STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnsbury Health & Rehab	1248 Hospital Drive Saint Johnsbury, VT 05819

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51189 Based on interview and record review, the facility failed to ensure that a Resident's choice regarding his/her advance directives (wishes regarding life sustaining treatment) were properly documented, ordered, and care planned for 1 of 39 residents sampled (Resident #192). Findings include: Per record review Resident #192 has an Advance Directive dated [DATE] which states the Resident does not want CPR (Cardiopulmonary Resuscitation) if my heart stops, does not want a breathing machine for any length of time, and does not want a feeding tube for any length of time. Per interview with Resident #192, s/he has an Advanced Directive and does not want CPR if his/her heart stops, does not want a breathing machine for any length of time, and does not want a feeding tube for any length of time as stated in the Resident's Advanced Directives form. The Resident also showed this surveyor a Do Not Resuscitate bracelet that was applied during a recent hospitalization that they were still wearing stating that s/he had left it on just in case there was any confusion. Per record review, Resident #192 has a Care plan Focus that states s/he has an established Advance Directive with a Goal that states his/her wishes as expressed in the Advanced Directive will be followed through the next review. A Physician's order dated [DATE] states that the Resident is a Full Code, and the Resident's dashboard (the main screen of an electronic chart) also states that the resident is a Full Code. Neither the Physician's order or Resident dashboard reflect the Resident's wishes to be a DNR per her/his documented Advanced Directives. Per interview on [DATE] at 03:45 PM, a Nurse stated that the nursing staff uses the information on the dashboard to determine a resident's code status. During interview on [DATE] at 4:01 PM, the Director of Nursing (DON) confirmed that the Physician's order for life sustaining treatment did not reflect the Resident #192's wishes regarding life sustaining treatment that were documented in his/her Advanced Directives.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 40258 Based on interview and record review the facility failed to ensure that a resident received scheduled showers based on resident preference and care plan for 1 of 2 residents in the applicable sample (Resident #49). Findings include: Review of Resident # 49's care plan revealed a focus that was last revised on 11/20/2024 related to resident preferences that stated It is important for me to choose between a tub bath, shower, bed bath or sponge bath. I prefer a shower as of now. Another care plan focus last revised on 10/31/24 related to resident activities of daily living states Provide opportunity for bathing preference: shower, tub bath, bed bath based on my tolerance. Tuesday/Friday, PRN [as needed]. use of bath bench with one assist. The Licensed Nursing Assistant (LNA) Care Kardex (a tool that reflects the Resident care needs that is based off the Resident care plan) reflects that Resident #49 should be offered on Tuesdays and Fridays. Review of LNA documentation in the November and December 2024 in the Documentation Survey Report reflects that of the eight scheduled shower days in November Resident #49 received a shower on only two of them, 11/15/24 and 11/23/24. There were no other showers documented. The December Documentation Survey Report reveals that between 12/1/24- 12/10/24 there were no documented showers provided for the Resident. Resident #49 also has a care plan focus related to refusals of care and specifies refusals of showers. However, review of the Documentation Survey Reports for November and December 2024 there is only one documented refusal which is on the evening shift of 12/9/2024. There is no other documented evidence that the scheduled showers were refused. Per interview on 12/10/24 at 3:20 PM with an LNA who is familiar with Resident #49 s/he stated it is often challenging to provide scheduled showers because the facility is under staffed and stressed by the amount of work. The LNA stated that there are residents who prefer to shower multiple times a week and one who wanted daily showers but it can't be done due to staffing.

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F 0686 Level of Harm - Minimal harm or potential for 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** 51189 Based on observation, interview, and record review, the facility failed to provide care necessary to prevent an in-house acquired pressure ulcer for 1 of 4 residents in the applicable sample (Resident #192). Findings include: Per record review, Resident #192 was admitted on [DATE] for short term rehab with diagnoses that include type 2 diabetes with diabetic neuropathy (nerve damage caused by diabetes). cerebral infarction (a serious condition that occurs when blood flow to the brain is blocked), muscle weakness, absence of right foot (toes), absence of left leg below the knee, and hemiparesis (partial paralysis on one side of the body). During an interview on 12/9/24 at 11:15 AM Resident #192 presented a copy of her/his care plan that the facility had given to her/him and began to review several interventions that s/he alleged were not being implemented. The Resident stated that the care plan intervention to assist patient with turning and repositioning was not being performed. The Resident also stated that the care plan intervention of daily diabetic foot checks was not being done. During the interview, Resident #192 stated that s/he had developed a wound on his/her foot because s/he slides down in the bed and had been using the foot board to push her/himself back up. The Resident further stated that at times s/he has been unable to reposition self, and because s/he cannot feel her/his foot s/he was unaware of the open area until staff noted blood on the sheets of the bed. Review of the admission MDS (Minimum Data Set, an assessment tool used for implementing a standardized assessment and for facilitating care management in Long Term Care) dated 11/27/24 Section M Skin Conditions reveals that Resident #192 did not have any skin issues on admission. A Nursing Advanced Skilled Evaluation dated 11/22/24 and a Nursing Admission Evaluation dated 11/23/24 identified no active skin issues. Review of the Resident's care plan revealed a focus initiated on 11/23/24 that identifies Resident #192 at risk for skin breakdown related to decreased activity and limited mobility with an intervention that reflects that the Resident should be assisted with turning and repositioning. Another care plan focus dated 11/23/24 regarding type 2 diabetes includes an intervention of diabetic foot check daily. Observe feet/toes/ankles/soles/heels noting alteration in skin integrity, color, temperature, and cleanliness. Toenails for shape, length and color . Another care plan intervention initiated on 11/24/24 states to observe skin for signs/symptoms of skin breakdown, i.e. redness, cracking, blistering, decreased sensation, and skin that does not blanche easily. S/he also has a care plan focus for requiring assistance with Activities of Daily Living, including extensive assistance of 1-2 for bed mobility initiated on 11/22/24. A review of Resident #192's Physician's orders reveals that daily diabetic foot checks were ordered to start on 11/25/24. Review of the Resident's Treatment Administration Record (TAR) for 11/2024 revealed that the diabetic foot checks were not completed on 11/28/24 and then was discontinued on 11/29/24. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Change in Condition form was completed by nursing on 12/4/24 for a blister/skin tear with no other description of the wound. On 12/6/24, two days after the wound was discovered, a Skin and Wound Evaluation form was completed describing an in-house acquired blister measuring total area of 3.9 cm, length 1.9 cm, width 2.6 cm, and depth not applicable, 100 % of wound covered, and the surface was intact on the right Dorsum (top of foot). A Wound photograph attached to the Skin Wound Evaluation also dated 12/6/24 shows a macerated, non-intact open blister with a large open crack from the top to the bottom of the wound on plantar aspect (the bottom of the foot). According to the Centers for Medicare and Medicaid Pressure Ulcer Guidelines a stage 2 pressure ulcer is a partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough or bruising. May also present as an intact or open/ruptured blister. On 12/9/24 at 3:10 PM, this surveyor observed a dressing change to Resident #192's wound performed by nursing staff. This surveyor noted an open wound with red beefy tissue with serosanguinous drainage (a clear or pink fluid from a wound) on the removed bandage. During the dressing change the Licensed Nurse, who stated that they were very familiar with Resident #192 and her/his care, confirmed that the open blister was a in-house acquired pressure ulcer that developed after admission. The Licensed Nurse stated that it was likely caused by pressure when the patient would slide down in bed, and the sole of his/her foot pressing on the foot board of the bed. Reference: https://www.cms.gov/files/document/pocket-guidepressure-ulcers-and-injuries-stages-and-definitions.pdf

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 51189 Based on observation, interview, and record review, the facility failed to provide appropriate supervision to prevent accidents/incidents for one of 9 residents in the applicable sample (Resident #81). Findings include: Per interview conducted on 12/9/24 at 11:11 AM, Resident #192 said Resident #81 has entered his/her room without permission on several occasions, once climbing into Resident #192's bed, and once holding a fork in her/his hand. During an interview on 12/9/24 at 2:30 PM, Resident #80 said Resident #81 climbed onto his/her bed while s/he was in it and grabbed his/leg, causing pain. Resident #80 also said it frightens him/her when Resident #81 enters their room as it is often in the middle of the night. During an interview with Resident #84 on 12/9/24 at 2:57 PM, Resident #84 said that Resident #81 often enters his/her room without permission. Resident #84 feels that this is an invasion of his/her privacy and has complained about it. Per record review, Resident #81 was admitted to the facility with diagnoses that include Alzheimer's dementia. An admission MDS (Minimum Data Set, an assessment tool used to develop the resident care plan) dated 8/8/2024 reflects that the Resident has a BIMS (Brief interview for mental status, used to identify cognitive status) of 6 indicating severe cognitive imparment. A care plan intervention initiated 9/17/2024 to provide supervision assist of 1 for ambulation. The Resident Care Kardex (a tool used to communicate resident care needs based off the resident care plan) instructs staff to Visualize resident to help prevent wandering into rooms. Multiple Nurses Progress Notes state the Resident wanders in the halls at night. A Nurse's Progress Note dated 11/05/24 states Resident wandering into other residents' rooms, taking things, sitting on other resident's beds, causing distress to other residents. A Nurse's Progress Note dated 11/28/24 states Resident #81 punched another resident while in the hallway. Per observation, Resident #81 was seen multiple times during the survey process wandering halls and entering other residents' rooms unaccompanied between 12/9/24 and 12/11/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 between 9:30 AM and 10:26 AM Resident #81 was initially sitting in a chair in the hall outside her/his room. There was no nursing staff present in the hall. A housekeeper who was entering and exiting other resident rooms would periodically stop and talk to Resident #81 and another Resident who was also sitting in a chair in the hall. At 9:48 AM a Licensed Nursing Assistant (LNA) walked by both residents not speaking to either of them and entered a room across the hall. At 9:52 AM the other Resident stood up and handed Resident #81 a fortified shake that had been left on the table in front of her/him. At 9:54 AM the hall continued to be unsupervised by staff. At 10:06 AM Resident #81 stood up and proceeded to walk up the hall without staff knowledge or supervision. At 10:10 AM s/he was observed standing at nurses station then walked down the hall and was standing at a resident room doorway. An LNA redirected her/him and asked her/him to move away from the door. The Resident wandered away and entered the Unit Manager's office. At 10:17 AM an LNA saw Resident #81 in the office and tried to get her/him to exit without success. The LNA then left the Resident in the office and walked down the hall. Resident #81 was then observed by this surveyor fiddling around touching papers and the computer keyboard located in the empty office. The Resident exited the office then at 10:19 AM s/he went back in. A nurse working at the medication cart saw her/him and said, come out of there you can't be in there. At 10:20 AM the Resident was standing at the doorway of the first room on the right. S/he then walked over to the medication cart and was touching the cups and papers. The nurse approached the medication cart and said [name omitted] what are you doing? You can't have those (referring to papers from the cart). At 10:23 AM Resident #81 was seen wandering around the nurse's station. There were staff at the station, however, none of them were actively supervising the Resident. At 10:26 AM Resident #81 was again standing at the medication cart unsupervised.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 50431 Based on observation, resident and staff interviews, and record review, the facility failed to ensure there are a sufficient number of skilled licensed nurses, nurse aides, and other nursing personnel to provide care and respond to each resident's basic needs and individual needs, such as timely medication administration, as required by the resident's diagnoses, medical condition, or plan of care, potentially impacting all residents of the facility. Findings include: 1. Per review of the facility's Medication Administration and Documentation-General policy, the responsibility of the licensed is nurse is listed as Administers medications within one hour before or after prescribed time. Per record review of Resident #3's Medication Administration audit report from 12/1/24 to 12/10/24 there were 52 medications that were given past the allotted time specified in the policy. The medications included Clonzaepam (medication used to treat anxiety), Topiramate (medication used to treat seizures), Eliquis (a medication to prevent strokes), Sertraline (a medication used to treat depression), Potassium chloride (medication used to treat low potassium), Advair (a medication used to treat respiratory problems), Fluticasone (a medication used to clear nasal sinuses), and Calcium-Vitamin D (a vitamin to increase calcium and Vitamin D in the bloodstream). Resident #3's list of medical diagnoses includes Major Depressive Disorder, Generalized Anxiety Disorder, Chronic Obstructive Pulmonary Disease, and hypertension. Per interview with LPN #1 and LPN #2 on 12/11/24 at 11:35 AM medications are often late because the licensed nurses must concentrate on patient care. LPN #1 and #2 discussed that sometimes medications are not prioritized due to other concerns and job duties occurring at the facility during medication administration times. 51189 2. During an interview on 12/10/24 at 9:34 AM Resident #41 stated that the facility was very short staffed. When asked if there had been any negative outcomes related to lack of enough staff she/he stated that his/her medication is frequently administered up to 4 hours late. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Per record review Resident #41 had a Physicians Order for baclofen (a muscle relaxant),10 mg to be administered twice daily . Review of Resident #41's November 2024 Medication Administration Audit Report (MAAR) showed that on 11/1/24 the baclofen ordered to be given at 10:00 pm was not administered until 11/02/2024 12:59 AM, 2 hours and 59 minutes after the prescribed time. Resident #41 has another Physicians Order for gabapentin (a pain medication) 200 mg, twice daily. Per review of the MAAR on 11/1/24 the gabapentin was ordered to be given at 12:00 noon but was not administered until 2:51 PM, 2 hours and 51 minutes after the prescribed administration time. On 11/20/24 baclofen, gabapentin, senna and docusate (the latter two are bowel medications) were scheduled for administration at 8:00 PM. They were not administered until 12:42 AM, 4 hours and 42 minutes after the prescribed administration time. On 11/24/24 baclofen, gabapentin, senna and docusate were scheduled for administration at 8:00 PM. They were not administered until 10:04 PM, 2 hours and 4 minutes after the prescribed administration time. The December 2024 MAR reveals that on 12/1/2024 baclofen and gabapentin were scheduled for administration at 8:00 AM. They were not administered until 12:52 PM, 4 hours and 52 minutes after the prescribed administration time. Per interview on 12/11/2024 at aproximately 1:45 PM a Registered Nurse (RN) indicated the past few weekends were really short staffed. There were Licensed Nursing Assistant (LNA) call outs, leaving the nursing units very short. S/he indicated administrative staff filled in but they do not participate in patient care. This leaves the scheduled direct care staff to provide care. During an interview on 12/11/24 at 3:45 PM a Licensed Practical Nurse said that medication is sometimes given late due to understaffing, especially on the night shift. During an interview on 12/11/24 at 4:01 PM the Director of Nursing (DON) confirmed that Resident #41's MAAR reflected that the above medications were administered late. The DON stated that this was due to the level of resident acuity and insufficient nursing staff to provide the services needed to care for the residents.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. 29776 Based on interview and record review, the facility failed to provide behavioral treatment and services to residents who display or are diagnosed with mental disorder or psychosocial adjustment difficulty in order to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being for 5 of 9 (sampled residents (Residents #67, # 8, 74, #73, & #2). Findings include: Review of the facility's 'Behaviors: Management of Symptoms policy' [Policy NSG206 Revised 7/1/24] reveals Based on the comprehensive assessment, staff must ensure that a patient: who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being. Under 'Practice Standards', the policy includes Behavioral health care and services shall be provided in an environment that is conducive to mental and psychosocial wellbeing. 1. Per review of Res.67's Care Plan, Res. #67 is identified as exhibits verbal and physical behaviors related to: History of verbal outbursts directed toward others (e.g., use of abusive language, pattern of challenging/confrontational verbal behavior), Poor impulse control, refuses cares, history of resident to resident [altercations], with interventions that include, Evaluate need/provide for Psychiatric/Behavioral Health consultation. Per record review, Res. #67 was receiving Psychiatry Evaluations approximately 3-4 times a month since June 2024 until Psychiatry services stopped at the facility on September 25, 2024. Psychiatry Evaluations including the final one dated 9/25/24 recorded Res. #67 would benefit from continued behavioral health. A Chronic Care Management (CCM) evaluation was conducted on Res. #67 on 11/26/24, 2 months after h/her last Psychiatric Evaluation. The CCM evaluation records Patient is eligible for Behavioral Health Integration (BHI) services due to having diagnosed mental health conditions including Major depressive disorder, Generalized anxiety disorder. A comprehensive care plan has been developed. Barriers to the comprehensive care plan include lack of resources and/or support. An interview was conducted with the Clinical Market Lead [CML] on 12/11/24 at 9:45 AM. The CML confirmed that the facility did not have Psychiatric Services in place since 9/25/24. The CML reported that the facility was pursuing a clinician to provide psychiatric services but the clinician was in the credentialling process and the facility anticipated they would achieve that soon. The CML stated that in the interim, the facility was providing talk therapy to the residents by a qualified individual. Per record review and confirmed by the CML, there was no documentation in Res. #67's records of any talk therapy having been conducted or any documentation entered by the staff member named by the CML. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Res. #67's roommate's medical record [Res. #8] revealed on 12/9/24 the roommate reported to staff that [Res. #67] was yelling at [h/her]. [Res. #8] placed in another room for the night. 2. Further review of Res. #8's medical record revealed the resident's Care Plan identified Res.#8 as at risk for complications related to the use of psychotropic drugs for Schizophrenia, Dementia, Bi-Polar disorder. Per record review, Res. #8 was receiving Psychiatry Evaluations approximately once a month since h/her admission in July 2024 until Psychiatry services stopped at the facility on September 25, 2024. Psychiatry Evaluations including the final one dated 9/25/24 recorded Res. #8 would benefit from continued behavioral health. Per interview with the Clinical Market Lead [CML] on 12/11/24 at 9:45 AM the CML confirmed that the facility did not have Psychiatric Services in place since 9/25/24. The CML stated the facility was providing talk therapy to the residents by a qualified individual. Per record review and confirmed by the CML, there was no documentation in Res. #8's records of any talk therapy having been conducted or any documentation entered by the staff member named by the CML. 3. A review was conducted of Res. #74's Care Plan. The Care Plan identified Res. #74 as having been involved in resident to resident altercations. Per record review, Res. #74 was receiving Psychiatry Evaluations approximately 1-2 times a month since h/her admission in April 2024 until Psychiatry services stopped at the facility on September 25, 2024. Psychiatry Evaluations including the final one dated 9/9/24 recorded Res. #74 would benefit from continued behavioral health. Per record review, Physician notes dated 11/25/24, 2 months after Res. #74's last psychiatric evaluation, reveal the resident being seen by a Physician for increased anxiety. The following day, a Chronic Care Management (CCM) evaluation was conducted on Res. #74 on 11/26/24. The CCM evaluation records Patient is eligible for Behavioral Health Integration (BHI) services due to having diagnosed mental health conditions including: Generalized Anxiety Disorder, Major Depressive Disorder, Post-Traumatic Stress Disorder, Chronic Adjustment Disorder with Mixed Anxiety and Depressed Mood, Attention-Deficit Hyperactivity Disorder, Mild Cognitive Impairment. A comprehensive care plan has been developed. Barriers to the comprehensive care plan include lack of resources and/or support. Per interview with the Clinical Market Lead [CML] on 12/11/24 at 9:45 AM the CML confirmed that the facility did not have Psychiatric Services in place since 9/25/24. The CML stated the facility was providing talk therapy to the residents by a qualified individual. Per record review and confirmed by the CML there was no documentation in Res. #74's records of any talk therapy having been conducted. 4. A review of Res. #74's roommate's medical record [Res. #73] revealed on 12/9/24 the roommate reported that [Res. #74] was threatening [h/her] and trying to hit [h/her] with [his/her] cane and [Res. #73] felt unsafe. Further review of roommate Res. #73's medical record revealed the resident's Care Plan identified Res. #73 has a history of resident-to-resident altercations. Per record review, Res. #73 was receiving Psychiatry Evaluations approximately once a month since h/her admission in May 2024 until Psychiatry services stopped at the facility on September 25, 2024. Psychiatry Evaluations including the final one dated 9/25/24 recorded Res. #73 would benefit from continued behavioral health. (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per interview with the Clinical Market Lead [CML] on 12/11/24 at 9:45 AM the CML confirmed that the facility did not have Psychiatric Services in place since 9/25/24. The CML stated the facility was providing talk therapy to the residents by a qualified individual. Per record review and confirmed by the CML there was no documentation in Res. #73's records of any talk therapy having been conducted. 48017 5. Per record review, Resident #2 was admitted to the facility with a diagnosis of post-traumatic stress disorder (a condition of persistent mental and emotional stress occurring because of injury or severe psychological shock, typically involving disturbance of sleep and constant vivid recall of the experience, with dulled responses to others and the outside world). On 12/9/2024 at approximately 12:30 PM, an interview with Resident #2 indicated that s/he had not been provided with behavioral health services since September. As far as s/he knew, the services were no longer available to him/her. Per record review, Resident #2 was receiving Psychiatry Evaluations until services stopped at the facility on September 25, 2025. A final Psychiatry Evaluation dated 9/25/2025 reads, would benefit from continued behavioral health. On 12/10/2024 at approximately 3:00 PM, the Director of Nursing (DON) indicated behavioral health services had not been provided to Resident #2 since September of 2024. It was unclear to him/her when services would resume for the facility. The DON confirmed that the facility was not providing appropriate treatment and services for Resident #2 to attain his/her highest practicable mental and psychosocial well-being.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Johnsbury Health & Rehab	1248 Hospital Drive Saint Johnsbury, VT 05819

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 0773 Level of Harm - Minimal harm or potential for 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** 48017 Based on interview and record review, the facility failed to provide or obtain laboratory services when ordered by a physician for 1 of 3 sampled residents (Resident # 36). Findings include: Per record review, Resident #36 has diagnoses of anemia (a lack of healthy red blood cells to carry oxygen to the body's tissues), chronic kidney disease stage 5 (end-stage disease, the kidneys have lost nearly all of their ability to function and can no longer filter waste for the body). A progress note written by an on-call provider, contacted by the facility after Resident #36 had fallen, with a date of 12/1/2024, reads Recommendations: on-call provider [name omitted] gave orders for a BMP (basic metabolic panel, a panel that measures substances in blood that reflect the body's chemical balance and metabolism), a CBC (a complete blood count measuring red blood cells and clotting factors) and a PT/INR (a prothrombin time/international normalized ratio, a test to help to determine if blood is clotting normally). A lab report dated 12/6/2024 from Northeastern [NAME] Regional Hospital indicates Resident #36's blood sample was not received until 12/6/2024, 5 days after the laboratory tests were ordered, and shows critical values that indicate a low hemoglobin (a protein in the blood that carries oxygen to the tissues). Per interview on 12/10/24 at approximately 3:36 PM, the Clinical Market Consultant and the Administrator confirmed that there had been a significant delay in obtaining the labs ordered by the provider.