Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002489	A. BUILDING: _____ B. WING _____	03/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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S 000	Initial Comments Special Focus Standard Survey An extended survey was conducted.	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 5 Violations: 300.610a) 300.1210a) 300.1210b)4) 300.1210d)2)3) 300.1620a) 300.1630d) 300.2040c) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for	S9999	**Attachment A** **Statement of Licensure Violations**	

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Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless

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circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be

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authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication

d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

Section 300.2040 Diet Orders

c) A written diet order shall be sent to the food service department when each resident is admitted and each time that the resident's diet is changed. Each change shall be ordered by the physician. The diet order shall include, at a minimum, the following information: name of resident, room and bed number, type of diet, consistency if other than regular consistency, date diet order is sent to dietary, name of physician ordering the diet, and the signature of the person transmitting the order to the food service department.

Section 300.3240 Abuse and Neglect

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a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to complete an initial assessment, and provide needed care and services to a newly admitted resident for one of one residents (R159) reviewed for care and services of a newly admitted resident in the sample of 61. These failures resulted in R159 not receiving ordered Intravenous (IV) antibiotics until 42 hours after admission causing inadequate levels of antibiotic in her system to treat her diagnoses of Meningitis, blood infection, infection of spinal column and lining of heart; failure of R159 not receiving any type of pain medications to relieve extreme pain for 46 hours after her initial admission; and failure to receive any fluids, any nutrition (5 meals) or turning and reposition for 42 hours after admission.

Findings include:

On 02/25/20 at 3:07 PM, V17, Licensed Practical Nurse (LPN) stated she was the admitting nurse for R159 on 02/21/20. V17 stated R159 arrived at the facility approximately 5:30 PM via ambulance from the hospital. V17 stated she began the admission process around 5:50 PM but was unable to complete. She stated she did not put any of R159's medications into the system. V17 stated she gave this information to V44, LPN

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(night nurse).

On 03/03/20 at 1:17 PM, V44, LPN stated she worked on 02/21/20 starting at 10:00 PM. She recalled being informed by V17, LPN of R159's admission, but was not informed to finish her admission. V44 stated the facility's computer system was down when she arrived until 5:30 AM. She stated she did not do any assessments, give any medications or go into R159's room during her shift. V44 stated she reported to V31, LPN the next morning that the system was down and that she did not know anything about R159.

On 02/23/20 at 11:45 AM, V7, Certified Nursing Assistant (CNA) stated that she was aware R159 was in her room but did not know when she was admitted. V7 stated on 02/22/20 at 12:00 PM she came into R159's to get her breakfast tray and was told by R159 that she did not receive a tray. V7 stated she told V41, LPN about the missing tray.

On 02/23/20 at 12:05 PM, V31, LPN stated that 2/22/20 was her first day and she and was not aware that R159 required IV antibiotics and pain medications, that she did not receive meal service or that she required turning and repositioning assistance. V31 stated she was aware that R159 had been admitted over the weekend but was not sure what day.

On 03/03/20 at 10:50 AM, V41, LPN stated that she worked on 02/22/20 helping to orient V31, LPN. V41 stated that at 11:00 AM, she answered a call light for R159. She stated she was not aware that anyone was even in the room. She stated R159 asked for something to eat and told her that she was admitted the night before and had not been fed yet. V41 stated that R159 told

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her that she was in extreme pain as well and had not been given any medications. V41 stated that V44, LPN (night nurse 02/21/20) had not made her aware that R159 had been admitted during the morning nursing report. V41 stated she did not believe that V44 knew that R159 was admitted either. V41 then helped V31 input some of the medications into the computer and notified V46, LPN/MDS Coordinator and V2, DON at this time that no one knew that R159 was in the building and that R159 had been neglected by not receiving any services up until this time.

On 02/23/20 at 11:50 AM, V30, Registered Nurse (RN) stated she knew R159 was admitted to the facility but did not know what day. V30 stated she was not aware that R159 required IV antibiotics and pain medications and that she had not received meal service or required turning and repositioning assistance.

On 02/23/20 at 10:00 AM, R159 was observed to have a bed without a side rail on the right side and a bed rail on the left side that was non-functioning. According to R159, she was unable to move her lower body without help from staff or having bed rails. On 02/23/20 at 11:30 AM, V2, DON was made aware. On 02/24/20 at 9:00 AM, R159 was observed in the same side lying position from the day before. R159 stated that staff had not assisted her in turning and repositioning since the day before. There were no pillows to support her lower limbs for pressure relief.

On 02/23/20 at 10:00 AM, R159 stated she had not received a meal since her admission on 02/21/20.

On 2/23/20 at 11:45 AM, V5, Dietary Manager,

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confirmed R159 was not in the facility's system and therefore a meal ticket was not generated for her to receive meals.

On 02/23/20 at 10:00 AM, R159 was in her room alone. She was lying in bed with an anxious look on her face. R159 was tearful, shaking and grimacing while she spoke and explained she had not received any medication, had not received any meal service, had not been turned or repositioned or given a bed with side rails for turning and repositioning herself (R159 is a paraplegic with no ability to move her lower body from the waist down), provided personal care needs and had no fluids provided since being admitted on 02/21/20. R159 had a disheveled appearance with oily, unclean hair that was not brushed or combed. R159 stated she had not had a bed bath or shower since her arrival. R159 stated she performs her own urine self-catherization and asked on 02/22/20 for soap and a basin of water and V7, Certified Nurse's Aide, CNA, stated the facility did not have soap in the building to give her. R159 was provided a basin of water and a urinal. On 02/23/20 at 10:00 AM, R159's urinal was on the bedside table several feet away out of reach from R159. There was no water basin observed in the room or bathroom. R159 stated she was in severe pain rating it "Beyond 10 out of 10" on the pain scale. R159 stated she had severe pain in her head and back and stated she felt like she was running a fever. R159 further stated that she felt isolated in her room with no television remote and cannot get up to turn it on and her bedside table was across the room. R159's call light was observed behind her hanging off the bed out of her reach. R159 stated she was admitted to the facility from the hospital for Intravenous (IV) medication treatment due to being diagnosed with Bacterial

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Meningitis (severe infection and inflammation of the brain), Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteremia of the blood and spinal cord (severe infection of the blood and spinal cord) and Infective Endocarditis (MRSA induced infection of the lining of the chambers of the heart). R159 stated V2, Director of Nursing (DON) told her on 02/23/20 at 9:30 AM that she was not in the facility's system and no one really knew she was here.

The Physician's Order Sheet (POS), dated 02/22/20 at 12:35 PM, documented an order for "Vancomycin 1 gm IV twice per day, start at 4:00 PM" was written by V41, Licensed Practical Nurse (LPN). At 2:41 PM, this order was discontinued by V27, LPN and a new order for the same medication was submitted by V27 to start at 4:00 PM on 02/22/20. This order was never carried out by staff on 02/22/20.

On 02/23/20 at 11:20 AM, V2 was observed preparing to hang two IV medications for R159. V2 stated that R159 was not put into the facility's system and therefore the medications did not get ordered properly. V2 was observed to hang Vancomycin (an antibiotic) 1 gm (gram) at 125 milliliters per hour through left forearm PICC (Peripherally inserted central catheter) line. At 11:40 AM, V2 was observed to hang Ceftriaxone (an antibiotic) 2 gm IV at 1 drop per minute.

On 02/23/20 at 11:40 AM, V2 stated she had a call out to the physician regarding pain medication. V2 stated that no pain medications were ordered at this time. At 12:35 PM, R159 was observed in bed. R159 stated she has had no change in her condition. At 1:00 PM, V2 stated she was still waiting on the call from the physician regarding R159's pain medications and that she

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could not give any medications until the physician called back. At 1:30 PM, 2:00 PM, 2:20 PM, 3:00 PM and 3:35 PM, R159 remained in extreme pain and had not received any pain medications. At 3:50 PM, V2, DON stated she had not heard from the physician regarding the pain medications for R159.

The POS, dated 02/23/20 at 3:30 PM, documented the order as "Norco tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1-2 tablets by mouth every 6 hours as needed for moderate pain."

On 02/23/20 at 4:00 PM, the Medication Administration Record (MAR) documented R159's pain assessment at 10 out of 10 on the pain scale. There were no pain medications documented as given at this time.

R159's MAR, dated 2/23/20 at 7:28 PM, documented Norco 5-325 mg two tablets were given to R159. This was approximately 49 hours after her initial admission.

On 02/24/20 at 9:00 AM, R159 was observed as anxious, tearful, shaking and complained of 10 out of 10 pain on the pain scale. She stated she had finally received pain meds last evening around 10:30 PM, but it did not completely relieve her pain and she did not see another nurse the rest of the night. She further stated she was in such severe pain that she did not sleep well.

On 2/24/20 at 9:10 AM, V3, Interim Assistant Director of Nursing gave R159 Norco 5-325 mg two tablets. R159 told V3 at this time that her pain level was 10 out of 10 on the pain scale.

R159's MAR, dated 2/24/20, documented at 5:43

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PM, R159 rated her pain at 5/10 on the pain scale. It documented she received one Norco 5-325 mg tablet.

R159's Nurse's Note, dated 2/24/20 at 7:23 PM, documented R159's pain was still at 5/10 on the pain scale.

R159's MAR, dated 2/24/20, documented 7:31 PM, the MAR documented one tablet of Norco 5-325 mg was given.

On 02/25/20 at 9:00 AM, R159 stated her pain level was 10 out of 10 on the pain scale and had not had any medication for pain since the day before. At 10:30 AM, R159 stated she still had not received anything for pain and had just talked to V43, Nurse Practitioner (NP) and that she was supposed to get something. At 11:20 AM, R159 still had not received anything.

On 02/19/20 at 10:00 AM, a hospital lab report prior to her admission to the facility documented R159's Vancomycin trough level was 8.4 mcg/ml.

On 2/27/20, at 11:20 AM, R159 stated she had been sent to the hospital to get labs drawn and had not received any medications yet. R159 rated her pain 6/10 on the pain scale at this time.

On 2/27/20, R159's MAR did not document R159 had not received any pain medications prior to her being sent out to the hospital for laboratory test.

On 02/28/20 at 1:30 AM, a Nurse's Note documented R159's Vancomycin trough level was 5.7 micrograms per milliliters (mcg/m). Normal range is 10.0 - 20.0 mcg/ml. The Nurse's Note documented that the pharmacist ordered another

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trough to be drawn prior to giving the next dose at 6:00 AM.

On 02/28/20 at 8:47 AM, a lab report documented R159's trough level was 8.0 mcg/ml. The POS, dated 02/28/20, documented a new order to give Vancomycin 1.25 gm IV starting at 6:00 PM. The MAR dated 02/29/20 at 6:00 PM, Vancomycin 1.25 gm IV was blank as not given.

On 02/29/20 at 10:01 AM, V38, Pharmacist stated that Vancomycin is an antibiotic used to treat bacterial infections, such as meningitis and MRSA blood infections. He stated that a blood trough level must be drawn after every third dose due to the risk of a patient becoming toxic which would affect organs of the body negatively. A low trough level is indicative of the wrong dose of antibiotic or that the medication was not given as often as needed to kill off the infective agent. V38 stated that protocol with a person with meningitis should have Vancomycin trough levels of 15.0 - 20.0 mcg/ml in order to metabolize properly to fight the infection. V38 stated that R159's trough levels are critically low, indicating the Vancomycin was not effective enough to fight off the infection. He further stated that Vancomycin in IV form was used in a longer period of weeks to months to fight off the infection and that with critical trough levels this would prolong her healing process.

On 02/26/20 at 11:31 AM, V20, Medical Director, stated he was not aware that R159 was admitted to the facility until 02/23/20 in the early afternoon when he received an order request for pain medication for R159. V20 stated he was not aware R159 was admitted on 02/21/20 and did not even know who the hospital physician was who cared for R159 while she was in the hospital. V20 stated he was not aware that IV medications,

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pain medications, assistance for turning and repositioning or meal service or fluids were not provided to R159 until 02/23/20. He also stated that he was not aware that isolation precautions were not initiated until 02/24/20. He stated that a resident with the type of systemic infections as R159 has, isolation precautions should have been initiated with at least gowns, gloves and masks until R159 was no longer in danger of increased complications from the infections and isolation was otherwise not warranted. V20 was not made aware of R159's care needs until he met her on 02/24/20 at 1:49 PM. V20 stated he would expect the facility to follow standards of practice from accepting a resident, following the protocols for medication management especially with IV therapy and pain management and providing a safe, therapeutic environment to ensure the residents needs are met. V20 stated the fact that the facility did not follow through with the admission process, the facility failed to set up the reasonable care measures to care for and provide effective treatment and services for R159. V20 stated he would expect the facility staff to provide continuous treatment according to the hospital discharge orders received. V20 stated he gave a verbal order for Vancomycin trough on 02/24/20 and was not aware that had not been drawn as of 02/26/20. V20 stated that if a Vancomycin trough result was low, it was indicative that the therapeutic levels were not adequate to be effective with the serious infections R159 had. V20 stated it was standard of practice that if a resident was on Vancomycin then a trough level must be drawn after every third dose in order to monitor the levels and adjust the dosage accordingly.

On 02/23/20, the policy and procedure titled, "Admission Agreement (Facility)" was reviewed. It

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APERION CARE CAPITOL	555 WEST CARPENTER SPRINGFIELD, IL 62702

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documented under, "Contract Between Resident and Facility: B. Facility Agreement: 2. The facility shall offer personal care, room, board, dietary services and laundry services. The facility will also offer nursing care, activities, restorative and rehabilitative services and psychosocial care as identified in the resident's plan of care established by the facility to the extent required by the facility standards and in accordance with the policies of the facility. 3. Medicines, treatments or special diets will be offered to the resident if ordered by the physician, the facility Medical Director ... 4. The facility will offer equipment required under facility standards. 5. The facility will exercise reasonable care toward the resident."

The Care Plan, dated 02/21/20, documented R159 was identified as having pain with interventions listed, in part as, "Administer analgesia (specify medication) as per orders. Anticipate the resident's need for pain relief and respond immediately to any complaint of pain. Monitor/document for side effects of pain medication. Observe for new onset or increased agitation, restlessness, confusion, hallucinations, nausea, vomiting...Report occurrences to the physician. Monitor/record pain characteristics and as needed: Quality, Severity, Anatomical location, Onset, Duration, Aggravating factors and Relieving factors. Monitor/record/report to nurse resident complaints of pain or requests for pain treatment. Notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain. Observe and report changes in usual routine, sleep patterns, decrease in functional abilities, withdrawal or resistance to care. Provide the resident with reassurance that pain is time limited. Pain - non-verbal sounds, vocal complaints, facial expressions and/or protective

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body movements or postures that indicate pain."

The Minimum Data Set (MDS), dated 02/28/20, documented R159 was cognitively intact and required extensive assist of two staff for bed mobility, transfers, locomotion, dressing and toilet use; required extensive assist of one staff for hygiene and bathing; and set up and supervision with eating. It documented R159 had pain with vocal complaints and frequency daily.

On 03/05/20, the policy and procedure titled, "Pain Management Program" was reviewed. It documented "Purpose: To establish a program which can effectively manage pain in order to remove adverse physiologic and physiological effects of unrelieved pain and to develop an optimal pain management plant to enhance or promote physiological and psychological wellness." The Policy documented "It is the goal of the facility to facilitate resident independence, promote resident comfort, preserve resident dignity and facilitate life involvement. The purpose of this policy is to accomplish that goal through effective pain management program."
The pain management program includes the following components: "Documentation of pain assessment and monitoring, assessment of non-verbal residents for signs and symptoms of pain, pain control mechanisms available. 10. Documentation of assessments and the resident's response to the pain management made with each assessment. 11. The resident's physician will be notified of the resident's complaints of pain which are not controlled by comfort measures, including pain medications."

The Facility's policy and procedure titled, "Abuse Prevention and Reporting - Illinois", dated 12/10/18, documented "The resident has the right

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to be free from abuse, neglect, misappropriation of resident property. " The Policy documented "Neglect is defined as the failure to provide goods and services to a resident that are necessary to prevent physical harm, pain, mental anguish or emotional distress."

(A)

2 of 5 Violations:

300.1010h)
300.1210b)
300.1210d)3)5)
300.3240a)

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

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resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, interview and record review, the Facility failed to assess and treat pressure injury for one of 7 residents (R70)

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reviewed for pressure ulcers/injury in the sample of 61. This failure resulted in R70 sustaining a left heel abrasion which declined to an unstageable pressure ulcer with no change in treatment for 49 days.

Findings include:

On 02/23/20 at 9:38 AM, R70 stated he has open area on left foot but doesn't know what happened. R70 stated it is a little sore. He stated the nurses change his dressing on the left heel on most days.

R70's Care Plan dated 8/9/18 documents R70 has the potential for impairment of skin integrity related to fragile skin. The Care Plan Interventions dated 8/09/18 documented staff are to assess/record changes in skin status and report pertinent changes in skin status to physician.

A Nurse's Note dated 1/8/2020 at 11:05 AM documents, "During routine rounds resident noted to be bleeding from his left heel; upon assessment abrasion noted 2.1 (centimeters) x (by) 1.5 (centimeters) x 0.1 (centimeter)." The Note documented the area was cleansed, dressing applied and V32, Nurse Practitioner was made aware.

R70's Physician's Order, dated 1/8/20 documented cleanse R70's left heel with normal saline, pat dry, cover with xeroform (non-adherent dressing which prevents air from reaching the wound) cut to the size and do dressing daily and as needed.

R70's Care Plan was not updated to address R70's new left heel pressure injury and how staff

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were to relieve pressure.

R70's Skin Condition Report, dated 1/14/20 documents an abrasion on R70 left heel measured 1.5 cm by 1.5 cm by 0.1 cm with no signs or symptoms of infection. The report documented the abrasion with pink granulation maceration noted at peri wound.

R70's Skin Condition Report, dated 1/21/20 documents the abrasion on R70's left heel measuring 2.5 cm by 2.0 cm with wound bed pink.

R70's Skin Condition Report, dated 1/29/20, documents the abrasion on R70's left heel measured 1.8 cm by 2.0 cm by 0.2 cm. The Report documented 100 % granulation to R70 wound bed with moderate serosanguinous exudate (fluid that is yellowish with small amounts of blood) with no signs of infection.

R70's January 2020 Treatment Administration Record documented R70 did not receive the treatment to his left heel on 1/11, 1/19, 1/23 and 1/28/20.

R70's Skin Condition Report, dated 2/6/20 documents the abrasion on R70's left heel measured 2.0 cm by 1.8 cm by 0.2 cm. There was no documented in change in treatment although R70's pressure ulcer had not improved in four weeks.

R70's Skin Condition Report, dated 2/13/20 documents the abrasion on R70's left heel measured 2.0 cm by 1.8 cm by 0.2cm with moderate amount of serosanguinous exudate, no pain or odor.

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R70's Skin Condition Report, dated 2/21/20 documents an abrasion measuring 1.7 cm by 2.5 cm by 0.2 cm with 100 % granulation; moderate serosanguinous exudate and no signs or symptoms of infection. There was no documented change in treatment although R70's pressure ulcer had not improved in six weeks.

R70's February TAR documented R70 had not received the treatment to his pressure ulcer on 2/7, 2/10, 2/12, 2/16 and 2/18/20.

On 02/25/20 at 2:01 PM, V13, Licensed Practical Nurse (LPN) removed the dressing from R70's left heel. R70 had quarter size round unstageable pressure ulcer with the entire wound base covered with yellow slough (a layer of dead tissue). V13 stated R70's wound was not an abrasion. V13 stated she would call it a wound but didn't know what type of wound it was. She stated, "You would need to ask the DON (Director of Nursing) about it."

Skin-Pressure/Diabetic/Venous/Arterial Wound Report dated 2/25/20 at 3:23 PM documented by V26, Assistant Director of Nursing, documented R70 had a facility acquired unstageable pressure injury to his left heel which was first observed on 1/8/20. The Report documented the wound was worsening and measured 2 centimeters by 2.3 centimeters with necrosis/100% white slough. V26 documented "Treatment changed to left heel cleanse with normal saline. Apply Santyl (ointment which debrides necrotic tissue) to wound bed and cover with dry dressing. Change daily and prn (as needed). Wound started as trauma and has since declined."

The NPUAP (National Pressure Ulcer Advisory Panel) at

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https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf documents the definition, "Unstageable Pressure Injury: Obscured full- thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed."

49 days after R70's initial treatment of xeroform to his pressure ulcer was given, a new physician's order was written. R70's Physician's Order, dated 2/25/20 documented staff were to cleanse R70 pressure ulcer with NS, apply Santyl Ointment 250 UNIT/GRAM (Collagenase) to his left heel every day-shift for wound care and cover with a dry dressing every day shift. In addition, R70's Physician Orders dated 2/25/20 included new orders to promote wound healing: 1) Dietician to consult; 2) Prostat Liquid (a nutritional supplement to promote wound healing 30 mls by mouth one time a day for nutrition for 24 days ; 3) Zinc Sulfate 220 mg one daily for zinc deficiency for wound healing -give until wound is healed; Ascorbic Acid 500 mg give one twice a day for wound healing for 14 days.

On 2/25/20 at 2:50 PM V27, LPN, stated, " The area on (R70's) left heel has never been an abrasion. It was a deep tissue injury from him using that heel to move himself with his wheelchair."

On 2/25/20 at 2:25 PM V43, Nurse Practitioner, stated she has been here for three weeks and she was just asked to assess R70's heel today. She stated she would probably call it a Stage II, but it did have slough covering the base of the wound.

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On 3/5/20 V6, Regional Nurse, stated she would expect staff to get a different treatment order if a wound is not improving."

The Facility's policy, Pressure Ulcer Prevention, dated 11/28/12 documents to prevent and treat pressure sores/ pressure injury "11. Use positioning devices or pillows, rolled blankets, etc. to reduce pressure and friction/shearing from heels, toes, and malleolus (a bony projection with a shape likened to a hammer head especially each of those on either side of the anke) as indicated. 12. Encourage resident to maintain proper nutrition and hydration, providing supplements."

(B)

3 of 5 Violations:

300.610a)
300.1210b)5)
300.1210d)6)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed

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and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the

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Act)

These Requirements are not met as evidenced by:

A. Based on observation, record review and interview, the facility failed to implement progressive interventions to prevent falls for 1 of 3 residents (R74) reviewed for falls in a sample of 61. This failure resulted in R74 falling and sustaining bruises to her forehead, lacerations to her eyebrow and finger, a nasal bone fracture and fractured teeth.

Findings include:

R74's Profile and Diagnosis Listing, undated, documents R74 was admitted with a diagnosis of Seizures, Cognitive Communication Deficit, Lack of Coordination, Abnormality of Gait, Unsteadiness on Feet, Difficulty Walking, Parkinson's Disease and Alzheimer's Disease.

R74's Care Plan Focus, dated 10/10/19, documented she was at risk for falls injury related to Parkinson's disease, Alzheimer's disease, Stroke, Dementia, Seizures and a history of falls. Care Plan Intervention dated 3/5/19 documented that therapy was to screen R74 for wheelchair positioning. Care Plan Intervention dated 4/1/19 documented she would be placed on the Falling Star Program (program to identify residents at risks for falls) with a star placed outside her door, on devices and in her room. Care Plan Intervention, dated 8/19/19, documented "Dycem (a non-slip pad) to w/c (wheelchair)."

R74's Fall Occurrence Report documents R74 to have had 4 recent falls, on 8/29/19, 10/5/19, 10/19/19, 1/10/20 and 2/19/20.

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R74's Fall Investigation Report, dated 8/29/19 at 6:35PM, documents an un-witnessed fall. The Report documented R74 was sitting on the floor in front of her bed, stating she slid off the bed. No injuries were noted.

Fall IDT (Interdisciplinary Team) note, dated 8/30/19 at 10:07AM, for the fall on 8/29/19, documents a root cause of R74's fall was R74 was sitting on the edge of the bed with a new intervention for non-skid strips at bedside.

R74's Fall Investigation Report, dated 10/5/19 at 4:30 AM, documents a witnessed fall. The Report documented R74 was observed on the floor in her room on her left side at the foot of the bed. R74's roommate at the time stated R74 attempted to self-transfer out of bed and fell. Range of motion was at "baseline" and no injuries were noted.

R74's Nurse's Note, dated 10/5/19 at 2:34 PM, documents R74 complaining of left hip pain upon movement and R74 was sent to the emergency room for further evaluation.

R74's Hospital Discharge Note, dated 10/8/19 documents a diagnosis of Closed Fracture of the Left Hip. R74 returned to the facility on 10/8/19.

R74's Interdisciplinary Team (IDT) note, dated 10/8/19 at 10:17 AM, for the fall on 10/5/19, documents a root cause of R74's fall was R74 self-transferring out of bed with a new intervention to move R74 closer to the nurse's station upon return to the facility.

R74's Fall Investigation Report, dated 10/19/19 at 9:26 AM documents an un-witnessed fall in R74's

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room next to the bed. The Report documented no injuries were noted. The Report documents the new intervention was to educate R74 on using the call light for help and the dangers of self-transferring.

R74's IDT note, dated 10/21/19 at 11:01 AM, for the fall on 10/19/20, documents a root cause of R74's fall was R74 was self-transferring from the wheelchair to the bed with new interventions for a medication review, continued skilled therapy and to encourage an evening snack. There were no documented interventions to address R74's need for increased supervision and lack of safety awareness to prevent future falls.

R74's Minimum Data Set (MDS), dated 1/9/20, documents R74 as having severe cognitive impairment, requiring an extensive assist of two with transfers, an extensive assist of one with toileting and only able to balance self with staff assist.

R74's Fall Investigation Report, dated 1/10/20 at 11:36 AM, documents a witnessed fall in the dining room. The Report documents no injuries were noted. The Report had no root cause identified for R74's fall. The Report documented the new intervention was for staff to monitor R74 in the dining room and provide frequent reminders not to self-transfer.

R74's Care Plan was not revised after the fall on 1/10/20 with interventions to prevent R74 from future falls and injury.

R74's Fall Risk Assessment, dated 2/19/20, documents R74 as being at risk for falls.

R74's Fall Investigation Report, dated 2/19/20 at

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9:30 AM, documents an un-witnessed fall by the activity room. R74 sustained a bruise to the forehead area and a laceration to the eyebrow area and finger. The Report documented R74 was sent to the emergency room for further evaluation.

R74's Hospital X-ray report dated 2/19/20 documents R74 sustained a displaced fracture of the tip of the nasal bone and fractured teeth. R74 then returned to the facility on 2/19/19.

R74's IDT note, dated 2/23/20 at 12:16 PM, for the fall on 2/19/20, documents a root cause of R74's fall was she was reaching for the door with new interventions for therapy to assess for positioning and to monitor the bruising and abrasions until healed. There were no documented interventions to address R74's lack of safety awareness and need for increased supervision.

On 2/23/20 at 12:33PM, R74 had bruises and abrasions to the nose, eyes and forehead area. When asked what happened, R74 stated "I fell". R74 unable to recall how the fall occurred.

On 2/25/20 at 1:29 PM, R74 was up in her wheelchair, there was no non-skid material in the wheelchair and no identifier on the wheelchair for the "Falling Star Program". R74's room was observed with non-skid strips under the bed, not in front on the bed and no identifiers outside or inside the room for the "Falling Star Program".

On 2/27/20 at 9:50 AM, V22 and V23, Certified Nurse's Aides (CNAs) were doing a two-person gait belt transfer with R74. The wheelchair was not locked prior to the transfer onto the toilet or when transferring back to the wheelchair. The

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gait belt was loose and not tight around the resident.

On 2/25/20 at 1:29PM, V44, Licensed Practical Nurse (LPN) stated she "thinks" R74 is on the "Falling Star Program" for fall prevention.

On 2/26/20 at 11:40 AM, V20, R74's Physician, stated R74 is cognitively impaired and educating a resident with impaired cognition is not an appropriate intervention to prevent falls.

On 3/5/20 at 2:05 PM, V2, Director of Nurses (DON), states "If a resident has a Brief Interview of Mental Status (BIMS) of 5, they aren't going to be able to retain the education."

The facility Policy and Procedure titled "Fall Prevention Program", dated 11/21/17, documents the facility will determine the individual needs of each resident by assessing the risk of falls and will implement appropriate interventions to provide necessary supervision.

B. Based on observation, interview and record review the facility failed to implement effective interventions to prevent residents at risk for elopement from leaving the facility for 7 of 7 residents (R7, R10, R20, R52, R53, R56, R71) reviewed for elopement in the sample size of 61.

Finding include:

1. R56's Care Plan dated 12/6/2019 documents: "I require use of a (resident monitoring device bracelet) alarm r/t attempts to exit the facility."

On 2/24/20 at 9:50 AM R56 in her room stated, "I just cleaned up the Senator's office and he just

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left for the day." R56 stated "I go outside by myself and with others for walks."

Throughout the survey, R56 was seen ambulating independently, getting on and off the elevator unsupervised, going from the 3rd floor down to the 2nd floor.

R56's Social Service Note dated 12/15/2019 at 11:18 AM documents: "(R56) Resident is sitting in the activity room with writer and other residents. 3rd floor staff reports that she had been trying to get out all morning and ask if she could stay with me for a while. Resident was with writer for 3 hours."

R56's Social Service Note, written by V4, Social Service, dated 12/15/2019 at 4:13 PM documents "(R56) Resident was found by writer in the main entrance of Hospital and resident was sitting in the doorway. She appeared confused and safe. She stated that she drove here, and her car was in the parking lot. Writer told resident to get in my car and we came back to the facility."

On 2/24/2020 at 12:40 PM V4 stated, "I can't remember what 3rd floor staff called me on my cell phone because I was home." V4 stated, "It was snowing that day, and staff stated they didn't see any footprints." V4 stated, "The administrator called me and told me to go pick her up at local hospital."

On 2/25/2020 at 2:55 PM V27 Licensed Practical Nurse (LPN) was interviewed regarding R56 elopement and stated, "CNA (unknown) stated she couldn't find (R56)." V27 stated "We then started looking around for her and called a Code Purple. "We went outside and jumped into our cars. I called 911 and the police were involved.

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The police told us that she was at the local hospital because the hospital had called." V27 stated "(R56) was wearing black yoga pants, black long sleeve sweater. "It was snowing like crazy that day." V27 stated "(R56) went downstairs on the elevator to the 1st floor and went outside." V27 stated "Those doors down there don't activate an (alarming bracelet)."

On 2/25/2020 at 9:00 AM V1, Administrator, stated, "I didn't do any investigation on (R56's) elopement because the resident didn't get injured or anything." V1 stated, "We watched the video where the resident (R56) walked out the doorway on the first floor." V1 stated, "The alarm did not go off because the first floor is uninhabited." V1 stated, "The other facility in town called us and told us that the local hospital called them that a resident (R56) was on their property." V1 stated, "I called (V4, Social Service) and told her to pick up the resident and return her back to facility."

2. The facility has four floors. The first floor is the basement floor and three floors above the basement floor. There is a main elevator which residents, facility staff and visitors can use to access all floors. There is no resident monitoring system alarm on this elevator.

On 2/25/2020 at 10:05 AM, this surveyor took the elevator from the 3rd floor down to the 1st floor/basement. Heading east down the hallway was a double wooden door that had a large red in colored sign reading "STOP" door is alarmed. This surveyor opened the door and no alarm sounded and walked east down a hallway and exited out of the building. There were no alarms going off. At 10:09 AM V28, Facility Transporter observed outside in parking lot stated, "I didn't hear any alarms going off."

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On 2/27/2020 at 9:10 AM, this surveyor took the elevator from the 3rd floor to the 1st floor. Heading east down the hallway, opening the double wooden door with the "STOP" sign and continued east down the hallway and exiting the building without any alarms or staff present.

3. The following residents have been care planned for wandering and elopement behaviors and who have access to the first floor/basement:

R7's Minimum Data Set (MDS) dated 11/12/19, documents R7 requires limited assistance of one staff for activities of daily living. R7's MDS documents R7 has severe cognitive impairment.

R7's Social Service Note dated 11/13/2019 documents "(R7) Resident tried to leave the building while all managers were in morning meeting."

R7's Care Plan dated 11/14/19 documents "(R7) I require use of an alarming bracelet." The Care Plan documented "11/13/18: R/T (related to) attempts to exit the facility. Diagnosis that contribute include intellectual disabilities, Bipolar disorder." The Care Plan Intervention dated 11/20/19 documented "Assess for and record any alarming bracelet related problems and report them to the physician. Observe for the following issues: Development of skin problems. Provide alarm as ordered: Alarming bracelet."

R10's MDS, dated 11/22/19, documents R10 requires limited assistance of one staff for activities of daily living. R10 MDS documents R10 has severe cognitive impairment.

R10's Care Plan, dated 11/15/19 documents "I

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require use of an alarming bracelet alarm, resident attempts to exit the facility. Diagnosis that contribute include Dementia." The Care Plan documented that R10 was an elopement risk and wanderer.

R20's MDS, dated 1/13/20, documents R20 requires limited assistance of one staff person for activities of daily living. The MDS documents R20 has severe cognitive impairment. The MDS does not document R20 has wandering behavior.

R20's Care Plan dated 2/17/20 documents: "I am an elopement risk/wanderer r/t exit seeking."

R52's MDS, dated 12/24/19, documents R52 requires limited assistance from one staff person for ADLs and has moderately impaired cognition.

R52's Care Plan dated 12/18/19 documents "I am an elopement risk/wanderer."

R53's MDS, dated 12/19/19, documents R53 requires limited assistance from one staff person for ADLs. The MDS also indicates a Brief Interview Mental Status being cognitively intact. The MDS for Section Wandering-Impact contain zeros in the code boxes.

R53's Care Plan, dated 12/13/19, documents, "I require use of an alarming bracelet alarm R/t (related to) attempts to exit the facility." The Care Plan Interventions document "Respond to alarm promptly. Redirect her away for exits as needed. Provide alarm as ordered."

R53's Nurse's notes dated 12/17/19 documents: "(R53) Resident wandering the floor, redirected to room several times. Writer heard door alarm going off resident attempted to go out the east

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end door to the stairs. Writer and CNA (Certified Nurse's Aide) attempting to redirect resident to room with resident being aggressive, pointing finger in staff faces stating 'I'm God'. Resident stated, 'As soon as I can get downstairs, I'm calling 911 to make a report because I'm not supposed to be here'."

R53's Nurse's note dated 12/14/2019 documents "Communication with Family Data: resident sister also said she was afraid resident may try to leave the bldg (building) and wanted an alarm bracelet. She was told that she had one on (put on this morning when resident found propelling another resident on another floor). She said that the resident didn't have one on and an aide told her it was on a leg. The sister went immediately to her to check that. She said her sister would never do what we told her that she did."

R53's Social Service note dated 12/14/2019 documents: "Staff notified writer that this resident tried to escape out the 2nd floor door. Writer gave the CNA, an alarming bracelet to put on the resident."

R71's MDS dated 1/7/20, documents R71 requires limited assistance of one staff person for ADLs. The MDS documents R71 has severe cognitive impairment.

R71's Care Plan dated 10/10/19 documents "I am an elopement risk/wanderer (exit seeking) r/t exit seeking. Interventions: Assess for fall risk. Monitor for fatigue and weight loss." The Care plan documented R71 had a (resident monitor device bracelet on her right ankle.

R71's Activity Note dated 10/12/2019 documents "(R71) got out of her wheelchair while in the

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activity room 3 times, so we decided to take her back down to the Certified Nurse's Assistant (CNA's). And she ended up back in the lobby area, another family member and resident were getting ready to leave out the door. I let them out (R71) wanted to go too, so she shoved me 3 times and told activity aide and I that we were stupid idiots. We tried to change her mind, but she got madder, she continued to call us names and walked out the door. Nurse notified."

Facility's Policy and Procedure "Missing Resident/Elopement" dated 11/15/2017 documents "All personnel are responsible for reporting a cognitively resident attempting to leave the premises, or suspected of missing, to the Charge Nurse as soon as practical. This includes any resident that did not sign out on pass and/or did not notify a staff member of his or her leaving. " The Policy documents "3) Should an employee discover that a resident is missing from the facility, he or she should: Complete incident report and notify the state agency according to reporting guidelines. Document appropriate notations in the medical record. 4) Upon return of the resident to the facility, The Director of Nursing or Charge Nurse should: 7. Complete the incident report, indicating when resident returned and condition of resident. 8. Make appropriate entries into the resident's medical record. Complete a new Elopement Risk Assessment and update plan of care as appropriate."

(B)

4 of 5 Violations:

300.1010h)
300.1210b)4)

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300.1210d)3)
300.3240a)

Section 300.1010 Medical Care Policies

h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. (B)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other

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functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (A, B) (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on observation, record review, and interview, the facility failed to administer tube feeding to maintain nutritional status and failed to administer tube feeding as ordered for 2 of 2 residents (R61, R205) reviewed for enteral feedings in a sample of 61.

This failure resulted in R61 having a significant weight loss of 26 pounds (Lbs) in 6 months.

Findings include:

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1. R61's Profile and Diagnosis Listing documents R61 was admitted to the facility on 3/31/05 with a diagnosis of Dysphagia and Gastrostomy Tube. V18, R61's son is listed as the responsible party.

R61's Minimum Data Set (MDS), dated 1/1/20 fails to document a weight loss.

R61's Care Plan, dated 1/2/20 document R61 requires tube feeding due to Dysphagia. Interventions include having a Registered Dietician (RD) evaluate quarterly and as needed, monitor caloric intake, monitor weight and report to the physician any weight loss.

R61's Physician's Order Sheet (POS) documents an order dated 9/23/19 for two-cal HN at 75 milliliters (ml) per hour at night for twelve hours and is to be turned on at PM and turned off at 6 am.

R61's weight records and Dietician notes were reviewed and document the following weights: August 2019 - 163 pounds (lbs.); September 2019 - 143 lbs.; October 2019 - 137; November 2019 - 140 lbs.; December 2019 - 143 lbs.; January 2020 - 143 lbs.; February 2020 - 137 lbs.

R61's Dietician note, dated 9/20/19, by V19, RD, documents a significant weight loss of 20 lbs in one month. R61's Body Mass Index (BMI) is 24.5 and R61's laboratory results showed a low albumin and total protein level.

R61's POS, dated 9/23/19 documents the tube feeding was increased from 65 ml/hour to 75 ml per hour at night for twelve hours per day due to weight loss per RD recommendation.

R61's Dietician note, dated 10/7/17, by V19,

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documents a weight of 137 lbs. and a BMI of 23.5. This is a 6 lb. weight loss in one month. V19, documents this is "acceptable despite triggered significant weight loss. All parties aware of weight loss which was desired by family as expressed in care plan meetings this year".

R61's Dietician note, dated 11/1/19, by V19, documents a weight on 10/25/19 of 141 lbs. with a BMI of 24.4 and this is "acceptable despite triggered significant weight loss. All parties aware of weight loss which was desired by family as expressed in care plan meetings this year."

R61's Dietician note, dated 12/16/19, by V19, documents a weight on 12/16/19 of 143 lbs. and a BMI of 24.4 and this is "acceptable despite triggered significant weight loss. All parties aware of weight loss which was desired by family as expressed in care plan meetings this year."

R61's Dietician note, dated 1/7/20, by V19, documents a weight of 143 lbs. with a BMI of 24.4 and this is "acceptable despite triggered significant weight loss in 6 months noted. Labs assessed for 12/16/19 with a low albumin noted."

R61's Dietician note, dated 2/6/20 by V19, document a February weight of 137 lbs. and a BMI of 23.5 and this is "acceptable despite triggered significant weight loss from months ago. Labs assessed 2/14/20 with a low albumin noted."

On 2/26/20 at 10:08 AM, V18, R61's Son and Responsible Party stated he has never requested that R61 lose weight and he has not been notified of the weight loss. R61 states he lives further away from the facility and relies on the facility to notify him of any changes with R61.

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On 2/26/20 at 10:56 AM, V19, stated R61's weight loss was planned per family request due to her reaching the obese range. V19 stated a past Director of Nurses (DON) of the facility told her there was a care plan meeting and the family requested R61 loose some weight. V19 did not verify this information with the family. V19 stated R61's weights have been "all over the place" and R61 does not have swelling or anything medical going on that could cause the weight variances. V19, stated R61 is at the low end of meeting her caloric needs.

On 2/26/20 at 11:40 AM, V20, R61's Physician, stated he was not notified of R61's weight loss. V20 stated he looks at the BMI of a resident and that 25 is ideal, anything less than that is not. V20 was notified of R61's BMI by the surveyor and stated that is not an ideal BMI for R61 and R61 has not had anything medical going on that would explain a medical reason for her weight loss.

On 3/5/20 at 2:05 PM, V2, Director of Nurses (DON) stated she would expect staff to notify the physician and/or family of a change in condition and to follow tube feeding orders as ordered by the physician.

The facility "Dietician - Nutritional Risk Referral" Policy and Procedure, dated 5/9/19, documents "Nutritional Risk may include, but not limited to: New / Re-admission tube feeding, Nutritional related abnormal labs, Significant weight change or gradual weight change on at risk residents".

The facility "Nutrition Risk" Policy and Procedure, dated 2014, documents "Residents who may be at high nutrition risk will be promptly identified and appropriate protocols will be implemented to

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prevent avoidable weight losses and nutritional decline. Once a resident has been suspected as high nutrition risk, immediate interventions, will be implemented by the facility to prevent the resident from experiencing avoidable weight loss."

The facility "Physician - Family Notification - Change in Condition" Policy and Procedure, dated 11/13/18, documents "The facility will inform the resident, consult with the resident's physician, the resident's legal representative when there is a significant change in the resident's physical, mental, or psychosocial status."

(C)

5 of 5 Violations:

300.610a)
300.686a)1)
300.686e)1)
300.1210b)
300.1210d)1)2)6)
300.1630e)
300.3240a)

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually

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by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Drugs

a) A resident shall not be given unnecessary drugs in accordance with Section 300.Appendix F. In addition, an unnecessary drug is any drug used:

1) in an excessive dose, including in duplicative therapy;

e) For the purposes of this Section:

1) "Duplicative drug therapy" means any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. For example, any two or more drugs, whether from the same drug category or not, that have a sedative effect.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the

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following and shall be practiced on a 24-hour, seven-day-a-week basis:

1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.

2) All treatments and procedures shall be administered as ordered by the physician.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.1630 Administration of Medication

e) Medication errors and drug reactions shall be immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

These Requirements are not met as evidenced by:

Based on interview and record review, the Facility

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failed to administer medications as ordered by the physician for 5 of 30 residents (R51, R59, R159, R160, R255) reviewed for medications in the sample of 61. This failure resulted in R51 requiring emergency medical treatment and hospitalization for opioid overdose.

Findings include:

1. On 02/23/20 at 1:35 PM, R51 was sitting in her wheelchair in her room. She stated she doesn't remember being in the hospital or why she was there. R51 was alert and oriented to person and place, speaking with clear speech, pleasant and friendly, stating she just finished lunch.

On 2/26/20, R51's Electronic Medical Record documented her Medical Diagnosis List which includes the following diagnoses: Multiple Sclerosis, Major Depressive Disorder, Unspecified Dementia without Behavioral Disturbance, Paranoid Schizophrenia, and Generalized Anxiety Disorder.

R51's Progress Notes, dated 1/20/20 at 6:45 PM, document, "Res (Resident) in hallway, speech is garbled, head is hyperextended, eyes are glazed and pupils pinpoint +1, not oriented to person or place, only self (barely) eyes are unable to track movement, lungs clear to auscultation, skin is warm, left hand noted to be discolored and flaccid, VS (Vital Signs) 146/97 (blood pressure) 98.7 (temperature degree Fahrenheit) 130 (pulse) 20 (respirations) SPO2 (Oxygen saturation level) 95% RA (Room Air). 911 called due to resident condition. V32, Nurse Practitioner, called for cond (condition) report and in agreement with ER (emergency room) eval (evaluation) 911."

R51's hospital MD Progress Notes, dated 1/21/20

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at 2:43 PM, documents under Impression: Acute toxic/metabolic encephalopathy, improved s/p (status / post) Naloxone (Narcan) in the Emergency Department; iatrogenic drug overdose (alleged co-administration of multiple sedating medications) at SNF (Skilled Nursing Facility).

www.merriam-webster.com/dictionary/iatrogenic: documents the medical definition of iatrogenic: induced inadvertently by a physician or surgeon or by medical treatment or diagnostic procedures.

R51's Emergency Department Documents, dated 01/20/20, documents R51 was transported to the hospital via ambulance on 01/20/20 at 7:10 PM. This document included description of chief complaint: "Pt (Patient) was brought in per EMS (Emergency Medical Service) from (Facility) with decreased LOC (Level of Consciousness), pt was found leaning to the right, equal grip strength, pt has pinpoint pupils and follows very few commands."

R51's Hospital Medical Records, "Nursing Intervention," dated 1/20/20 at 7:56 PM, documents, "Explained to (V27), nurse at (Facility) that patient is coming around and acting more like herself. (V27) states there will be an investigation about the medication schedule." Another "Nursing Intervention" in R51's Hospital Medical Records, dated 1/20/20 at 7:55 PM, documents: Called (Facility) and spoke with (V27), patient received all her nighttime meds and her 8 PM meds at one time. Pt got her Tramadol and Ativan early because it was due at 9 and she got it at 6, pt got all her night meds at the same time."

The Emergency Department Impression and

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Plan, dated 01/20/20 at 10:22 PM by V33, Emergency Room Physician, documents, "will admit for iv (intravenous) fluids, iv abx (antibiotics), observation after Nacaine (Narcan) iv. Plan: Admit to Inpatient Unit."

The www.narcan.com website documents, "Narcan is a medication used for the treatment of an opioid emergency or a possible opioid overdose with signs of breathing problems and severe sleepiness or not being able to respond."

R51's Hospital Discharge Summary, dated 01/22/20 at 4:25 PM, documents, "The patient was admitted to the hospital. She was noted to be lethargic, somnolent (abnormally drowsy), and encephalopathic (an altered mental state that is sometimes accompanied by physical changes per MedicineNet) in the ED (Emergency Department), and she responded to 6 mg total Narcan ordered by the ED physician. Her encephalopathy was felt to be toxic/metabolic in the setting of Urinary Tract Infection (UTI) and likely over-administration of sedating medications in a short period just prior to admission. These medications were slowly reintroduced at appropriate intervals while hospitalized and were ultimately not all restarted or were changed to lower doses." The same Discharge Summary documents, "The following includes patient education materials and information regarding your injury/illness: "Hospital Summary: I was in the hospital because: Unresponsive. The medical name for this condition is UTI, Opioid Overdose."

R51's January 2020 Medication Administration Record (MAR) documents the following physician ordered medications on the 2:00 PM to 10:00 PM shift on 01/20/20:
1. Gabapentin (Medication to treat seizures and

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nerve pain) 300 milligrams (mg) one capsule 3 times daily (6 AM, 3 PM, 10 PM) ordered to be given at 3:00 PM.
2. Glatopa (Medication to treat Multiple Sclerosis) 20 mg/milliliter (ml) injected subcutaneously every evening, ordered to be given at 6:00 PM.
3. Remeron (Psychotropic medication to treat depression) 30 mg one tablet at bedtime ordered to be given at 8:00 PM.
4. Sertraline (psychotropic medication to treat depression, obsessive-compulsive disorder, social anxiety disorder and panic disorder) 100 mg one tablet at bedtime to be administered at 9:00 PM.
5. Tramadol (Narcotic to treat severe pain) 50 mg one tablet 3 times daily (6 AM, 12 noon, 8 PM) ordered to be given at 8:00 PM. According to R51's Medication Administration Audit Report this medication was documented as administered at 7:43 PM on 01/20/20.

R51's January 2020 MAR documents all the above medications were initialed by V35 with a check mark in the box corresponding to the date and time they were to be given on 01/20/20, which indicated that she did administer all of those medications on that date. Medications that were not given, Zyprexa and Ativan, had a "6" in the box, which indicated the reason they were not given is because R51 was in the hospital. There were no administration times on the MAR, only check marks indicating the medications were given.

R51's Medication Administration Audit Report, printed on 02/25/20 for R51's medications that were administered on 01/20/20, V35, Licensed Practical Nurse (LPN), documented at 7:43 PM on 01/20/20 that she gave R51's medications, Gabapentin, Oxybutynin, Cholecalciferol,

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Glatopa, Remeron and Tramadol. The Report documented V35 administered R51's Sertraline at 8:58 PM.

On 1/28/20 at 1:40 PM, V2, Director of Nursing (DON), stated she did not do a Medication Error Report for R51's incident on 01/20/20 because there was no medication error made, even though R51's MAR and Medication Administration Audit form documented the medications were given. R51's Controlled Drug Administration Record for her Tramadol also documented that V35 did give R51 a dose of Tramadol that was scheduled for 8:00 PM, even though hospital medical records show R51 was not in the building at that time. V2 stated all controlled medications are counted every shift change. V2 stated V35 only made a transcription error. V2 stated V35 said she signed out some medications that she had not given to R51 in error because R51 was already out of the building at the time those medications were ordered to be given. V2 stated the hospital just assumed R51 had overdosed, but could not prove it because they did not do a toxicology screen.

On 02/26/20 at 2:43 PM, V34, Assistant Vice President of Clinical Operations, presented an unsigned, undated document regarding R51's Medical Record Review of her hospitalization, which she stated V6, Regional Nurse, just completed on the morning of 2/26/20, which documented, "Upon a comprehensive thorough investigation, including Medical Record review, staff interviews, it was undetermined on whether (R51's) medications were administered per Physician Orders."

On 02/26/20 at 11:40 AM, V20, R51's Primary Care Physician (PCP), stated he was not notified

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of R51's overdose or hospitalization on 01/20/20, but stated he is not surprised because there is no narcotic supervision by the nursing staff in the facility. V20 stated he has educated the nurses on the Passero Sedation Scale, which has specific guidelines for determining if a resident should receive a narcotic medication based on their assessment. V20 stated the nurses do not use the Passero Scale.

RN.com states the Passero Opioid-Induced Sedation Scale (POSS) enables the nurse to determine a patient's level of sedation before and after the administration of an opioid. A POSS score of S, 1, or 2 indicates an acceptable level of sedation, whereas a score of 3 or 4 indicated over-sedation and the need for a reversal agent.

On 2/27/20 at 4:55 PM, V42, R51's daughter/POA, stated V27, the nurse who takes care of her mother sometimes, had called her on 1/20/20 at about 6:30 PM and told her that he had seen R51 come out of her room in her wheel chair and her head fell back, and he thought she had had a stroke so he had called 911. V42 stated the doctor in the Emergency Room told her that R51 was given too much pain medicine that caused an overdose, but that when she went back to the facility to demand answers, V27 told her R51 didn't get any pain medicine, but stated R51 must have gotten all of her other medicines at one time. V42 stated V27 told her R51 must have gotten her medicines around dinner time because it was given before he got there at the start of his shift.

On 1/28/20 at 2:05 PM, V35 stated on 01/20/20 when she was R51's nurse, she did give R51's medication at the wrong time. V35 stated R51

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was complaining of pain so V35 decided to give her dose of Gabapentin that was scheduled for the night shift early. V35 stated she got wrote up and suspended for one day and had to be trained by the DON on doing a medication pass. V35 stated she did not give all the medications she signed out, but could not remember what medications she gave and what she did not give, because she waited until she had finished all her duties that evening and then went back and signed out her medications. V35 stated she was not sure exactly what time she gave R51 her medications on 01/20/20, but she worked the 2:00 PM to 10:00 PM shift on that date. V35 stated she knows she can give medications an hour before they are ordered or an hour after they are ordered, except for narcotics.

On 3/3/20 at 2:20 PM, V35, LPN, stated on 1/20/20 she gave R51 her medications at about 4:30 PM or 5:00 PM on that evening, but nothing before supper. V35 stated R51 was yelling that she was in pain, so she did go ahead and give her the 6:00 PM Gabapentin. V35 stated R51 was communicating with her without problem when she gave her her medications.

On 2/29/20 at 10:45 AM, V37, Hospitalist/Medical Doctor at local hospital where R51 was treated on 1/20/20 for an opioid overdose, stated the drug, Narcan, strictly reverses symptoms of an opioid overdose. V37 stated she would assume V39, Emergency Department Physician, would have seen some improvement with the administration of the initial dose of Narcan, or he would not have administered two more doses. V37 stated Narcan would not have improved any other condition other than an opioid overdose. She stated it would not have improved the signs and symptoms associated with a Urinary Tract

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Infection (UTI).

On 2/29/20 at 11:00 AM, V38, Pharmacist, stated Narcan only works on opioid receptors, and a suspected opioid overdose would have been the only reason it would have been given. He stated Tramadol given along with all of R51's other mind sedating medications given at the same time would explain her being lethargic. V38 stated he has never heard of Narcan being administered to treat lethargy or unresponsiveness from a UTI.

2. On 02/29/20 at 2:03 PM, R59's Medication Error Report, dated 01/23/20, documents R59 had a medication error on 1/23/20 when the nurse gave her AM and Noon medications at the same time. According to the medication error report, R59 felt "a little sleepy but was OK."

R59's Physician Order Summary, dated 2/29/20 for active orders as of 1/31/20, documents her diagnoses which include: Hypertension, Prosthetic Heart Valve, Anxiety Disorder, Paroxysmal Atrial Fibrillation, Heart Failure, Bipolar Disorder, and Pain in Right Lower Leg.

R59's January 2020 MAR documents she was to receive the following medications on 1/23/20 at 9:00 AM: Amiodarone 100 mg one tablet; Amlodipine 5 mg one tablet; Demadex 20 mg two tablets; Lamotrigine 25 mg give one tablet; Losartan 100 mg one tablet; Duloxetine 60 mg one capsule; Glucosamine-Chondroitin 3 tablets; Omeprazole 20 mg give one tablet; Metolazone 2.5 mg one tablet; Metoprolol Succinate ER 25 mg one tablet; Buspirone 10 mg one tablet; Indomethacin 25 mg one tablet; Primidone 50 mg one tablet; Potassium Chloride 20 mEq (milliequivalents)/15 mls.
R59's MAR documents the following medications

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ordered to be given on 1/23/20 at Noon: Buspirone 10 mg one tablet; Indomethacin 25 mg one capsule, Potassium Chloride 20 mEq/15 mls. R59 received two doses at one time of each of her noon medications on 1/23/20 when V41, LPN, administered her 9:00 AM and 12:00 PM medications all at the same time.

On 2/29/20 at 12:45 PM, R59 stated, "I'm ok. I don't have anything else to say."

On 03/3/20 at 10:55 AM, V41 stated she made a medication error on R59 on the day shift on 01/23/20 by giving R59 her morning medications and noon medications at the same time. V41 stated she put R59's morning medications in a cup and signed them out on her MAR on the computer, but when she went to give R59 the medications at 9:04 AM, R59 refused to take them at that time. V41 stated when she started her noon medication pass at 11:00 AM on 01/23/20, she gave R59 her morning medications, including her liquid potassium, and then also administered her noon doses of Buspirone, Indomethacin, and Potassium Chloride. V41 stated she reported this medication error to V32, Nurse Practitioner, who stated it was considered "double dosing", and said to monitor the resident. V41 stated she received a counseling from V45, Corporate Nurse, and two other corporate nurses, regarding the steps she should take if a resident refuses their medication,and was told not to go back and give medications after the one hour time frame was past. V41 stated the Facility has not had any inservices for nurses regarding medication administration or medication errors since she made the error with R59's medication.

3. On 02/23/20 at 09:47 AM, R255 stated the

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nurses missed some of his IV antibiotics when he was first admitted. R255 stated he still has some pain in his right side and is worried that he still has an infection.
On 02/24/20 at 11:23 AM V13, LPN, stated R255 missed his IV antibiotics because his Peripherally Inserted Central Catheter (PICC) line had come out and he couldn't get his IV's until it was replaced. She did not know how long his PICC line was out. V13 stated sometimes it takes a few days for R255's Medical Doctor (MD) to get back to the Facility with an order that is needed to send R255 out to the hospital to get his PICC line replaced.

R255's Patient Discharge Plan, dated 1/23/2020 at 3:44 PM, documents under Follow-up Instructions: "Contact hospital's (Medical Imaging Service), (included telephone number to call) for any of the following: If PICC line or Midline Catheter appears to be coming out." The Facility did not notify the Medical Imaging Service when R255's PICC line came out.

R255's Minimum Data Set (MDS), dated 01/30/20, documents he is alert and oriented to person, place, time and situation.

R255's Physician Orders, dated 1/24/20, documented the order: Vancomycin HCl in NaCl (normal saline) 1.25-0.9 Gram/150 ml %; Directions: use 1.25 Grams intravenously two times a day related to urinary tract infection.

R255's EMR documents his Medical Diagnoses include Urinary Tract Infection, Unspecified Cirrhosis of the Liver, Acute Viral Hepatitis, Type 2 Diabetes Mellitus, Polyneuropathy, Anemia, Gastro-esophageal Reflux Disease, and Polyneuropathy.

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R255's Patient Discharge Plan, dated 1/23/20 at 3:44 PM, documents under new medications: Vancomycin 1.25 Grams/150 ml intravenously every 12 hours; continue until drain removed. R255's discharge orders also included a laboratory order, dated 1/23/20, that documented his diagnoses to include: Infected Subcapsular Hematoma on Vancomycin IV.

R255's Order Recap Report, dated 03/05/20 at 9:06 AM, documents the following orders: 01/23/20 Vancomycin HCl in Normal Saline Solution 1.25-0.9 Gram/150 ml-% Use 1.25 gram intravenously two times a day related to Urinary Tract Infection, site not specified (N39.0) Vanco trough every Friday; fax to (Infectious Disease Clinic); 01/26/20 may have today's IV when returns from an outing; 02/03/20 Single lumen PICC line to be reinserted; 02/12/20 and 02/14/20 d/c (discontinue) PICC line.

R255's Emergency Room Hospital Records, dated 2/7/20 and ordered by ER physician at 7:09 PM, document under Follow Up: "Make sure you keep your follow up appointments. I will send an order for (Facility) to get you into the infusion unit to make sure you get your appropriate antibiotics."

R255's January 2020 and February 2020 MARs were reconciliated with his Medication Administration Audit Report, dated 02/25/20 for medications administered 1/24/20 through 2/25/20. According to both reports R255's IV antibiotic, Vancomycin, was not given or was given at the wrong times on the following dates: 1/24/20: the 8:00 AM dose was administered at 3:47 PM and the 8:00 PM dose was administered just 6 hours later at 9:36 PM.

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1/25/20: the 8:00 AM dose was administered at 10:23 AM and the 8:00 PM dose was not given.
1/26/20: the 8:00 AM dose was administered at 2:45 PM and the 8:00 PM dose was not given.
1/27/20: the 8:00 AM dose was administered at 11:46 AM and the 8:00 PM dose was administered at 9:13 PM
1/28/20: the 8:00 AM dose was administered at 11:10 PM and the 8:00 PM dose was administered at 9:39 PM
1/29/20: the 8:00 AM dose was administered at 5:23 PM and the 8:00 PM dose was administered just 3 hours later at 8:35 PM
1/30/20: the 8:00 AM dose was administered at 12:45 PM and the 8:00 PM dose was not administered because V2, DON, stated it was contaminated, but the next day the pharmacy stated they had sent out 4 doses on 1/30/20, but no explanation was given as to why one of the other doses was not administered.
1/31/20: the 8:00 AM dose was administered at 11:17 AM and then R255 pulled out his PICC line when removing his shirt.
2/1/20 No antibiotics given due to the PICC line being out.
2/2/20 No antibiotics given due to the PICC line being pulled out.
2/3/20 No antibiotics given. Nurses Note, dated 2/3/20, documents the PICC line to be replaced in the AM.
2/4/20 PICC line reinserted, but no antibiotics given due to medication on hold, but no order found stating medication on hold.
2/5/20 the 8:00 AM dose was administered at 10:42 AM and the 8:00 PM dose was not administered.
2/6/20 the 8:00 AM dose was administered at 9:54 AM and the 8:00 PM dose was not administered.
2/7/20 neither the 8:00 AM dose nor the 8:00 PM

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dose was administered as ordered.
2/8/20 the 8:00 AM dose was administered at 7:48 AM and the 8:00 PM dose was not administered.
2/9/20 the 8:00 AM dose was administered at 11:37 AM and the 8:00 PM dose was not administered.
2/10/20 the 8:00 AM dose was administered according to the MAR by V2, but there was no documentation time on the Medication Administration Audit Report, and the 8:00 PM dose was not given.
2/11/20 the 8:00 AM dose was administered by V2 at 11:32 AM and the 8:00 PM dose was not given.
2/12/20 No 8:00 AM dose was given and the medication was discontinued before the 8:00 PM dose was due to be given.

On 3/6/20 at 9:20 AM, V6, Regional Nurse, stated she would expect nurses to give residents their medications as ordered by the physician.

The Facility's Medication Administration Policy, dated 1/1/2015, documents, "Medications must be administered in accordance with a physician's order, e.g. (for example), the right resident, right medication, right dosage, right route, and right time. Medications may not be pre-poured, e.g., only prepare and administer medications for one resident at a time." This policy also documents "If a medication and/or treatment error occurs, the licensed nurse will: a. Immediately notify the attending physician, b. Describe the error and the resident's response in the Nurse's Notes, c. Complete an incident report, d. Identify the error on the 24 hour report, and e. Monitor the resident's status." The policy further documents, "When Class II medications (e.g. Tramadol) are administered, the medication is - a. Recorded on

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the Medication Administration Record by a licensed nurse, and b. Accounted for on the resident's individual, 'Control Substance Record' by a licensed nurse."

4. On 02/23/20 at 10:00 AM, R159 was observed in bed tearful, shaking and grimacing while she spoke and explained she had not received any medications for pain or for her infections. R159 stated she was admitted to the facility on 02/21/20. R159 stated she was in severe pain rating it "Beyond 10 out of 10" on the pain scale. R159 stated she had severe pain in her head and back and stated she felt like she was running a fever. R159 stated she was admitted to the facility from the hospital for IV medication treatment due to being diagnosed with Bacterial Meningitis (severe infection and inflammation of the brain), Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteremia of the blood and spinal cord (severe infection of the blood and spinal cord) and Infective Endocarditis (MRSA induced infection of the lining of the chambers of the heart). R159 stated V2, DON, told her on 02/23/20 at 9:30 AM that she was not in the facility's system and no one really knew she was here.

R159's After Visit Summary from her hospitalization, dated 2/21/20, documents her Medication List: START: Baclofen (muscle relaxer) 10 mg tablet Take 1 tablet by mouth 3 times daily, last given 2/21/20 at 8:10 AM- R159 missed at least 6 doses of this medication; Rifampin (antibiotic) 300 mg capsule Take 1 capsule by mouth every 12 hours, last given 2/21/20 at 8:11 AM- R159 missed at least 4 doses of this medication; Sodium Chloride 0.9% solution 50 ml with Ceftriaxone (antibiotic) 2 g

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(gram) Inject 2 g into the vein daily, last given 2/21/20 at 12:58 PM- R159 missed one dose of this medication; Vancomycin (antibiotic) 1-0.9 GM/250 ml-% solution IV piggyback Inject 250 mls into the vein every 12 hour hours, last given 2/21/20 at 2:19 PM- R159 missed 3 doses of this medication; CONTINUE: Gabapentin (for nerve pain) 100 mg capsule Take 200 mg by mouth nightly at bedtime, last given 2/20/20 at 8:33 PM- R159 missed 2 doses of this medication; Remeron (antidepressant) 15 mg tablet Take 15 mg by mouth nightly at bedtime, last given 2/20/20 at 8:34 PM- R159 missed 2 doses of this medication; Zanaflex (muscle relaxer) 4 mg tablet Take 4 mg by mouth 3 times daily, last given 2/21/20 at 12:20 PM- R159 missed at least 5 doses of this medication.

On 02/23/20 at 11:20 AM, V2 was observed preparing to hang two IV medications for R159. V2 stated that R159 was not put into the facility's system and therefore the medications did not get ordered properly. V2 was observed to hang Vancomycin 1 gm (gram) at 125 ml/hr through left forearm PICC line. At 11:40 AM, V2 was observed to hang Ceftriaxone 2 gm IV at 1 drop per minute.

R159's Physician's Order Sheet (POS), dated 02/22/20 at 12:35 PM, documented an order for "Vancomycin 1 gm IV twice per day, start at 4:00 PM" was initiated by V41, Licensed Practical Nurse (LPN). At 2:41 PM, this order was discontinued by V27, LPN, and a new order for the same medication was submitted by V27 to start at 4:00 PM on 02/22/20. This order was never carried out by staff on 02/22/20.

On 02/23/20 at 11:40 AM, V2 stated she had a call out to the physician regarding pain

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medication. V2 stated that no pain medications were ordered at this time.
At 12:35 PM, R159 was observed in bed. She stated she has had no change in her condition. At 1:00 PM, V2 stated she was still waiting on the call from the physician regarding R159's pain medications and that she could not give any medications until the physician called back. At 1:30 PM, 2:00 PM, 2:20 PM, 3:00 PM and 3:35 PM, R159 remained in extreme pain and had not received any pain medications. At 3:50 PM, V2, DON stated she had not heard from the physician regarding the pain medications for R159.

R159's MAR documented R159 received the first dose of Norco (Hydrocodone/Acetaminophen) 5/325 mg on 02/23/20 at 7:28 PM.

R159's POS, dated 02/23/20 at 3:30 PM, documented the order as "Norco tablet 5-325 mg (Hydrocodone-Acetaminophen) give 1-2 tablets by mouth every 6 hours as needed for moderate pain."

On 02/24/20 and 02/25/20, R159 continued to report extreme pain in her head and back and was not receiving pain medications as ordered.

The Controlled Drug Administration Record Tablet for R159 documented on 02/23/20, 16 tablets of Norco 5-325 mg were received at the facility.

On 02/29/20 at 10:01 AM, V38, Pharmacist, stated that the facility received and signed for 16 tablets of Norco 5-325 mg on 02/24/20 at 1:36 AM. V38 stated that an emergency physician to pharmacist call had been conducted on 02/23/20 at 4:29 PM in which the physician agreed to the order for the Norco for R159. However, R159 did not receive the first dose of Norco until 7:28 PM.

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On 02/25/20 at 3:07 PM, V17, LPN, stated she was the admitting nurse for R159 on 02/21/20. V17 stated R159 arrived at the facility approximately 5:30 PM via ambulance from the hospital. V17 stated she began the admission process around 5:50 PM and was only able to complete the initial skin, pain and diet portions of the admission. V17 stated she did not put in any medications or look to see what was ordered. V17 stated V2, DON, was in the facility when R159 arrived, but was gone when she had to stop doing the admission due to having to return to her medication pass for her other residents. V17 stated that at approximately 8:30 PM, she informed V2 that she was unable to finish R159's admission and was told to pass the admission to the next nurse on duty to finish. V17 stated she gave this information to V44, LPN (night nurse).

On 03/03/20 at 1:17 PM, V44, LPN, stated she worked on 02/21/20 starting at 10:00 PM. She recalled being informed by V17, LPN of R159's admission, but was not informed to finish her admission. She stated she did not do any assessments, give any medications or go into R159's room during her shift.

On 03/03/20 at 10:50 AM, V41, LPN, stated that she worked on 02/22/20 helping to orient V31, LPN. V41 stated that at 11:00 AM, she answered a call light for R159. She stated she was not aware that anyone was even in the room. V41 stated that R159 told her that she was in extreme pain as well and had not been given any medications.

On 02/26/20 at 11:31 AM, V20, Medical Director, stated he was not aware that R159 was admitted to the facility until 02/23/20 in the early afternoon

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when he received an order request for pain medication for R159. V20 stated he was not aware that IV medications and pain medications were not provided to R159 until 02/23/20. V20 stated he would expect the facility to follow standards of practice from accepting a resident, following the protocols for medication management especially with IV therapy and pain management. V20 stated the fact that the facility did not follow through with the admission process, the facility failed to set up the reasonable care measures to care for and provide effective treatment and services for R159. V20 stated he would expect the facility staff to provide continuous treatment according to the hospital discharge orders received.

R159's POS, dated 02/28/20, documented a new order to give Vancomycin 1.25 gm IV starting at 6:00 PM.

R159's MAR dated 02/29/20 at 6:00 PM, Vancomycin 1.25 gm IV was blank as not given.

On 02/29/20 at 10:01 AM, V38, Pharmacist stated that Vancomycin is an antibiotic used to treat bacterial infections, such as meningitis and MRSA blood infections. He stated that a blood trough level must be drawn after every third dose due to the risk of a patient becoming toxic which would affect organs of the body negatively. A low trough level is indicative of the wrong dosing or that the medication was not given as often as needed to kill off the infective agent. V38 stated that protocol with a person with meningitis should have Vancomycin trough levels of 15.0 - 20.0 mcg/ml in order to metabolize properly to fight the infection. V38 stated that R159's trough levels are critically low, indicating the Vancomycin was not effective enough to fight off the infection. He

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further stated that Vancomycin in IV form was used in a longer period of weeks to months to fight off the infection and that with critical trough levels this would prolong her healing process.

5. On 02/23/20 at 10:30 AM, R160 was observed with a PICC line in his left forearm. R160 stated it was used for his IV antibiotics. R160 denied having any other IV access.

R160's POS, dated 02/12/20, documented an order for Vancomycin 1.5 gm IV one time per day for 23 days.

The Medication Admin Audit Report for R160 documented:
On 02/12/20 at 7:31 PM, V50, LPN, administered Sodium Chloride Solution 0.9 % 10 ml IV to R160.
On 02/14/20 at 7:37 PM, V50, LPN, administered Sodium Chloride Solution 0.9 % 10 ml IV to R160.
On 02/17/20 at 5:29 PM, V50, LPN, administered Saline flush Solution 0.9 % 5 ml IV to R160.
On 02/18/20 at 8:05 PM, V27, LPN, administered Saline Flush Solution 0.9 % 5 ml IV to R160. At 8:59 PM, V27, LPN administered Sodium Chloride Solution 0.9 % 10 ml IV to R160.
On 02/19/20 at 6:08 PM, V50, LPN, administered Saline Flush Solution 0.9 % 5 ml IV to R160.
On 02/20/20 at 8:47 PM, V27, LPN, administered Saline Flush Solution 0.9 % 5 ml IV to R160. At 8:48 PM, V27, LPN administered Sodium Chloride Solution 0.9 % 10 ml IV to R160.
On 02/21/20 at 1:30 PM, V48, LPN administered Vancomycin 1.5 gm IV to R160. At 1:31 PM, V48, LPN administered Heparin flush 3 ml to R160.
On 02/22/20 at 11:20 AM, V31, LPN, administered Vancomycin 1.5 gm IV to R160. At 11:21 AM, V31 gave Heparin flush 3 ml IV to

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R160. At 7:27 PM, V27, LPN administered Saline Flush Solution 0.9 % 5 ml and Sodium Chloride Solution 10 ml IV to R160.
On 02/23/20 at 9:37 PM, V27, LPN administered Saline Flush Solution 0.9 % 5 ml IV to R160. At 9:38 PM, V27, LPN administered Sodium Flush Solution 0.9 % 10 ml IV to R160.
On 02/24/20 at 9:30 PM, V17, LPN administered Saline Flush Solution 0.9 % 5 ml IV to R160. At 9:35 PM, the Report documented V17, LPN administered Sodium Chloride Solution 0.9 % 10 ml IV to R160.

On 02/25/20 at 3:07 PM, V17, LPN stated she does not do anything with the PICC lines because she was not allowed to due to being a LPN.
On 02/25/20 at 3:12 PM, V27, LPN stated he does not touch a resident's PICC line and that anything to do with it has to be done by a RN.

(A)