| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515173 | A. Building<br>B. Wing | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| E.A. Hawse Healthcare Center | 18086 State Route 55<br>Baker, WV 26801 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>50795<br><br>Based on observation, and interview, the facility failed to ensure that residents were treated with dignity and respect, as demonstrated by leaving urinary catheter bags uncovered. This was a random opportunity for discovery during the Long-Term Care Survey Process. Resident identifiers #47 and #257. Facility census: 54.<br><br>Findings included:<br><br>a) Resident #47<br><br>On 11/12/24 at approximately 11:50 AM, Resident #47 was observed wheeling her chair down the corridor with her uncovered catheter bag and tubing resting in her lap.<br><br>During an interview with Registered Nurse (RN) #1 at approximately 11:55 AM on 11/12/24, the RN confirmed that the catheter bag should not be placed in the resident's lap and should have been covered. The RN instructed a Nursing Assistant (NA) to find a cover for the resident's catheter bag or to place a blanket over the resident's lap immediately. The RN also confirmed that Resident #47 requires a two-person lift and cannot get into her chair without assistance.<br><br>A review of Resident #47's care plan revealed the following:<br><br>This resident is unable to do the following tasks d/t medical reasons:<br><br>SIT TO LYING, LYING TO SITTING, SIT TO STAND. Date Initiated: 07/31/202<br><br>This resident is unable to do the following tasks d/t medical reasons:<br><br>TRANSFERS: Assist X2 with mechanical lift.<br><br>Date Initiated: 04/22/2024<br><br>b) Resident #257<br><br>During an interview with Resident #257 on 11/11/24, at approximately 2:30 PM, it was noted that the resident's catheter bag was uncovered and dangling off the foot of the bed.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A follow-up observation on 11/12/24, at approximately 1:00 PM revealed Resident #257's catheter bag remained uncovered and was still dangling off the foot of the bed.<br><br>At approximately 1:15 PM on 11/12/24, RN #1 confirmed that the catheter bag needed to be covered. The RN called out and instructed a NA to cover the bag. |

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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340<br><br>Based on resident interview, record review, and staff interview, the facility failed to promote self-determination and honor resident preferences regarding bathing/showers. This was true for two (2) out of five (5) residents reviewed under choices. Resident identifiers: #23 and #33. Facility census: 54.<br><br>Findings included:<br><br>a) Resident #23<br><br>During an interview, on 11/12/24 at 12:15 PM, Resident #23 reported she had not had a bath in a week. She also stated she had asked a half a dozen people not to have her shower day on Tuesday because she does not like to attend church services with her hair wet. The resident stated, I must not have asked the right people because they keep doing it. Resident #23 went on to state, I frequently do not accept a shower on Tuesdays because of my preference to not have wet hair when going to church but despite telling each CNA about my preference to have a different shower day, it has never been changed.<br><br>A record review completed on 11/12/24 at 1:08 PM, confirmed resident's refusals for Tuesday's showers. In addition Section C of the Quarterly MDS, dated [DATE], reflected a Brief Interview for Mental Status (BIMS) score of 13, indicating that resident was cognitively intact. A Physician Determination of Capacity, dated 11/05/23, reflected resident had capacity to make medical decisions.<br><br>During an interview, on 11/12/24 at 1:15 PM, the Director of Nursing (DON) stated she was not told about resident's request to have a different shower day. The Regional Director of Clinical Operations #104 stated a resident should not need to request a change in shower schedule with six (6) different staff and that the facility should and would the honor the resident's request for a different shower day.<br><br>b) Resident #33<br><br>During an interview on 11/12/24 at 2:30 PM, Resident #23 stated she has dandruff/itchy scalp and she has requested over and over again that the CNAs assisting with her shower actually scrub her scalp but they all just get her hair wet, add the shampoo, and then immediately rinse her hair. Resident reported she tries to demonstrate how she would like to have her hair scrubbed but it is difficult for her to do so because of her limited range of motion. Resident stated she has never had a nurse speak to her about her request nor has there ever been an order for dandruff shampoo.<br><br>During an interview on 11/12/24 at 2:38 PM, the DON reported that the CNAs should report any resident concerns to the nurse on duty and the nurse should follow-up with the physician for any new orders. The DON stated she would check in to the possibility of dandruff shampoo being ordered and re-educate staff about adhering to a resident's preference. |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795<br><br>Based on record review and interview, facility failed to develop a baseline care plan that addressed the risks associated with catheter-related urinary tract infections (CAUTI) and did not implement any protocols for the care of the in-dwelling catheter. Additionally, the facility failed to notify the physician, and obtain orders for the care of the indwelling catheter for a newly admitted resident This was a random opportunity for discovery. Resident Identifier: Resident #257. Facility Census: 54.<br><br>Findings included:<br><br>a) Resident #257<br><br>During an interview with Resident #257 on 11/11/24 at approximately 2:30 PM, resident was observed to have an in-dwelling catheter. The resident stated that the catheter had been inserted at the hospital.<br><br>Record review on 11/12/24 at approximately 2:15 PM revealed that the resident had been admitted to the facility on [DATE]. Further record review revealed neither a physician's order for an in-dwelling catheter, nor any orders for catheter care.<br><br>A review of the facility matrix provided to the surveyors showed no evidence that Resident #257 had an indwelling catheter.<br><br>On 11/12/24, at approximately 3:00 PM, further investigation revealed that the resident's baseline care plan did not indicate any awareness of the resident's in-dwelling catheter. Additionally, the plan failed to address the risks associated with catheter-related urinary tract infections (CAUTI) and did not implement any protocols for the care of the in-dwelling catheter.<br><br>During an interview with the Minimum Data Set (MDS) Registered Nurse (RN) #8, who was responsible for the Care Plans, on 11/12/24 at approximately 11:14 AM, MDS RN #8 confirmed that the care plan did not address the resident's catheter. MDS RN #8 stated that she received information on each resident during a meeting with other clinical staff. She further stated that there had been no mention of an in-dwelling catheter for Resident #257.<br><br>During an interview with the Director of Nursing (DON) on 11/12/24 at approximately 1:35 PM, DON confirmed that the resident's care plan had not been updated, and no physician's orders had been obtained for the care of the catheter.<br><br>During an interview with the Regional Director of Clinical Operations (RDCO) #104 on 11/13/24 at approximately 9:45 AM, RDCO stated that the physician had prescribed orders for the removal of the in-dwelling catheter.<br><br>Follow-up observation of the resident at approximately 9:50 AM revealed that the catheter had been removed. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>50795<br><br>Based on observation, interview, and record review, the facility failed to revise and update the care plan based on the changing preferences and needs of the resident. Resident identifier: #16. Facility Census: 54.<br><br>Findings:<br><br>a) Resident #16<br><br>During a brief interview on 11/11/24 at approximately 12:09 PM, resident #16 stated that she was unable to move her left sided extremities. Resident's Medical Power of Attorney (MPOA), who was present in the room, explained that resident had recently been diagnosed with a malignant neoplasm of the right temporal lobe, and stated that resident had lost the use of her left side.<br><br>Resident's bedside table was observed on the left side of the bed with the resident's eyeglasses, and a cup of water on it.<br><br>Resident wanted some water, and upon being asked whether she could reach the water, the resident stated that she could not, because her left arm did not work.<br><br>Resident's MPOA then retrieved the cup of water and offered it to the resident.<br><br>Observation on 11/12/24 at 9:28 AM again revealed the bedside table with resident's water and eyeglasses on the left side of the bed.<br><br>A review of Resident #16's care plan revealed a note that stated:<br><br>Place call light to resident's right side<br><br>Date Initiated: 10/23/2024<br><br>Revision on: 11/01/2024<br><br>During an interview with the Minimum Data Set (MDS) Registered Nurse (RN) #8, on 11/12/24 at approximately 11:14 AM, she stated that the resident had been care planned for left sided paralysis.<br><br>An interview with RN #1 on 11/12/24 at approximately 12:15 PM confirmed that the bedside table should be on the resident's right side. She stated that she would make sure that the table was positioned at the resident's right side.<br><br>However, observation on 11/13/24 at approximately 9:08 AM revealed that the bedside table had been pushed away from the right side of the bed, to make space for fall pads that had been placed on the floor. When this was brought to the attention of Licensed Practical Nurse (LPN) #95, LPN stated that it would be taken care of. |

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| F 0661<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43340<br><br>Based on record review and staff interview, the facility failed to provide a resident with a discharge summary that was completed by all departments and failed to ensure it included follow-up dates and times for medical appointments. This was true for one (1) of two (2) residents reviewed under the discharged pathway. Resident identifier: #56. Facility census: 54.<br><br>Findings included:<br><br>a) Resident #56<br><br>A record review, completed on 11/12/24 at 8:56 PM, revealed the following details:<br><br>-Resident #56 was admitted to the facility on [DATE].<br><br>-Resident went home with his significant other on 09/23/24.<br><br>-Resident was cognitively intact<br><br>-Resident was able to complete tasks independently.<br><br>-An After Visit Summary from the hospital, dated 09/20/24, listed a follow-up neurosurgery appointment in two (2) weeks.<br><br>-A facility discharge report, dated 09/23/24, reflected that the Nursing section was completed. However the Social Services section, Dietary Manager section, and the Activity Director section were left blank and incomplete.<br><br>-The facility discharge report also incorrectly indicated that Resident #56 did not have any follow-up appointments.<br><br>During an interview on 11/13/24 at 11:00 AM, the Director of Nursing acknowledged form was incomplete and inaccurate. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>42120<br><br>Based on record review, and staff interview, the facility failed to provide<br><br>activities of daily living (ADL's) to maintain good personal hygiene for dependent residents. This is true for 0ne (1) of three (3) residents reviewed for ADL care. Resident Identifiers: #20, #17, #33, #23, #16 and #34. Facility census: 54.<br><br>Findings included:<br><br>a) Resident #17<br><br>During an annual recertification with a simultaneous complaint investigation for Residents not being groomed adequately found Resident #17 on 11/11/24 not get his showers per schedule.<br><br>Medical record review revealed, Resident #17's shower schedule and preference are two (2) times weekly.<br><br>A continued review of Resident #17s ADL documentation found:<br><br>No documentation for showers given.<br><br>On 11/12/24 at 1:11 PM the Director of Nursing (DON) verified the facility could not provide documentation for Resident #17's showers.<br><br>b) Resident #20<br><br>During an observation 11/11/24 at about 1:54 PM Resident #20 appeared to be unkept, with oily hair and facial hair.<br><br>Medical record review revealed, Resident #20's shower schedule and preference are two (2) times weekly.<br><br>A continued review of Resident #20s ADL documentation found:<br><br>No documentation for showers given.<br><br>On 11/12/24 at 1:11 PM the Director of Nursing (DON) verified the facility could not provide documentation for Resident #20's showers.<br><br>43340<br><br>c) Resident #23<br><br>A record review, completed on 11/12/24 at 12:02 PM, revealed Resident #23 had one (1) shower (on 11/08/24) over the last 30 days.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 11/12/24 at 1:11 PM, the DON verified the facility was unable to produce evidence that showers were provided to residents on a consistent basis within the last 30 days.<br><br>d) Resident #33<br><br>A record review, completed on 11/12/24 at 12:15 PM, revealed that Resident #33 had two (2) showers (on 11/02/24 and 11/08/24) over the last 30 days.<br><br>On 11/12/24 at 1:11 PM, the DON verified the facility was unable to produce evidence that showers were provided to residents on a consistent basis within the last 30 days. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50801<br><br>Based on record review and staff interviews, the facility failed to ensure Resident #18's environment remained as free of accident hazards as possible; and that each resident received adequate supervision and assistance devices to prevent accidents. Resident #18 had a care plan for nonskid footwear which were not in place at the time of a fall. The Central Supply closet which contained harmful chemicals was not secured by a locking door. Resident identfieir: #18. Facility census: 54.<br><br>Findings included:<br><br>Resident #18<br><br>a) Record review of nursing progress notes dated [DATE] revealed Resident #18 was found on the floor with a head injury and complaining of right leg pain. It was noted that Resident #18's feet were bare during assessment after the fall.<br><br>On [DATE] at 3:15PM, During an interview with the Director of Nursing and the Assistant Director of Nursing They both confirmed resident #18 did not have nonskid footwear on at the time of her fall.<br><br>Resident #18's Care Plan, dated back to [DATE], revealed the resident was to have nonskid/footwear.<br><br>A nursing note dated [DATE] 2:40 PM revealed:<br><br>Called to resident's room by staff member, upon entering room, resident was observed to be laying on the floor on her right side between her bed and the wall, a pool of bright red blood was on the floor behind resident's head, pressure dressing was held in place to the right side of resident's head, during this time resident was only verbal stating My right leg when asked if it hurt she moaned, blanket placed between leg and floor and resident appeared to feel some comfort with this measure per her bodylanguage - pupils were reacted to light - foley catheter was patent and intact with clear yellow urine present, resident's feet were observed to be bare, Physical Therapy had been in room minutes before the fall - paramedics were notified by another staff member. When paramedics arrived, taking charge of situation, paramedics lifted resident off floor, performing a log roll blanket carry, and placed on stretcher, Resident was taken to (name of hospital). - POA (name) notified via phone call of incident<br><br>39043<br><br>b) Central Supply Closet<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] at 11:40 AM, the central supply closet in the resident hallway A opened when this surveyor turned the door handle. The door had a keypad on it. This surveyor entered the room to look around. The Director of Nursing (DON) entered the central supply closet. She stated she had entered the keypad code to open the closet door. This surveyor showed the DON that the door opened without the keypad code being entered. The DON confirmed this and stated she did not know how long this had been occurring. She stated she would immediately notify maintenance.<br><br>The supply closet was noted to contain the potentially hazardous substances:<br><br>- DermaRite's GelRite Instant Gel Hand Sanitizer, which contained the following warnings on the bottle, Avoid contact with eyes. In case of contact, flush thoroughly with water and In case of accidental ingestion contact a physician or poison control center right away.<br><br>- Dermarite's Dermaklenz wound cleanser, which contained the following warning on the bottle, For external use only. Avoid eye contact.<br><br>- Bacitracin first aid antibiotic ointment, which contained the following warning on the box, If swallowed get medical help or contact poison control center right away.<br><br>- Good Sense Diphenhydramine ointment, which contained the following warnings on the box, If swallowed get medical help or contact poison control center right away and Avoid contact with the eyes.<br><br>- Hibiclens antimicrobial skin cleanser, which contained the following warning on the box, Keep out of eyes, ears, and mouth. May cause serious and permanent eye injury if permitted to enter and remain in the eye or may cause deafness when instilled in the middle ear through perforated eardrums.<br><br>On [DATE] at 3:00 PM, the Administrator stated the keypad battery had died and had been replaced.<br><br>No further information was provided through the completion of the survey.<br><br>The facility failed to provides an environment that is free from accident hazards over which the facility has control |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50795<br><br>Based on observation, interviews, and record review, the facility failed to notify the physician, and obtain orders for the care of the indwelling catheter, for a newly admitted resident. Resident identifier: #257. Facility Census: 54.<br><br>Findings:<br><br>a) Resident #257<br><br>Record review on 11/12/24, at approximately 2:15 PM revealed that the resident had been admitted to the facility on [DATE]. Further record review revealed that there was neither a physician's order for an in-dwelling catheter, nor any orders for catheter care.<br><br>A review of the facility matrix, provided to the surveyors, showed no evidence that Resident #257 had an indwelling catheter.<br><br>On 11/12/24, at approximately 3:00 PM, further investigation revealed that the resident's baseline care plan did not indicate any awareness of the resident's in-dwelling catheter. Additionally, the plan failed to address the risks associated with catheter-related urinary tract infections (CAUTI) and did not implement any protocols for the care of the in-dwelling catheter.<br><br>During an interview with the Minimum Data Set (MDS) Registered Nurse (RN) #8, who was responsible for the Care Plans, on 11/12/24 at approximately 11:14 AM, MDS RN #8 confirmed that the care plan did not address the resident's catheter. MDS RN #8 stated that she receives the information on each resident during a meeting with other clinical staff, she further stated that there had been no mention of an in-dwelling catheter for Resident #257.<br><br>The Director of Nursing (DON), during an interview on 11/12/24, at approximately 1:35 PM, confirmed that the staff were aware that the resident had an indwelling catheter. However, the resident's care plan had not been updated, and no physician's orders had been obtained for the care of the catheter.<br><br>During an interview with the Regional Director of Clinical Operations (RDCO) #104 on 11/13/24 at approximately 9:45 AM, RDCO stated that the physician had prescribed orders for the removal of the in-dwelling catheter.<br><br>Follow-up observation of the resident at approximately 9:50 AM revealed that the catheter had been removed. |

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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 0770<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely, quality laboratory services/tests to meet the needs of residents.<br><br>39043<br><br>Based on record review and staff interview, the facility failed to obtain laboratory services to meet the needs of its residents. This deficient practice had the potential to affect one (1) of five (5) residents reviewed for the care area of unnecessary medications. Resident identifier: #15. Facility census: 54.<br><br>Findings included:<br><br>a) Resident #15<br><br>Review of Resident #15's medical records showed a physician's order written on10/19/24 for laboratory testing consisting of Prothrombin Time/International Normalized Ratio (PT/INR) to be performed on 10/19/24. Resident #15 was receiving the medication Coumadin (warfarin) to prevent blood clots. PT/INR testing helps to determine effective Coumadin dosing.<br><br>No PT/INR laboratory testing results for 10/19/24 were found in the resident's medical record.<br><br>A physician's order was written on 10/23/24 for PT/INR every week for four (4) weeks, then monthly. The first INR was to be obtained on Wednesday 10/23/24 and then the laboratory testing was to be performed on Thursdays on night shift.<br><br>A lab results report for a PT/INR specimen received 10/24/24 stated the testing could not performed because the specimen tube received was underfilled.<br><br>A lab results report for a PT/INR specimen received 10/25/24 stated the testing could not be performed because the specimen was not received at room temperature.<br><br>On 10/26/24, a PT/INR specimen was received by the laboratory. The test was performed on 10/27/24.<br><br>A nursing note written on 10/28/2024 at 4:30 PM stated, [Physician] notified of resident's current PT/INR Values - No new orders received.<br><br>On 11/12/24 at 3:11 PM, the Regional Director of Clinical Operations confirmed results for PT/INR testing were not available for 10/19/24. She stated blood had been drawn for laboratory testing and sent to the laboratory, but she didn't know what happened to the specimen after that. The Regional Director of Clinical Operations also confirmed PT/INR testing could not be performed on 10/24/24 and 10/25/24 because the specimens were incorrect.<br><br>On 11/13/24 at 11:40 AM, the Director of Nursing stated laboratory testing specimens were obtained by facility nursing staff and sent to the laboratory via courier. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 515173 | A. Building<br>B. Wing | 11/14/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
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|---|---|
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>42120<br><br>The facility failed to serve food in a safe sanitary manner in regards to hand washing after coughing and touching soiled items and storing medical ice packs in the freezer in the residents pantry. This has the potential to affect all resident that gets their nutrition form the kitchen. Facility census: 54.<br><br>Findings Included:<br><br>a) Resident Pantry<br><br>During the tour on 11/11/24 at 12:20 PM to the Resident pantry found multiple medical Ice packs stored in resident freezer.<br><br>An interview 11/11/24 at 12:20 PM with the Dietary Manager confirmed the medical ice packs should not be stored with resident food.<br><br>b) Kitchen<br><br>An observation on the second tour to the kitchen 11/13/24 at 12:35 PM found the [NAME] #46 testing holding temperatures, she coughed and stepped away to the office area, she then opened the trash with her hands, returned to tray line and started to continue temperature testing without washing her hands until surveyor intervention. [NAME] #46 verified she should have washed her hands prior to returning to steam table, she stated that she forgot.<br><br>During an interview 11/13/24 at 1:18 PM with the Dietary Manager confirmed the cook #46 should have washed her hands prior to returning to work. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>42120<br><br>Based on record review and staff interview, the facility failed to ensure an admission assessment was completed with an antipsychotic and residents reviewed during the long-term care survey process had a Physician Orders for Scope of Treatment (POST) form completed per directions specified by the [NAME] Virginia Center for End-of-Life Care in conjunction with the [NAME] Virginia Health Care Decisions Act (16-30-1). The POST forms were unsigned by the Resident or Medical Power of Attorney (MPOA). Resident identifiers: Resident #31and #15. Facility census: 54.<br><br>Findings Included:<br><br>a) Resident #31<br><br>Record review on 11/11/24 at 2:55 PM found, a POST Form patient information and section F health care provider on Resident #31's chart was completed with the Physicians Full name, Licenses number and phone number. The POST was dated 06/14/24.<br><br>11/13/24 09:18 AM 104 Corp nurse verified no physician full name<br><br>During an interview on 11/13/24 at 9:18 AM with the Corporate Nurse #104, she confirmed Resident #31's POST form was incomplete without a physician's information.<br><br>39043<br><br>b) Resident #15<br><br>Review of Resident #15's physician's orders showed the resident was ordered the medications Seroquel (quetiapine), an antipsychotic medication, and Reglan (metoclopramide) on 10/16/24.<br><br>Resident #15's discharge instructions from the hospital on 10/16/24 included instructions to continue the medications Seroquel (quetiapine), which is an antipsychotic medication, and Reglan (metoclopramide), a medication for nausea.<br><br>A side-effect of antipsychotic medications and the medication Reglan is a movement disorder called tardive dyskinesia (TD). Abnormal Involuntary Movement Scale (AIMS) assessments can be performed to assess the presence or worsening of TD.<br><br>On 11/12/24 at 2:00 PM, the Regional Director of Clinical Operations stated the facility did not have a policy regarding Abnormal Involuntary Movement Scale (AIMS) assessments. She stated AIMS assessments are performed on admission for residents receiving antipsychotic medications and then every six (6) months following admission.<br><br>Resident #15's Nursing Admission Evaluation dated 10/16/24 answered No to the question regarding whether the resident was receiving an antipsychotic and/or Reglan medication.<br><br>(continued on next page) |

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 11/13/24 at 10:13 AM, the Regional Director of Clinical Operations confirmed Resident #15's Nursing Admission Evaluation was incorrect. She stated a Yes response to the question would have triggered an Abnormal Involuntary Movement Scale (AIMS) assessment. |