagnoses including but not limited to: Chronic Obstructive Pulmonary Disease (COPD), Unspecified Severe Protein-Calorie Malnutrition, Gastro-Esophageal Reflux Disease (GERD) without Esophagitis, Aphasia, Dysphasia, Acute Respiratory Distress Syndrome, and Unspecified Systolic Congestive Heart Failure. Review of R36's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility admitted the resident on 08/15/23. Further review of the MDS revealed the resident had both short-term, and long-term memory loss, and the resident had a feeding tube in which he/she received 51 percent (%) or more of their nutritional status and 501 ML per an average day intake. During an observation on 10/09/24 at 2:00 PM, Licensed Practical Nurse (LPN)A administered medications to R36. LPNA prepared the contents of two (2) Gabapentin Capsules 300 milligrams (MG) in a medication cup that also contained approximately 15 milliliters (ML) of water. LPNA also crushed a Reglan five (5) MG tablet and placed it in a separate medication cup filled with approximately 15 MLs of water. The nurse was observed to administer the medications separately into the resident's gastrostomy tube (g-tube) without having checked for any residual gastric contents in the stomach. Continued observation revealed LPNA had not assessed for the correct placement of the g-tube by the instillation of air into the tube and auscultation via a stethoscope to hear if the air had entered the stomach. Furthermore, LPNA did not flush the g-tube between having administered the two (2) medications. Review of R36's Care Plan revised on 10/08/24, stated, Focus - [R36] is at risk for altered nutrition and complications related to Tube Feeding. At risk for weight loss. [He/She] is NPO [nothing by mouth] .Goal - Resident will tolerate TF [Tube Feeding] .Interventions . - Check placement and residual per facility protocol, Date Initiated 06/04/2024. Continued review of the Care Plan revised 08/05/24 revealed, Focus - At risk for complications related to feeding tube. Goal - Will not have complications r/t [related to] feeding tube through next review date . Interventions - Check placement and residual per MD [Medical Doctor] order & [and] facility protocol . Revision on: 08/28/2024. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/10/24 at 1:54 PM, LPNA realized he/she had not checked R36's g-tube for placement or residuals prior to having administered the resident's medications. LPNA stated normally, he/she would have checked placement of a g-tube by pushing air into the tube and auscultating with a stethoscope for a gurgling sound in the stomach area. LPNA revealed medications administered via g-tube without a placement check could possibly end up in other cavities of the resident or could possibly cause an abscess. LPNA concluded that they had been trained to give medications via g-tube separately. During an interview on 10/11/24 at 9:13 AM, LPNB revealed any time a resident was given medications via a g-tube, the medications should be crushed up and placed in a different medication cup along with 10 to 15 MLs of water and given down the tube one (1) medication at a time with a 30 ML water flush between each medication. LPNB stated that the placement of the g-tube should be done first by the insertions of 10 to 15 MLs of air inserted into the tube and by auscultating the stomach area for a gurgle sound to ensure proper placement. The nurse also revealed if the g-tube was not in proper position in the stomach, the medications might be accidentally administered into the lungs or the small intestine. LPNB further stated the physician should be notified if residuals greater than 60 MLs were obtained. LPNB concluded Aspiration Pneumonia could possibly be prevented by checking the placement of the tube per auscultation with a stethoscope. Review of the education provided to staff, titled, Medication Administration and Gastrostomy Tube Medication Administration, dated 07/15/24 revealed both LPNA and LPNB had attended. During an interview on 10/11/24 at 1:55 PM, the Director of Nurses (DON) revealed crushed medications should be administered together in one (1) medication cup baring there were provider orders not too. The DON stated ensuring placement of the g-tube as well as a residual check should be done prior to the administration of medications to ensure the tube was in the correct space. The DON concluded if the g-tube was not in the correct space when medications were administered, the contents could go into the abdominal wall and create an abscess.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20005 Based on observations, interviews and record review, the facility failed to address indications of pain and did not treat pain appropriately for Resident (R)21, who experienced pain during dressing changes. This failed practice affected one (1) resident out of 19 sampled residents. Findings include: Review of the facility policy titled Pain Management, revised on January 2023, documented Purpose: To ensure that the residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the residents' choices, related to pain management Procedure: 1. The resident will be screened for the presence and level of pain upon admission, readmission, quarterly, with significant change in condition, and as indicated . 4. The risk for pain will be identified in the resident's care plan, to include history or current OUD [Opioid Use Disorder] and medication as ordered by physician. 5. Facility staff will observe for verbal and nonverbal indicators which may indicate the presence of pain and notify provider if indicators present. [sic] Review of R21's medical record revealed R21 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including but not limited to: Diabetes Mellitus with Diabetic Arthropathy, Peripheral Autonomic Neuropathy, and Morbid Obesity. Review of R21's Annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated the resident was cognitively intact. The MDS also revealed that R21 had occasional pain. The pain was coded as mild and didn't affect day-to-day activities or therapy. The MDS documented that a staff assessment for pain was not needed. Review of R21's Physicians Orders revealed an order for Tramadol HCL (Hydrochloride) oral tablet 25 mg (milligrams), give one (1) tablet twice a day. The order was dated 09/30/24. There was also an order to assess the resident's level of pain every shift. Review of R21's Care Plan, updated on 07/19/24, revealed under Focus, Alteration in comfort and pain related to Osteoarthritis, right rotator cuff tear, fracture of right malleolus, PVD and neuropathy. Listed under Goals - Pain/Discomfort will be relieved after intervention. Interventions listed, Administer TLC measures (change in position, back rub, etc.) as needed. Encourage resident to report pain noting location, duration, intensity, and severity. Medication as ordered. Notify physician as needed. Observe for effectiveness of pain medication. Observe for non-verbal signs of pain: moaning, restlessness, grimacing, diaphoresis. Review of R21's most recent Health Management Resources (HMR) Pain Screen, dated 08/20/24, documented R21 had mild pain per verbal description, pain intensity (non-verbal) was checked as grimacing/wincing and fidgeting/restlessness. The document was checked that the resident had occasional pain over the last five (5) days. Review of the Nursing Progress Notes, dated 08/12/24, indicated the resident had a new wound to his/her coccyx, unstageable pressure (2x1), order in place and wound doctor to evaluate on next round 8/15/24. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Wound Physicians weekly notes were as follows: 08/15/24 - Patient has a wound on his sacrum. Stage three (3) 2.5x3.5x.2 cm. Surface area 8.75, moderate serous exudate, 90% slough, 10% granulation. The treatment plan was to apply alginate calcium once daily, apply foam silicone border three (3) times per week, and use house barrier cream daily. Recommendations were to offload the wound, reposition per facility protocol, and use a group 2 mattress. A debridement was done to remove necrotic tissue. 08/22/24 - Patient has a wound on his sacrum. Stage three (3) pressure wound on sacrum full thickness 4.0x 3.5x .2cm, 14 cm surface area with moderate serous exudate, 90% slough, 10% granulation tissue. The dressing treatment plan and recommendations were the same as above. A debridement was done to remove the necrotic tissue. 09/3/24 - Patient has a wound on his sacrum. Stage three (3) pressure wound on sacrum full thickness, 4. 1x3.7x.2 cm, surface area 15.17 cm, 90% slough, 10% granulation. The dressing treatment plan and recommendations remained the same. A debridement was done to remove necrotic tissue. 09/11/24 - Patient has wounds on his/her sacrum and right buttocks. Stage three (3) pressure wound on sacrum full thickness, 4.8x4x.2 cm, surface area 19.20 cm, exudate moderate serous, thick adherent devitalized necrotic tissue 100%. Listed under Additional Wound Detail, Not offloading wound Wound progress: Exacerbated due to patient noncompliance with wound care. Unstageable DTI [deep tissue injury] of the right buttock undetermined thickness, 4x4x not measurable cm, surface area 16.00 cm. Skin intact with purple/maroon discoloration. Additional Wound Detail: Air mattress broke and deflated. Dressing: Skin prep apply once daily for 30 days. Recommendation: limit sitting to 30 minutes, reposition per facility protocol, off-load wound: turn to side in bed every one to two (1-2) hours if able. 09/18/24 - Patient has wounds on sacrum and right buttock. Stage four (4) pressure wound to sacrum full thickness, 4.5x4x1 cm, surface area 18.00cm, exudate moderate serous, thick adherent devitalized necrotic tissue 50%, slough 50%, wound progress not at goal. Additional Wound Detail: Patient reported significant pain, had trouble tolerating. Consider debridement in OR [operating room]. The dressing treatment plan was Dakin's, apply twice daily, wet gauze with Dakin's, foam silicone solution boarder apply three (3) times per week, house barrier cream daily, recommendations: Off-Load wound, reposition per facility protocol, group 2 mattress. Stage three (3) pressure of the right buttock full thickness 4x 3.3x.1 cm, surface area 13.2 cm, cluster wound open ulceration area of 1.32 cm, exudate moderate serous, slough 10%, skin intact normal color 90%, wound improved evidenced by decreased surface area. Dressing- skin prep apply daily: alginate calcium w/silver apply once daily, gauze island w/border daily, recommendations: limit sitting to 30 minutes, reposition per facility protocol, off-load wound, turn side to side in bed every one to two (1-2) hours. Debridement was done to remove necrotic tissue. 09/25/24 - Patient has wounds on sacrum and right buttock. Stage four (4) pressure wound sacrum full thickness, 5.3x4.4x2cm, surface area 23.32 cm exudate moderate serous, thick adherent devitalized necrotic tissue 50%, slough 50%, wound progress not at goal. The treatment plan remained the same along with recommendations. Debridement was done to remove necrotic tissue. Stage three (3) pressure wound of the right buttock, full thickness, measued 3.8x3.5x.1cm surface area 13.3 cm, exudate moderate serous, slough 50%, granulation tissue 50%. The treatment and recommendations remained the same. Debridement was done to remove necrotic tissue. Wound progress - at goal. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/02/24 - Patient has wounds on sacrum and right buttocks. Stage four (4) wound sacrum full thickness. 5. 1x4.4x2cm surface area 22.44 cm. undermining 2cm at 12 o'clock exudate moderate serous, thick adherent devitalized necrotic tissue: 40%, slough:20%, granulation tissue 40%, wound progress: improved. Additional wound detail revealed now has type 2 (two) mattress, treatment remained the same. Debridement of necrotic tissue. Stage three (3) pressure wound of right buttock full thickness 3.5x3.1x.01 cm surface area 10.85, exudate moderate serous, slough 50%, granulation tissue 50%, wound progress; improved evidenced by decreased surface area. The dressing treatment and recommendations remained the same. The wound was debrided to remove necrotic tissue. Review of R21's Skin and Wound Evaluation dated 10/09/24, revealed that the sacrum was an in-house acquired injury and that there was pain during the dressing changes. During an observation and interview on 10/11/24 at 11:15 AM, wound care was conducted for R21, with the Wound Care Nurse (WCN). Prior to entering the resident's room, the WCN explained that R21 habitually yelled out during wound care, turning, and repositioning. The WCN went on to explain that facility staff felt the yelling was a behavior. During this conversation, R21 could be overheard from his/her room yelling out, Ow! Ow! repeatedly. Upon entering the room, two (2) staff members were assisting R21 with turning to his/her right side in bed as he/she continued to yell out. When asked whether he/she was experiencing pain, R21 stated, Hell yea I am! When asked to rate the pain he/she was experiencing on a scale from 0-10, R21 stated, At least a 10! When asked about the location of the pain, R21 stated, All around my back. R21 went on to explain that any time he/she was moved or repositioned in bed, he/she experienced this pain and described the pain as a sharp, stabbing sensation. When asked whether he/she received any pain relief measures or medications, R21 explained that he/she received medication sometimes but stated, It doesn't do anything. As the WCN removed the gauze packing from R21's sacral wound, R21 again started yelling out in pain and displayed a significant degree of facial grimacing. The pain indicators briefly subsided once the gauze was removed and before the WCN began cleaning the wound with saline-moistened gauze. As the WCN began cleaning the wound, R21 again began yelling, Ouch! repeatedly. The WCN continued cleaning the wound despite the resident voicing that he/she was in pain and stated, I know. I'm almost done. During an interview 10/11/24 at 12:49 PM, R21 stated that he/she often had pain during his/her dressing changes. During an interview on 10/11/24 at 1:30 PM, the WCN stated that R21 typically yelled out when he/she did their dressing change. During an interview 10/11/24 at 1:32 PM, the WCN explained that R21 received Tramadol twice daily for pain and again added that facility staff believed the resident's indicators of pain were more of a behavior. When asked how facility staff had reached that conclusion, the WCN stated, It's just been long standing. When asked to clarify long standing the WCN stated, Really since admission. When asked whether R21 had a history of pain concerns during wound care, the WCN stated, Yes. I guess you could say that. When asked whether the medical provider had been notified of R21's unresolved pain, the WCN stated, I'm not really a part of that. That's more of the primary nursing team's job. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/11/24 at 2:00 PM, the Director of Nursing (DON) stated that if the resident was in pain, he/she expected the WCN would have adjusted the pain medications. The DON stated that if the pain medications weren't effective, he/she should have ordered proper pain medications to alleviate the pain. The DON stated he/she was not aware that the resident had been in pain during treatment changes. The DON also stated that he/she thought pain evaluations were part of a yearly competency training for the nurses. However, when she looked it up, there was not a competency for pain assessment.

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F 0773 Level of Harm - Actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42070 Based on interviews and record review, the facility failed to notify the Medical Provider of urinalysis results ordered on 06/25/24 and 07/2/24, resulting in subsequent hospitalization of a Resident (R)12 with a Urinary Tract Infection. This deficient practice affected one (1) of one (1) residents reviewed for indwelling urinary catheters from a total of 19 residents sampled. Findings include: Review of R12's medical record revealed an initial admitted [DATE]. R12's primary medical diagnosis was Incomplete Paraplegia. His/her secondary medical diagnoses included Neuromuscular Dysfunction of Bladder. Review of R12's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 06/28/24, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating R12's cognition was intact. The assessment also identified the presence of an indwelling urinary catheter. During an observation on 10/10/24 at 12:34 PM, R12 was observed in his/her wheelchair in the common area of the 6B unit watching television. R12's catheter drainage bag was hanging from the right side of his chair. A subsequent interview was conducted with R12. When asked about the care and services he/she was receiving for the indwelling urinary catheter, R12 explained that the catheter had been in place for a while and was placed due to his/her inability to empty his/her own bladder. R12 went on to explain that he/she had suffered a few Urinary Tract Infections since the catheter was placed and that he/she had been hospitalized for antibiotic treatment. A preliminary review of R12's Plan of Care revealed a focus area for Urinary Tract Infection risk related to the presence of a suprapubic catheter. Related interventions directed nursing staff to observe and report any signs or symptoms of Urinary Tract Infections such as burning, pain, fever, and foul odor, and to notify the Physician as needed. Review of R12's nursing progress notes revealed an entry dated 06/25/24 at 12:46 PM, which indicated the Nurse Practitioner had been in to see R12 and that a STAT (immediate) urinalysis with culture and sensitivity was ordered due to the presence of cloudy urine. Review of R12's Urine culture and sensitivity results dated 06/26/24, revealed the results were signed by the Director of Nursing and were dated 07/1/24 with a statement that read, Will repeat. The urine culture results suggested that the urine sample was contaminated and instructed staff to consider appropriate recollection if clinically indicated. Continued review of R12's nursing progress notes revealed no entries on or around 06/26/24, indicating that the Medical Provider had been notified of the results or that another urine sample had been collected. (continued on next page)

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F 0773 Level of Harm - Actual harm Residents Affected - Few	Review of R12's Physician Orders revealed an order dated 07/01/24, for a urinalysis with culture and sensitivity. An additional order dated 07/01/24, was noted for Macrobid (an antibiotic) 100 milligrams (mg) to be administered for a total of seven (7) days. Review of R12's Medication Administration Records (MARs) for July 2024, revealed that the entire course of Macrobid was documented as administered. Review of R12's Urine culture and sensitivity results dated 07/04/24, revealed the results were not signed or acknowledged by a nursing or medical professional. The results indicated that mixed flora was isolated in the specimen and included a recommendation to recollect a clean-catch specimen if clinically indicated. Continued review of R12's nursing progress notes revealed an entry dated 07/05/24 at 12:22 PM, which indicated that the urinalysis results were reviewed by the Nurse Practitioner and that a new order was obtained to repeat the urinalysis on 07/10/24, after the course of Macrobid was completed. Continued review of R12's nursing progress notes revealed an entry dated 07/10/24 at 6:56 AM, indicating that dark, bloody urine was observed in the catheter drainage bag. Review of R12's Urine culture and sensitivity results dated 07/10/24, revealed the results were reported to the facility on [DATE]. The results identified the presence of Klebsiella Pneumoniae and was noted to be resistant to Macrobid. Continued review of R12's nursing progress notes revealed no entries on or around 07/13/24, indicating that the Medical Provider had been notified of the results or that the identified organism was resistant to the recently completed course of antibiotics. Continued review of R12's nursing progress notes revealed an entry dated 07/15/24 at 3:33 PM, that the most recent urine culture and sensitivity results were reviewed by the Nurse Practitioner and that new orders were received to transfer R12 to the hospital for treatment and evaluation of the culture and sensitivity report. According to a readmission assessment by the Medical Provider dated 07/22/24, revealed R12 was admitted to the hospital and was treated for a Complicated Urinary Tract Infection. The condition required treatment with intravenous antibiotic therapy. During an interview on 10/11/24 at 1:45 PM, the Director of Nursing (DON) confirmed that the urinalysis results on 06/26/24, should have been called to the Medical Provider as soon as they were received - particularly because the Medical Provider ordered the test to be completed STAT (immediately). The DON acknowledged that waiting a period of approximately five (5) days before the Medical Provider reviewed the results likely contributed to R12's hospitalization for a Complicated Urinary Tract Infection on 07/15/24.