| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525639 | A. Building<br>B. Wing | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St Elizabeth Nursing Home | 109 S Atwood Avenue<br>Janesville, WI 53545 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on interview and record review, the facility failed to immediately consult with a physician when needing to alter treatment for 1 of 3 (R3) residents reviewed for physician notification.<br><br>R3 had four instances of hypotension (low blood pressure) from November 2024 to January 2025. The facility did not call the on-call physician to report R3's hypotension to allow for an alteration of treatment if the physician deemed it necessary.<br><br>This is evidenced by:<br><br>The facility policy titled Change of Condition and Provider Notification with a review date of 8/10/23 states in part; a change of condition (COC) is a deviation from an individuals baseline .a licensed nurse is involved in the assessment process and contributes to the collection of the data base, the planning of interventions and evaluation of the individuals response to the COC .The primary care provider will be contacted for notification and to obtain further orders from the provider as necessary.<br><br>According to American Medical Directors Acute Change of Condition in Long Term Care Setting indicates a blood pressure (BP) less than 90 requires immediate MD notification and a pulse greater than 100 requires immediate notification.<br><br>Of note the facility uses INTERACT as their standard of practice. According to INTERACT II dated 2010 a blood pressure (BP) less than 90 requires immediate MD notification.<br><br>R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Obstructive Pulmonary Disease (Chronic lung disease that progressively obstructs the resident's ability to breathe), Congestive Heart Failure (Failure of the heart to adequately pump blood, causing fluid to back up into the lungs), chronic kidney disease (kidneys inadequately filtering blood), Atrial fibrillation (irregular heart rhythm), and obstructive sleep apnea (inadequate lung ventilation while sleeping).<br><br>R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/18/24 states that R3 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R3 is cognitively intact.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0580<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/8/25, Surveyor reviewed R3's After Visit Summary and Discharge Transfer Orders documents from her hospital stay from 11/8/24-11/11/24. These documents indicate R3 had transfer orders that include, in part: to notify the physician of a systolic blood pressure under 90, a diastolic blood pressure under 60.<br><br>R3's Vital Sign documentation states, in part:<br><br>11/3/24 at 10:29 AM: Blood Pressure (BP) 87/67. Warning: Systolic (Blood pressure when heart contracts) Low of 90 exceeded.<br><br>11/22/24 at 7:29 PM: BP 88/60. Warning: Systolic Low of 90 exceeded.<br><br>12/30/24 at 7:20 PM: BP 89/54. Warning: Diastolic (Blood pressure when heart relaxes) Low of 60 exceeded, Systolic Low of 90 exceeded.<br><br>1/1/25 at 9:11 PM: BP 81/46.<br><br>Surveyor reviewed R3's progress notes. No progress notes were written indicating a physician was notified of these vital signs for the listed dates. Surveyor requested DON B (Director of Nursing), RN C (Registered Nurse) to review the facility's secure chat log and other facility documents for any evidence that a physician was notified for these dates. No documentation was able to be provided to Surveyor regarding physician notification.<br><br>On 1/8/25 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing) and RN C (Registered Nurse). Surveyor asked DON B and RN C if they consider discharge transfer orders to be physician orders. DON B and RN C indicate that these are orders and should have either been transcribed into the electronic medical record or provided to the facility physician for review. Surveyor asked DON B if a complete RN assessment, including a full set of vital signs, should have been conducted upon the discovery of R3's hypotension. DON B indicates a full RN assessment, including a full set of vital signs should have been conducted. Surveyor asked DON B and RN C if a physician should have been notified following identification of R3's hypotension and tachycardia. DON B and RN C indicate a physician should have been notified at that time. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49434<br><br>Based on interview and record review, the facility failed to meet professional standards of quality for 1 of 3 Residents (R3) reviewed for weights.<br><br>R3 has a history of Congestive Heart Failure (Failure of the heart to adequately pump blood, causing fluid to back up into the lungs) and had no physician order for weights, and was not weighed for months at a time.<br><br>This is evidenced by:<br><br>The facility policy, entitled, Weighing Individuals, dated 6/13/23, states, in part: Policy: Individuals are weighed according to orders. Procedure: A. Weights are obtained per order and reviewed: 1. On admission/readmission, 2. Weekly for the first four weeks, 3. Monthly. B. Weights are documented and reviewed with previous weights for any changes. C. The Provider is updated with weights as ordered or indicated .<br><br>R3 was admitted to the facility on [DATE] with diagnoses that include, in part: Chronic Obstructive Pulmonary Disease (Chronic lung disease that progressively obstructs the resident's ability to breathe), Congestive Heart Failure, chronic kidney disease (kidneys inadequately filtering blood), Atrial fibrillation (irregular heart rhythm), and obstructive sleep apnea (inadequate lung ventilation while sleeping).<br><br>R3's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 11/18/24 states that R3 has a Brief Interview of Mental Status (BIMS) of 14 out of 15, indicating that R3 is cognitively intact.<br><br>Surveyor reviewed R3's physician orders. R3's physician orders do not include an order for weights.<br><br>R3's Weight Summary from July 2024-December 2024 shows:<br><br>7/18/24: 143 lbs. (pounds)<br><br>9/12/24: 137 lbs.<br><br>11/11/24: 156 lbs.<br><br>(Of note: The American Heart Association (AHA) recommends daily weights for people with heart failure because it can be an early indicator of worsening heart failure. This is due to the body retaining fluid due to the improper functioning of the heart. The AHA recommends having knowledge of the physician's recommended weight change parameters and notifying the physician if this weight change occurs). Source: https://www.heart.<br>org/en/health-topics/heart-failure/warning-signs-of-heart-failure/managing-heart-failure-symptoms<br><br>On 1/3/25 at 7:57 AM, Surveyor reviewed NP D's (Nurse Practioner) progress note. This note states, in part: . Monitor weights/volume status-no recent weight .<br><br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/8/25, Surveyor reviewed R3's Discharge Transfer Orders documents from her hospital stay from 11/8/24-11/11/24. These documents indicate R3 had transfer orders that include, in part: to notify the physician of a weight gain or loss of 3 lbs. in a day or 3 lbs. in a week.<br><br>On 1/8/25 at 1:30 PM, Surveyor interviewed DON B (Director of Nursing) and RN C (Registered Nurse). Surveyor asked DON B and RN C if they consider discharge transfer orders to be physician orders. DON B and RN C indicate that these are orders and should have either been transcribed into the electronic medical record or provided to the facility physician for review. Surveyor asked DON B and RN C if the facility has a standard for weighing residents, whether that be every resident gets weighed weekly, monthly, etc. RN C indicates there is no standard, and the facility follows physician orders. Surveyor asked DON B and RN C if R3 should have a physician order for weights due to her history of congestive heart failure. DON B and RN C indicate that R3 should have an order for weights.<br><br>On 1/8/25 at 1:58 PM, Surveyor called NP D, to ask questions regarding their expectation for resident care. NP D did not answer, and a message was left with a request for a return call. NP D did not return Surveyor call regarding R3's care. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992<br><br>Based on observation, interview, and record review, the facility did not ensure drugs and biologicals used in the facility were labeled in accordance with current accepted professional principles for 1 of 1 residents (R2) reviewed for insulin administration.<br><br>Surveyor observed Medication Technician Med Tech E (Medication Technician) administer Humalog (Lispro) to R2 from a vial with no resident name indicated.<br><br>This is evidenced by:<br><br>The facility policy, Medication Administration, effective May 2018, documents, in part, as follows: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to he facility's medication distribution system (procurement, storage, handling, and administration.) Five Rights: Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. Check #1: Select the Medication- label, container and contents are check for integrity and compared compared against the medication administration record (MAR) by reviewing the 5 Rights. Check #2: the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. Check #3 : Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights.<br><br>R2 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: diabetes mellitus type 2 (a disease that occurs when your blood sugar is too high), chronic respiratory failure with hypercapnia (a condition where there is too much carbon dioxide in the blood over a prolonged period of time), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and dementia (a group of thinking and social symptoms that interferes with social functioning).<br><br>R2's current Physician Orders document the following order: Insulin Lispro Injection Solution 100 units/ml (milliliter) (Insulin Lispro) Inject as per sliding scale: if 151-200=5 <60 hypoglycemia protocol and call physician, [PHONE NUMBER]=10, 251-300=14, 301-350=17, 351-400=20, 401-450=26, >400 25 units and call physician subcutaneously three times a day for DM2 (diabetes mellitus type 2) with meals.<br><br>On 1/8/25 at 12:05 PM, Surveyor observed Med Tech E (Medication Technician) administer 5 units of Humalog (Lispro) to R2. Surveyor observed there is no resident name on the vial or the clear plastic bag containing the vial. The date opened indicated 1/6/25.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 1/8/25 at 12:08 PM, Surveyor spoke with Med Tech E (Medication Technician). Surveyor asked Med Tech E if R2's name was on the Humalog vial. Med Tech E stated, no. Med Tech E stated, this has to be R2's as he is the only person that receives Humalog for this cart. Med Tech E stated, this vial of Humalog was pulled from contingency (due to not having resident name indicated).<br><br>On 1/8/25 at 12:10 PM, Surveyor spoke with LPN F (Licensed Practical Nurse). Surveyor asked LPN F if the Humalog vial should be labeled with a resident name. LPN F stated, yes. LPN F stated, she notified the DON (Director of Nursing) and labeled the vial.<br><br>On 1/8/25 at 3:10 PM, Surveyor spoke with DON B (Director of Nursing). Surveyor asked DON B, when a medication is pulled from contingency what is the process for labeling. DON B stated, staff should label the medication right away with the resident name and room number. Surveyor asked DON B, should all medications be labeled. DON B stated, yes. |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30992<br><br>Based on interview and record review the facility did not ensure an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This affected 1 of 4 sampled residents (R2).<br><br>On 10/15/24, R2 was seen in the Emergency Department (ED) where he was diagnosed with a Urinary Tract Infection (UTI) that grew greater than 100,000 colonies of Enterobacter cloacae complex and greater than 100,000 colonies of Methicillin Resistant Staphylococcus aureus (MRSA), a multi-drug resistant organism. The facility failed to obtain R2's Urinalysis Culture and Sensitivity (UA C/S) from the hospital to ensure R2 was receiving the appropriate antibiotic. R2 was not receiving the correct antibiotic to effectively treat MRSA. On 10/19/24, R2 began experiencing abdominal pain, exhibiting signs of distress including heaving breathing and groaning, was febrile (running a fever) with an elevated pulse, and experiencing general weakness when he was sent to the ED. Subsequently, R2 was hospitalized for sepsis due to the UTI and treated with Vancomycin, Cefepime and Levaquin via IV (intravenously) and required an intravenous fluid (IVF) bolus.<br><br>This is evidenced by:<br><br>The facility's Antibiotic Stewardship policy and reviewed 12/5/24, documents in part: The organization will implement an Antibiotic Stewardship Program (ASP) as outlined below. Procedure: Leadership i. The Infection Preventionist (IP) will be identified to support the facility's safe and appropriate use of antibiotics. ii. The IP will communicate the facility's expectations for antibiotic use to the medical director and collaborate in communicating these to prescribing clinicians. 2. Accountability i. The IP will collaborate with the Medical Director, Executive Director, Director of Nursing, pharmacy consultant, and laboratory representative as needed to: 1. Review infections and monitor antibiotic usage patterns through Quality Assurance Performance Improvement (QAPI) process. 2. Obtain and review antibiograms for institutional trends of resistance as available. 3. Monitor antibiotic resistance patterns and infections. ii. Laboratory will provide facility-specific antibiogram as available.4. Action i. Licensed nurse to complete evaluation at time of signs and symptoms or when antibiotic is ordered. ii. IP and/or designee will review completed Infection Screener Evaluation which follows McGeers Infection Criteria. iii. Appropriateness of use and duration of antibiotic(s) will be monitored and reviewed as needed. 5. Education i. educational opportunities as identified by the QAPI Team should be provided for clinical staff as well as residents and their Resident Representative on appropriate use of antibiotics<br><br>R2 was admitted to the facility on [DATE] with diagnoses including, but not limited to, the following: diabetes mellitus type 2 (a disease that occurs when your blood sugar is too high), chronic respiratory failure with hypercapnia (a condition where there is too much carbon dioxide in the blood over a prolonged period of time), heart failure (a chronic condition in which the heart doesn't pump blood as well as it should), and dementia (a group of thinking and social symptoms that interferes with social functioning).<br><br>R2 is his own decision maker.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 10/15/24 at 6:49 PM, the facility documented the following eInteract SBAR (Situation, Background, Assessment and Recommendations): Situation: The Change in Condition reported to the CIC (Change in Condition) Evaluation are/were: Abdominal pain.<br><br>At the time of the evaluation resident/patient vital signs, weight and blood sugar were: Blood Pressure: 111/74 (9/4/24 at 2:02 PM-not current); Pulse: 95 (9/4/24 at 2:04 PM-not current); R: 18 (9/4/24 at 2:04 PM-not current); Temp: 98.0 (9/4/24 at 2:04 PM-not current); Weight 337.6 (10/15/24 8:12 AM); Pulse Oximetry: 96% oxygen via Nasal Canula (9/4/24 at 2:04 PM-not current)<br><br>Primary Diagnoses: Chronic Respiratory Failure with Hypercapnia<br><br>Relevant medical history is CHF, COPD (Chronic Obstructive Pulmonary Disease-a lung disease that makes it difficult to breathe) or, Dementia, Diabetes<br><br>Code Status: Full Code<br><br>Resident/Patient had the following medication changes in the past week: N/A (not applicable)<br><br>Resident/Patient is on Coumadin/warfarin: No<br><br>Outcomes of Physical Assessment: Positive findings reported on the resident/patient evaluation for this change in condition were:<br><br>Mental Status Evaluation: No changes observed.<br><br>Functional Status Evaluation: No changes observed.<br><br>Behavioral Status Evaluation: Blank<br><br>Respiratory Status Evaluation: Blank<br><br>Cardiovascular Status Evaluation: Blank<br><br>Abdominal/GI (gastrointestinal): Abdominal pain<br><br>GU/Urine Status Evaluation: Lower abdominal pain or tenderness<br><br>Skin Status Evaluation: Blank<br><br>pain Status Evaluation: Does the resident/patient have pain: Yes.<br><br>Neurological Status Evaluation: Blank<br><br>Nursing observation, evaluation, and recommendations are:<br><br>Primary Care Provider Feedback: Primary Care Provider responded with the following feedback:<br><br>A. Recommendations: (Name and clinic) notified of resident transfer to hospital.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | New Testing Orders: Urinalysis or culture<br><br>New Intervention Orders: Blank<br><br>New or Change in Medications: Blank<br><br>On 10/15/24 at 7:28 PM, R2's Progress Notes document as follows: Per family request, Resident sent to ER (emergency room ) at 3:30 PM for severe abd (abdominal)/groin pain. Resident stated his catheter is not releasing urine. The nurse did a flush of Resident catheter without experiencing any resistance. Call made to provider to notify them of the transfer to ER. Resident's family member with him for entire visit. Resident returned with a diagnosis of Acute cystitis with hematuria. Order for Cefdinir has been sent to pharmacy.<br><br>On 10/15/24, R2's hospital emergency room report documents, in part, the following: Patient (Pt) presents to ED with concern that his Foley isn't draining. He has had this in for about a month now. They attempted to flush it at the facility, and it seemed to be working properly. Pt (patient) seems to have a little pain at the tip of his penis, no wound appreciated there. Pt reports he feels like he is having some bladder pain as well. Pt with no fevers/chills<br><br>Medical Decision Making: Resident presents to ED with some urinary discomfort/bladder pain. Pt has a Foley in place. This is draining well. Bladder scan here is negative. I don't believe flushing or replacing is needed at this point. Will check UA (urinalysis), does feel like might have UTI (Urinary Tract Infection). Pt also notes some constipation as well. Pt with very benign abdominal exam. Low suspicion for obstruction or diverticulitis (doesn't have an appendix). I discussed possible labs/CT (Computed Tomography is an x-ray/imaging of the inside of the body) to further assess, but at this point we are in agreement with holding off.<br><br>On 10/15/24 at 4:58 PM, the ED physician ordered a STAT (immediate) urinalysis with reflex culture if indicated.<br><br>On 10/15/24 at 6:09 PM, R2's UA C/S indicate the following:<br><br>>100,000 CFU/ml (colonies) Enterobacter cloacae complex<br><br>>100,000 CFU/ml **Methicillin Resistant Staphylococcus aureus<br><br>The physician documents the UA (urinalysis) does have some evidence of infection. After reviewing previous cultures, will start him on Omnicef Family member given strict return precautions. Pt to follow up with PCP (Primary Care Provider).<br><br>Clinical Impression:<br><br>Acute cystitis with hematuria<br><br>New Prescriptions<br><br>Cefdinir (Omnicef) 300 mg (milligrams) oral capsule - Take 1 capsule by mouth 2 (two) times daily for 7 days.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | It is important to note, Cefdinir is not an effective medication to treat MRSA.<br><br>On 10/15/24, R2 returned to the facility (at an unknown time). The facility did not begin administered Cefdinir until the following morning as it is not available in contingency.<br><br>It is important to note, the emergency department ran a urine culture and sensitivity (C&S) to identify the appropriate antibiotics for R2's urinary tract infection. This was collected on 10/15/24 and resulted on 10/18/24. The facility did not request these results or follow up on the urine culture and sensitivity, and thus did not recognize a cephalosporin such as Cefdinir was not indicated to treat the MRSA infection. If the facility would have called for the C&S and noted Cefdinir was not indicated for MRSA, they could have consulted with the physician to perhaps initiate another antibiotic or an additional antibiotic.<br><br>R2's C&S dated 10/15/24 and resulted (lab results were ready) 10/18/24 state in part:<br><br>>100,000 CFU/ml (colonies) Enterobacter cloacae complex<br><br>>100,000 CFU/ml **Methicillin Resistant Staphylococcus aureus (MRSA)<br><br>Under Enterobacter cloacae complex the following cephalosporins are sensitive (ok to use to treat this bacteria) Cefepime, Cefptaxime and Ceftazidine. It should be noted under MRSA these cephalosporins are blank indicating cephalosporins were not indicated for MRSA. On page 2 of the C&S report there are multiple other antibiotics which are sensitive to both Enterobacter and MRSA.<br><br>On 10/18/24 at 7:35 PM, R2's Progress Notes document as follows: Resident has had several episodes of loose stool this evening. Placed call to on call to have resident's Loperamide order reinstated. Awaiting call back from on call.<br><br>On 10/19/24 at 7:53 PM, R2's Progress Notes document as follows: Resident has fever that is not responding to Acetaminophen. Temp 100, BP 146/96, P 113, Resp 20, O2 95% at 3 liters. Provider contacted on call physician to receive order to send Resident to ER (emergency room ). Family member notified of Resident's condition and will meet him at the ER.<br><br>On 10/19/24, R2's hospital notes document the following: Pt (Patient) was admitted on [DATE] for issues with genital discomfort and generalized body aches. He had associated SOB (shortness of breath). He was previously on a course of cefdinir for a UTI prior to this issue but had no improvement in symptoms. Initial work up revealed lactic acidosis along with urine clx (culture) positive gram-negative bacteria. He did initially receive Vancomycin and Cefepime (intravenous antibiotics) for abx (antibiotic) coverage but was later switched to Levaquin (a third intravenous antibiotic) as indicated by culture susceptibilities. He also received 1L (liter) IVF (intravenous fluid). The following day patient had resolution of his lactic acidosis. He did tolerate antibiotic change well and did have his foley catheter changed He is to finish his course Levaquin - last day of administration would be on 10/27/24.<br><br>Admission Diagnosis:<br><br>UTI<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 525639 | A. Building<br>B. Wing | 01/08/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| St Elizabeth Nursing Home | 109 S Atwood Avenue<br>Janesville, WI 53545 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Urinary tract infection associated with indwelling urethral catheter.<br><br>Sepsis, due to unspecified organism, unspecified whether acute organ dysfunction present<br><br>Secondary Diagnoses:<br><br>Sepsis secondary to UTI<br><br>R2 was hospitalized on [DATE] and discharged back to the facility on [DATE].<br><br>On 10/19/24 at 9:53 PM, R2's progress notes document as follows: This nurse spoke to Registered Nurse at ER. Resident is to be admitted with unresolved UTI. Antibiotics will be given via IV (Intravenous).<br><br>On 10/20/24 at 6:24 PM, the facility documented the following eINTERACT SBAR Summary for Providers (a late entry):<br><br>Situation: The Change in Condition/s reported on this CIC (change in condition) Evaluation are/were: Abdominal pain, Abnormal vital signs (low/high) BP, heart rate, respiratory rate, weight change)<br><br>At the time of evaluation resident/patient vital signs, weight and blood pressure were:<br><br>Pulse: P 113 - 10/19/24 6:28 PM Type: Regular<br><br>RR: R 20 10/19/24 at 6:28 PM<br><br>Temp: T 100 10/19/24 at 6:29 PM<br><br>Weight: 337.6 pounds 10/15/24 at 8:12 AM<br><br>Pulse Oximetry: O2 96% 9/4/24 at 2:02 PM Oxygen via Nasal Canula<br><br>Blood Glucose: BS 159 10/19/24 at 3:14 PM<br><br>Resident/Patient is in the facility for Long Term Care<br><br>Primary Diagnosis is: Chronic Respiratory Failure with hypercapnia.<br><br>Relevant medical history is CHF, COPD, Dementia, Diabetes<br><br>Code Status: Full Code<br><br>Advance Directives: N/A (not applicable)<br><br>Resident/patient had the following medication changes in the past week: Cefdinir.<br><br>Resident/patient is not anticoagulant other than warfarin: Yes.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Resident is on hypoglycemic medications: Insulin.<br><br>Outcomes of physical assessment: Positive findings reported on the resident for this change in condition were:<br><br>Mental Status Evaluation: No changes observed.<br><br>Functional Status Evaluation: General weakness.<br><br>Behavioral Status Evaluation: Blank.<br><br>Respiratory Status Evaluation: Blank.<br><br>Cardiovascular Status Evaluation: Resting pulse greater than 100 or less than 50.<br><br>Abdominal/GI Status Evaluation: Diarrhea, Abdominal pain.<br><br>GU/Urine Status Evaluation: Lower abdominal pain or tenderness.<br><br>Skin Status Evaluation: Blank.<br><br>Pain Status Evaluation: Does the resident/patient have pain: Yes.<br><br>Neurological Status Evaluation: Blank.<br><br>Nursing observations, evaluation, and recommendations: Resident exhibiting signs of distress with heavy breathing and groaning. Temp elevated as well as pulse.<br><br>Primary Care provider Feedback: Primary Care Provider responded with the following feedback: Recommendations: On call nurse contacted and order given to send Resident to ER for further assessment.<br><br>New Testing orders: Urinalysis or culture.<br><br>New Intervention Orders: Blank.<br><br>Other: Resident admitted to hospital for IV (intravenous) antibiotic therapy.<br><br>It is important to note, on 10/15/24 the facility failed to obtain R2's UA C/S (Urinalysis Culture and Sensitivity) from the hospital laboratory to ensure R2 was receiving the appropriate antibiotic. Note, R2 was not receiving the correct antibiotic to effectively treat MRSA (Methicillin-Resistant Staphylococcus Aureus). Subsequently, R2 was hospitalized for sepsis due to the UTI (Urinary Tract Infection) and treated with IV (intravenously) antibiotics and IVF (intravenous fluid) bolus.<br><br>It is also important to note, the facility did not contact the physician about the culture results.<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 1/8/25 at 3:10 PM, Surveyor spoke with DON B (Director of Nursing) and RN C (Registered Nurse - Corporate). Surveyor asked DON B and RN C, what is the process when a resident is diagnosed with a UTI in the ER and discharges back to the facility. RN C stated, there should be follow up regarding the culture and sensitivity to ensure the resident is receiving the correct antibiotic. RN C stated this process is considered antibiotic stewardship. RN C stated, the facility recognizes that there is an overall lack of follow up and stated they are working to be better. RN C stated, the previous DON (Director of Nursing) who was also the IP (Infection Preventionist) is no longer employed at the facility due to lack of follow up. RN C stated this was the previous DON's responsibility to follow up on culture and sensitivity reports to ensure residents are receiving the correct antibiotic. RN C stated, this was not done, and it should have been. RN C stated, we have to always track down the culture and sensitivity. RN C stated, the facility does not have access to EPIC Link (electronic charting used by the hospital), so they need to call the lab and request the results be faxed to them. Surveyor asked RN C, was the physician notified of the culture and sensitivity. RN C stated, no, the physician was not notified and he/she should have been notified. |