| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 105749 | A. Building<br>B. Wing | 12/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Abbey Rehabilitation and Nursing Center | 7101 Dr Martin Luther King Jr St N<br>Saint Petersburg, FL 33702 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768<br><br>Based on observations, interviews, and record review, the facility failed to keep residents free from neglect related to 1.) failing to inform the attending physician of critical lab values in a timely manner and infusing three doses of Vancomycin after receiving those critical labs for one resident (Resident #1) of three sampled residents, requiring Resident #1 to be admitted to the Intensive Care Unit and receive renal dialysis and 2.) failing to provide a safe, secure environment, and adequate supervision for one resident (Resident #3) of three sampled residents, who had a history of alcohol abuse, methamphetamine abuse, homelessness, and leaving medical facilities against medical advice (AMA). The facility also failed to properly assess Resident #3 for Leave of Absence, who had an Intravenous site at the time.<br><br>Findings included:<br><br>1.<br><br>During an observation on 12/11/2024 at 11:10 a.m. Resident #1 was lying in bed on an air mattress. An interview was conducted with Resident #1. He stated he had a big a decubitus ulcer on his bottom from being in another facility. The resident had a urinary catheter and an IV (intravenous) access in his left upper arm. He stated he was getting antibiotics. It was noted on the door he was on contact isolation precautions. He stated the staff mostly used gowns and gloves when they come in the room.<br><br>Resident #1 was admitted on [DATE] and readmitted on [DATE]. Review of the Admission Record showed diagnoses included but not limited to pressure ulcer of sacral region, stage IV, necrotizing fasciitis, chronic kidney disease, neuromuscular dysfunction of bladder, extended spectrum lactamase (ESBL) resistance, diabetes, hypertension, benign prostatic hyperplasia with lower urinary tract symptoms, retention of urine, and adult failure to thrive.<br><br>Review of Resident #1's Minimum Data Set (MDS) assessment dated [DATE] showed the following:<br><br>- Section C - Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 11 (moderately impaired).<br><br>- Section I - Active Diagnoses showed wound infection, renal insufficiency or renal failure, and pressure ulcer of sacral region stage IV.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - Section M - Skin Conditions showed one stage IV pressure ulcer.<br><br>- Section N - Medications showed the resident was on antibiotics.<br><br>- Section O - Special Treatments, Procedures, and Programs showed he was receiving Intravenous (IV) antibiotics.<br><br>Review of Resident #1's Order Summary Report, for the date range 10/28/2024 to 11/30/2024, showed the following:<br><br>- Pharmacy to dose Vancomycin (Vanco) as of 11/1/2024.<br><br>- Transmission Based Precautions, Contact Precautions-ESBL, wound as of 10/30/2024.<br><br>- Vancomycin HCL (hydrochloride) in NaCL (sodium chloride) Intravenous Solution 750-0.9 mg (milligrams)/250 ml (milliliters) % use 750 ml intravenously two times a day for ESBL in wound as of 10/29/2024.<br><br>- Vanco trough, one time only for monitoring and fax results to pharmacy, ordered on 11/13/2024 and revised on 11/14/2024.<br><br>- Vanco trough only, NO VANCO PEAK and fax results to pharmacy ordered on 11/13/2024 and revised on 11/14/2024.<br><br>- CBC (Complete Blood Count) with differential, CMP (Comprehensive Metabolic Panel) STAT (right now) ordered on 11/13/2024 and revised on 11/14/2024.<br><br>- Appointment on 11/14/2024 with the Infectious Disease physician at 10:00 a.m.<br><br>Review of Resident #1's November 2024 Medication Administration Record (MAR) showed the following:<br><br>- Vancomycin HCL in NaCL Intravenous Solution 750-0.9 mg /250 ml.% use 750 ml intravenously two times a day for ESBL in wound as of 10/29/2024 was administered on 11/13/2024 at 5:20 a.m. by Staff J, Licensed Practical Nurse (LPN), 11/13/2024 at 6:02 p.m. by Staff H, LPN, and 11/14/2024 at 5:52 a.m. by Staff I, Registered Nurse (RN).<br><br>Review of Resident #1's November 2024 Treatment Administration Record showed the following:<br><br>- CBC, CMP, sed rate and Vanco trough scheduled for 11/13/2024<br><br>- Vanco trough, one time only for monitoring and fax results to pharmacy, performed on 11/13/2024 at 6:32 a.m.<br><br>- Vanco trough only, NO VANCO PEAK and fax results to pharmacy was performed on 11/14/2024 at 7:38 a.m.<br><br>- CBC with differential, CMP, STAT performed on 11/14/2024 at 8:25 a.m.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of Resident #1's lab values showed the following:<br><br>- On 11/13/2024 Vancomycin Peak was drawn at 7:00 a.m.: Vancomycin Peak was 78.3 (20.0 -40.0). On 11/13/2024 at 9:29 a.m. the critical results were read back and acknowledged.<br><br>- On 11/13/2024 a CBC, CMP was drawn STAT at 8:30 p.m. with the following results: Sodium 122 (L) (136-145), Potassium critical value 8.1 (HH) (3/5-5.1), Creatinine 4.45 (H) (0.70-1.30), eGFR (estimated glomerular filtration rate) 13 or below, 15 may mean kidney failure. On 11/13/2024 at 10:41 p.m. the following critical results were read back and acknowledged by Staff I, RN: a Potassium level of 8.1, high critical.<br><br>- On 11/14/2024 a Vancomycin Trough was drawn at 3:45 a.m. The Vancomycin Trough was 74.1 (10.0-20. 0). On 11/14/2024 at 6:16 a.m. the critical results were read back and acknowledged by Staff I, RN.<br><br>A review of Resident #1's Progress Notes showed the following:<br><br>- On 11/13/2024, 3:37 p.m. a Summary for Providers note, written by Staff F, LPN, revealed Resident #1 had a change in condition, documented under the section titled Situation: Other change in condition. The section titled Primary Care Provider Feedback documented: perform stat labs and urine.<br><br>- On 11/13/2024 at 3:43 p.m. a CNA (Certified Nursing Assistant) reported Resident #1 had a small amount of urine in the Foley bag, which was reported to the M.D. (Medical Doctor). Received an order to irrigate and change Foley catheter. Blood work on electronic chart and urine sample in the soiled utility room fridge. Passed to the next shift. Written by Staff F, LPN.<br><br>- On 11/14/2024 at 7:59 a.m., a Post Event Every Shift Nursing Note Assessment Initiated showed MD notified and treatment initiated. Written by Staff G, RN, Unit Manager (UM).<br><br>- On 11/14/2024 at 8:46 p.m. an eMAR (electronic medication administration record) Note showed Resident #1 was at the hospital. Written by Staff H, LPN.<br><br>Review of Resident #1's Hospital records showed the following:<br><br>- A Nephrology consult dated 11/14/2024 showed: (Resident #1) presented due to abnormal labs that were drawn the evening before. Labs at 2030 (8:30 p.m.) yesterday evening showed a potassium of 8.1, sodium 122, chloride 91, CO2 (carbon dioxide) of 20, BUN (Blood Urea Nitrogen) 78, creatinine of 4.45. Patient has been treated for hyperkalemic protocol. He is apparently on Vancomycin and Vancomycin peak was 78.3 and trough of 74.1. Assessment: Acute kidney injury secondary to bladder outlet obstruction in combination with Vanco toxicity hyperkalemia, hyponatremia, metabolic acidosis, Vanco toxicity, large sacral decubitus, BPH [benign prostatic hyperplasia] with urinary retention. Plan: daily dialysis for Vanco toxicity, stat Vanco level 81.9, daily Vanco levels, do not resume Vanco at this time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - An Infectious Disease Service Consult on 11/14/2024 showed Vanco level was found to be 74 and Vanco was discontinued. Assessment: necrotizing fasciitis sacral area, suspected osteomyelitis of sacral area, bilateral pneumonia with possible aspiration with Haemophilus influezae, suspected UTI (urinary tract infection) with E. (Escherichia) coli, vancomycin related nephrotoxicity with hyperkalemia, diabetes, and respiratory failure. Plan: will continue to monitor once Vanco level falls below 15 then will start patient on daptomycin.<br><br>- An Internal Medicine note dated 11/17/24 showed Acute renal failure, suspected Vanco toxicity, hyperkalemia, hyponatremia, d/c (discontinue) Vanco due to acute renal failure.<br><br>Review of Resident #1's care plan showed the resident had a sacral/coccyx stage 4 wound, complications related to wound healing related to infection, diabetes, and PVD. Interventions included but not limited to Enhanced Barrier Contact Precautions, obtain and review lab/diagnostic work as ordered, and report results to MD and follow up as indicated, as of 11/21/2024. Resident #1's care plan also revealed the resident is on antibiotic therapy related to having MRSA (Methicillin-resistant Staphylococcus aureus) in sacral/coccyx wound. Interventions included but not limited to administer medication as ordered and report pertinent lab results to MD.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During interview on 12/12/2024 at 10:02 a.m. Staff G, RN, UM, stated Resident #1 was a long-term care resident with a wound on his buttocks. The resident was receiving Vanco and another antibiotic IV for his wound. Staff G RN, UM stated the resident required total care, including a mechanical lift, and he rarely got out of bed because he did not want to get out of bed. Staff G RN, UM stated Resident #1 had a Stage III pressure ulcer and got labs drawn one to two times a week, to manage the Vanco levels. Staff G RN, UM also stated they sent the results (lab) to the ID (Infectious Disease) doctor. Staff G RN, UM stated the day Resident #1 was going to the ID doctor, they physically put the lab results in an envelope instead of faxing the labs to the doctor, which was done by the nurse. Staff G RN, UM also stated she printed the labs, but did not look at them and did not review the labs. Staff G RN, UM stated she logged into the lab website, clicked and printed the labs, and the nurse picked the labs up off the printer. The nurse involved was Staff F, LPN on 11/13/2024. Staff G RN, UM stated she does not remember when the labs came in and she was not notified of any abnormal labs when she came in that morning on 11/13/2024. Staff G, RN, UM stated now, she checks the labs herself to see all the labs. Staff G RN, UM also stated the nurses notify her sometimes now, but not all of the nurses notify her. Staff G RN, UM stated she works Monday through Friday, 7 a.m. to 3 p.m. and the weekend supervisor or the nurses working on the weekend should check the labs on evenings and weekends. Staff G RN, UM stated they (the nurses) were all trained and went through the process to make sure they were following up with the labs, calling the doctor and the family. Staff G RN, UM also stated she started at the facility on 11/12/2024 and started that process with the DON (Director of Nursing) to make sure they were following up with the labs, calling the doctor and the family. Staff G, RN, UM stated they all received the log-in documentation to get labs and call the doctor and they are to document in the progress notes that they talked to the doctor. The lab results are kept in the patient's hard/paper chart. Staff G RN, UM stated on Monday she goes to the portal and checks the labs, checks the patient chart and MAR to make sure all labs are completed, and the DON double checks the labs. Staff G RN, UM also stated the nurses are responsible to review the labs, call the doctor and write orders. Staff G RN, UM stated they normally do Vanco troughs here for every patient, the labs are sent to the pharmacy, and based on pharmacy recommendations the dosing and follow-up labs are followed. Staff G RN, UM stated Staff F, LPN was the day nurse on 11/13/2024, and just took the labs off the printer and put them in the envelope for the transport. Staff G RN, UM stated Staff I, RN was the night nurse who had received the call the night before about the lab results. Staff G, RN, UM stated her expectation was for any critical labs to be called to the doctor, no matter what time.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/12/2024 at 10:48 a.m. Staff F, LPN stated she had worked with Resident #1 a couple of times at the facility. Staff F, LPN stated, I was having to log in for labs, but I did not have access at that time [on 11/13/2024]. That day they hired a UM, and she was the one who brings the labs. Staff F, LPN stated, I did not look at the labs. The UM printed everything and put it in an envelope and the face sheet. I was passing meds and asking for help. The laptops do not print, and I asked for help from the UM to print the forms and went back to passing meds. Staff F, LPN also stated, They only told me, I don't remember what was abnormal (labs) but not the Vanco level. Staff F stated, The labs were done the night before. [Staff I, RN] reported to me something was abnormal but not the Vanco. Staff F, LPN also stated, I don't have any way to see [the labs]. Staff F, LPN stated she went to the DON when she started working at the facility and asked her for the lab access, but she was a traveling DON and did not know how to get access. Staff F, LPN also stated she did not ask the UM for labs. Staff F stated, The way [Staff I, RN] reported, [the doctor] had the [lab] report, they did these labs, and [Resident #1's] was okay. Staff F, LPN also stated, [Staff I, RN] said she called the doctor and to keep an eye on when the doctor calls. Staff F, LPN stated she wrote a statement about the incident and, [the facility] knew what was going on over there, the UM started that day. They did not tell me about the appointment. I knew I needed a face sheet, labs, meds. Everything was a rush. So, the UM handed me the face sheet, med list, and labs. I put them into the envelope and rushed off.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/12/2024 at 11:44 a.m. with the Nursing Home Administrator (NHA) and the DON, the NHA stated on 11/14/2024 she was observing on the 100 main nursing station and overheard Staff F, LPN talking to the Infectious Disease clinic and asking questions in reference to the labs sent with Resident #1. The NHA stated Staff F, LPN was speaking with them (ID) and the ID clinic was transferring Resident #1 to the hospital. Staff F, LPN told the NHA, Resident #1 had a critical lab. The NHA stated she started the investigation and spoke with Staff E, Traveling DON and Staff G, RN, UM in the conference room. The NHA stated she told Staff E, Traveling DON and Staff G, RN, UM the ID clinic was sending Resident #1 to the hospital. The NHA stated Staff F, LPN initially told her she was not aware of the lab results when she gave the labs to transportation, she put the results in the envelope and handed them over. The NHA also stated once they started to investigate and looked back, they looked at the orders and lab results. The NHA stated Staff G, RN, UM told her she was not aware of the lab results; she just printed them. The NHA verified Staff I, RN's first statement which showed resident had abnormal blood work results. RN was passing meds. I intended to call MD in a.m. where I thought I would get a response. There was an admission I had to work on my shift. The resident had no [signs and symptoms] of the abnormal labs in my shift. Signed 11/14/24. The NHA verified the second statement by Staff I, RN showed, on 11/20/24, on the night in question, I had many things to tend to. I believe that a Vanco trough level was drawn sometime that evening or early night shift. I believe that if I knew I should have placed a phone call out to the MD. I do know I hung the 0500 Vanco and passed the results of the trough off to the day nurses with another lab result. And explained to her that I hadn't called the MD in the night. Both statements were provided by the NHA. The NHA stated, I called [Staff I, RN] and spoke to her first, she came in and wrote a statement. I explained that there was critical lab/Vanco level. She said she tended to the admission and did not call the doctor. [Staff I, RN] did admit that she knew the Vanco was critical. I asked her why she did not follow the protocol, call the DON and the MD. She instead handled the admission. The NHA stated they brought Staff I, RN back in after doing the investigation. The NHA stated, [Staff I, RN] admitted hanging the Vanco after getting the critical Vanco lab. She acknowledged she should have followed a different protocol, of calling the MD, calling the DON, and not hanging the Vanco. She stated she mentioned to [Staff F, LPN] about the abnormal labs, but it was just word of mouth at this time. The NHA stated Staff F, LPN was getting ready to send Resident #1 out to the appointment around 8 a.m., and she just grabbed the paperwork and sent it off. The NHA verified the statement from Staff F, LPN dated on 11/14/2024 showed, During report nurse-to-nurse today, my co-worker report [to] me only results from Vanco levels. No more labs was reported to pass to me. The NHA verified a second statement from Staff F, LPN on 11/15/2024, showed, that morning night shift only report me Vanco trough levels. I start passing meds, but I stop for print face sheet and med list from the patient. I went to the nurse station and log me in from the print the papers if request to the UM to print the recent labs. She found an envelope and pass the envelope to me. I put the face sheet and med list papers inside and give it to transport. Labs all ready was in the envelope. The NHA stated during the investigation, they got the information about the 11/14/2024 incident and found the 11/13/2024 critical Vanco peak. The NHA stated, I asked [Staff F, LPN] if she called a doctor about the 11/13/2024 [Vanco peak] and she stated to me I called him for several things, and I thought for sure I told him about the labs. She was not confident enough to say she had or not. The NHA stated she called the doctor herself just to ask him (MD) if Staff F, LPN called him about the critical labs. He (the doctor) stated he did not recall, and he had spoken with Staff F, LPN several times and knows his orders would be standard to send the resident out. The NHA stated when she interviewed Staff F, LPN, She stated to me, when she got the envelope, she put the labs in the envelope and gave it to the transportation. The NHA verified two nurses had knowledge of Resident #1's critical labs on two different days, and no one called a doctor or the DON, and the protocol was to call both. The NHA verified the statement from Staff J, LPN which showed, labs were drawn at 2:30 a.m. on 11/13/24 for trough and peak. Peak was drawn by mistake. Call labs back and reordered trough at 8:30 a.m. peak was mistakenly ordered by the nurse. The NHA stated after they obtained the statements, they continued their investigation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/12/2024 at 1:06 p.m. Staff I, RN stated she was working the night shift on 11/12 through 11/13/2024, and she checked on Resident #1 many times. Staff I, RN also stated, I received the lab results and was going to call the doctor the next morning .The results came in late in the night. It was an elevated abnormal potassium. I make a little mistake once in a while and not call a doctor. All I remember is [the lab] calling about the potassium. I know they drew the Vanco. I was busy putting in orders and room changes. The potassium level was 74. That was the potassium level. There is just so much to do there. I had 28-30 patients to work with. I was going to call [the doctor] at 7 a.m., I forgot to call. I left all the things on the desk and told the day nurse. I expected the day nurse to call the doctor. I have called the doctors many times at night, and they do not call back. I had a lot to do that night. I have not been involved in Vanco levels, hanging the antibiotics. It is a difficult place to work.<br><br>During an interview on 12/12/24 at 2:03 p.m. Staff E, Traveling DON, stated she was notified by the NHA, and the UM, Resident #1 had gone to an appointment and had critical labs and was sent to the hospital on 11/14/2024. Staff E, Traveling DON also stated, I was told he had a critical Vanco trough level. The NHA said she called the Risk Manager regarding, and they said to report it, and an investigation was started. I with the NHA spoke with [Staff I, RN], the night nurse. I did ask why she did not use her nursing judgment and call the doctor, and her response was [the doctors] don't answer on night shift. I asked [Staff I, RN] about using her nursing judgement to send him to the hospital. Staff E, Traveling DON stated Staff I, RN responded, I guess you're right. Staff E, Traveling DON stated Staff I, RN had to come in and write a statement. Staff E, Traveling DON also stated she was not informed of Resident #1's abnormal potassium levels and was only aware of the abnormal Vanco levels initially. Staff E stated, Once I looked at the labs and saw the critical potassium. I could not understand [Staff I, RN's] thinking. I am not sure if [the labs] were called at the same time. Staff E, Traveling DON verified the dates and times of the critical labs and stated, They were not acted upon, I see that. Staff E, Traveling DON verified two extra doses of Vanco was given even though there were critical labs and stated, My expectation was nursing 101, critical labs call the doctor. Immediately send him out and call the doctor. Nurse to call the DON. Pharmacy gets a copy to dose. If pharmacy had received, they would have given us orders to hold or next process. The nurse was responsible to fax [the labs] to the pharmacy. She did not talk to the doctor. Staff E, Traveling DON stated the only part of the investigation she was part of was to speak with Staff I, RN. Staff E, Traveling DON also stated, I did the education on lab logins, how to use labs, input the labs into the computer, process of to call the doctor, write a progress note if orders or change orders. I did not include sending to the pharmacy. Lab results are filed in the hard chart. They are to get a report-to-report. Staff E, Traveling DON stated the labs are in the lab book of who had labs that day and there was a printout of who had labs for the day. The critical labs are brought to the morning meeting, if the nurse documents in the clinical dashboard.<br><br>During a second interview 12/12/2024 at 2:30 p.m. with the NHA and the DON, they stated they found the elevated potassium level after the fact when they went deeper into the investigation.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/12/2024 at 3:05 p.m. with Resident #1's attending physician, the attending physician stated, I just started coming here. If [the labs] had been reported to us, we would have sent [Resident #1] to the hospital. I have a lot of patients and don't remember them all. My expectation was for the nurse to call me and call pharmacy with critical labs. Call right away and not wait. With elevated potassium of 8.1, sodium of 122, creatine of 4.45; the Vanco peak of 78.3 and Vanco trough of 74.1 the Vanco was frying his kidneys. He needed to be in the ICU. The attending physician also stated, Yes, we have someone on 24/7, they should have called as soon as they got the critical results.<br><br>During an interview on 12/12/2024 at 3:29 p.m. with the Consulting Pharmacy providing the Vanco to Resident #1, the Pharmacist stated their expectation was to receive labs for the dosing of the Vanco. He would expect to get a fax of the lab results. If they had any questions they would call the facility. If the labs are critical, they would prefer a call so they can be discussed.<br><br>Review of the facility policy titled Laboratory Services, dated August 2024, showed under Policy, the facility will provide or obtain laboratory services to meet the needs of its residents. The facility will be responsible for the quality and timeliness of services whether provided by the facility or an outside agency. The policy also showed the following under Procedure:<br><br>1. Assure laboratory test or completed and results provided to the facility within time frames normal for appropriate interventions.<br><br>2. Provide or obtain laboratory services only when ordered by a physician.<br><br>3. Assure nursing notifies the physician promptly of the findings .<br><br>5. Assure the laboratory reports submitted by the laboratory and filed in the resident / patient's clinical record contain at least the following: a. date B. Resident name C. Name and address of the testing laboratory<br><br>6. Monitor services, timeliness, and quality through the Quality Assurance Committee.<br><br>Review of the facility policy titled Care Plan-Interdisciplinary Plan of Care form Interim to Meeting, dated February 2024, showed under Policy, the facility shall support that each resident must receive, and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The facility shall assess and address each issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition, and responding with appropriate interventions. The comprehensive care plan is an interdisciplinary communication tool. It includes measurable objectives, and time frames and describes the services that are to be furnished to or attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The overall care plan should be oriented towards: 1. Preventing avoidable declines in functioning or functional levels or otherwise clarifying why another goal takes precedence. Managing risk factors to the extent possible or indicating the limits of each of such interventions.<br><br>(continued on next page) |

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|---|---|---|---|
| | 105749 | A. Building<br>B. Wing | 12/12/2024 |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Review of the facility's policy titled Medication Administration, September 2018, showed under Policy, medications are administered as prescribed in accordance with the manufacturers' specifications, good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication.<br><br>50434<br><br>2.<br><br>Review of Resident #3's Hospital record revealed Resident #3 was hospitalized from 8/1/2024 to 8/15/2024. The History of Present Illness (HPI) section revealed the following: Patient (Resident #3) is a [AGE] year old male with a past medical history of hypertension, alcohol use, tobacco use, and history of open reduction internal fixation, who presents to the ER (emergency room ) with complaints of worsening right wrist pain. He was recently admitted on [DATE], due to a right wrist abscess, which was MRSA positive osteomyelitis for which he underwent irrigation/debridement. He required 6 weeks of IV Vancomycin as per ID recommendations for which he received a total of 10 days of antibiotics before leaving AMA on July 26th. Today (8/1/2024), the patient arrived at ER due to progressive worsening pain and swelling of the right wrist.<br><br>Review of Resident #3's Admission Record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including primary osteoarthritis right wrist, arthritis due to bacteria, great wrist, alcohol abuse, housing instability, housed, homelessness and past 12 months, other psychoactive substance abuse, tobacco use, and patient's other noncompliance with medication regimen for other reasons.<br><br>Review of Resident #3's medical record revealed two elopement risk assessments, both completed on 8/16/2024, which did not indicate Resident #3 was an elopement risk.<br><br>Review of Resident #3's Order Summary Report for December 2024 revealed the following orders:<br><br>- 8/19/2024: LOA Independent<br><br>- 8/16/2024: IV: Change Injection cap every 7 days as well as PRN (as needed). Injection cap to be changed after each blood draw. Every day shift every 7 day(s) for iv therapy.<br><br>- 8/16/2024: IV: Change IV dressing every 7 days as well as PRN for soiling and or dislodgement. Every evening shift every 7 days.<br><br>- 8/16/2024: IV: Measure external catheter length every 7 days and as needed with dressing change. Every day shift every 7 days for maintain iv access IV.<br><br>- 8/16/2024: Vancomycin HCl in NaCl intravenous Solution 750-0.9 MG/250 mL-% (Vancomycin HCl-Sodium Chloride) Use 1 dose intravenously every 12 hours for osteomyelitis until 9/12/2024 13:01 (1:01 p.m.).<br><br>Review of Resident #3's Progress Notes revealed:<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | - A note dated 8/16/2024 at 1:15 p.m. documenting a skin check was completed for Resident #3. Resident has a PICC (peripherally inserted central catheter) line in the left upper arm, for IV therapy post incision 7.5 cm (centimeters) right wrist, all other skin completely intact; will continue to monitor.<br><br>- An Admission note dated 8/16/2024 at 1:50 p.m.: Admitting Diagnosis: Right wrist osteomyelitis, observation of resident speech: clear .The resident stated reason for admission: IV therapy .The resident or resident representative stated discharge goal: other discharge location arrangements (i.e. group home or hotel) .No, the resident does not use alcohol. No, the resident does not use illegal drugs .The resident has NOT had any of the following: current psychotropic medication use, balance issue with sitting, standing or walking, wandering use of restraint .Yes, Is resident currently receiving antibiotics Route: IV .The resident is Independent for Eating. The resident is Independent for setting up supplies and/or brushing their teeth or Dentures. The resident is Independent for toileting. The resident is Independent for bathing .<br><br>- A note dated 8/16/2024 at 3:02 p.m. documenting Resident #3 was admitted for IV therapy and would like to go LOA to the store. A call was placed to physician for instructions.<br><br>- A Shift Level Administration note dated 8/17/2024 at 7:35 a.m.: Spoke to the pharmacist regarding the order of Vancomycin HCl IV not be delivered yet. The pharmacist requested new order for serum creatinine level to be drawn. Laboratory order placed and creatinine was drawn. Waiting for results. Day shift made aware.<br><br>- A Medication Administration note dated 8/17/2024 at 11:38 a.m. documenting Resident #3's Vancomycin HCl IV would be delivered that evening.<br><br>- A Medication Administration note dated 8/17/2024 at 1:48 p.m. documenting the facility was awaiting lab results for Resident #3.<br><br>- A Medication Administration note dated 8/17/2024 at 11:20 p.m. documenting Resident #3 was absent from the facility.<br><br>- A note dated 8/18/2024 at 4:21 p.m.: Resident [#3] is alert and oriented, with independent LOA Order. On 8/17/2024, he left the facility in stable condition to go to [a local] hospital. On 8/18, the admissions department was notified by .Hospital this resident was admitted for Osteomyelitis. Signed by the DON.<br><br>- A Social Services note dated 8/19/2024 at 6:59 p.m. documenting a wellness check was conducted for Resident #3 while Resident #3 was in the hospital.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview on 12/11/2024 at 2:50 PM the NHA stated Resident #3 was alert and oriented and he was able to mobilize independently. She stated on 8/17/2024, she received a call from nursing staff stating Resident #3 was missing from the facility. The NHA started the investigation by asking staff when the last time they saw Resident #3. She stated the nurse assigned to Resident #3 stated she went to administer the IV antibiotics and noticed he was gone. The NHA interviewed the smoking-aide, who stated she had not seen the resident at the last smoking session. At this point, she started a full investigation, called the police, Department of Children and Families (DCF), and reported to the State Agency. She called all of the staff from that day to check on the resident's demeanor. When she contacted the emergency contact for Resident #3, he provided information related to where the resident would normally hang out. The NHA stated she started to call hospitals and found the hospital where Resident #3 was. She was able to speak with Resident #3, who told her he snuck out of a window. He told her he was able to twist the screws from the window and popped the window open. He then used a bench that was in front of the fence and jumped over the fence into the neighbor's yard. The NHA stated they also found a note on Resident #3's bedside table explaining he left the building.<br><br>During an interview on 12/12/2024 at 11:16 a.m. with Staff C, CNA, she stated Resident #3 kept asking the nurse for his IV antibiotics, and they were scheduled at certain times. Resident #3 kept reminding the nurse throughout the day and the nurse would just brush him off. Staff C, CNA stated around 2 or 2:30 p.m. on 8/17/2024, she reassured Resident #3 he would get his medication. Staff C, CNA also stated before she left her shift around 3:00 p.m., she saw Resident #3 out on the patio smoking. She stated as she was returning to |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34768<br><br>Based on observations, interviews, and record review, the facility failed to implement an effective Infection Control and Prevention program by 1.) failing to ensure staff donned appropriate personal protective equipment (PPE) while caring for a resident under Enhanced Barrier Precautions for one resident (Resident #5) of two residents sampled for Infection Control precautions, and 2.) failing to ensure staff donned appropriate PPE while in the room of a resident under Transmission Based Precautions for one resident (Resident #4) of two residents sampled for Infection Control precautions.<br><br>Findings included:<br><br>A review of Resident #5's Admission Record showed Resident #5 was admitted on [DATE] and was readmitted on [DATE]. Review of the Admission Record also showed diagnoses including but not limited to cachexia, obstructive and reflux uropathy, gastrostomy status, neuropathic bladder.<br><br>Review of Resident #5's Order Summary Report, active as of 12/12/2024, showed an order dated 6/24/2024 for Enhanced Barrier Precautions while providing direct care for G-tube (gastrostomy tube) and wound.<br><br>Review of Resident #5's care plan showed the resident required Enhanced Barrier Precautions related to gastrostomy tube and IV (intravenous line) as of 11/18/2024. Interventions included but not limited to Enhanced Barrier Precautions/gloves and gowns to be worn when providing high touch resident care as of 05/13/2024.<br><br>A review of Resident #4's Admission Record showed Resident #4 was admitted on [DATE]. Review of the Admission Record also showed diagnoses included but not limited to cellulitis of right and left lower limbs, cutaneous abscess of limb, sepsis, and MRSA (Methicillin-resistant Staphylococcus aureus).<br><br>Review of Resident #4's Order Summary Report, active as of 12/12/2024, showed an order dated 12/7/2024 for Transmission Based Precautions/Contact Precautions - ESBL (extended-spectrum beta-lactamase)/MRSA.<br><br>Review of Resident #4's care plan showed the resident has an infection, MRSA/ESBL. Interventions included but not limited to Contact Precautions as of 12/9/2024.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an observation on 12/11/2024 at 10:06 a.m., Resident #5 was lying in bed. Resident #5 asked to have her brief to be changed. Resident #5 turned on her call light at 10:06 a.m. Observed Resident #5 had a feeding tube in place. On the door, Contact Precautions, everyone must: clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. (Photographic Evidence Obtained) An employee walking down the hallway went in the room and came out of the room and was overheard telling Resident #5 she would get her aide. Staff K, Certified Nursing Assistant (CNA) came down the hallway, performed hand hygiene, and entered the room at 10:09 a.m. and stated she would be back. Staff K, CNA exited the room without hand sanitizing. While going down the hallway, Staff K, CNA touched another resident on the shoulder. Staff K, CNA went to the closet in the hallway and gathered a bag of towels. Staff K, CNA returned to the room at 10:12 a.m. and entered without a gown or gloves on and shut the door. At 10:20 a.m. Staff K, CNA was observed providing care without a gown on, only gloves. Staff K, CNA exited the room at 10:33 a.m. and walked down hallway to another closet for more items. Staff K, CNA returned to the room and an interview was conducted. Staff K, CNA stated she washed her hands only and the sign on the door was for contact precautions. Staff K, CNA also stated she did not see the sign and she should have put on a gown and gloves, but she only put on gloves. Staff K, CNA stated she did not know which residents were on the contact isolation precautions and she did not know which one was on Enhanced Barrier Precautions (EBP) and there was not an EBP sign on the door. Staff K, CNA stated residents with a catheter should be on EBP and she was not sure if a resident with a g-tube should be on EBP or not. Staff K, CNA also stated, they usually tell us, but I did not get report. Staff K, CNA stated she did not see the PPE container outside of the door nor the posted signage. Staff K, CNA was observed to have long, artificial fingernails. Staff K, CNA was not able to state any concerns related to infection control and having long fingernails.<br><br>During an interview on 12/12/2024 at 10:02 a.m. Staff G, Registered Nurse/Unit Manager (RN/UM) stated Resident #5 was a long-term care resident and was receiving Vancomycin (Vanco) for osteomyelitis. Staff G, RN/UM also stated Resident #5 had a gastrostomy tube and no wounds and the resident was on Enhanced Barrier Precautions due to the g-tube, not due to having an IV. Staff G, RN/UM stated Resident #4 was on Contact Precautions due to having MRSA in a right hip wound and ESBL in the urine. Resident #4 was also receiving Vanco via IV. Staff G, RN/UM stated Resident #4 had a #6 sign above her bed, meaning she was on Contact Precautions. Staff G, RN/UM also stated there should be an Enhanced Barrier sign on the door also because Resident #5 is on EBP. Staff G, RN/UM stated the staff should know the type of precautions the residents are on, which should be communicated during report for each resident. Staff G, RN/UM stated due to Resident #5 being on Contact Precautions, the staff should put on a gown and gloves for incontinence care and if a possibility of spilling, they need goggles as well. Staff G, RN/UM also stated the aide should have worn a gown, gloves, and if possible splashing, she needed a face shield while performing incontinence care for Resident #5.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview on 12/12/2024 at 2:48 p.m. the Infection Control Preventionist/Assistant DON (ICP/ADON) and DON stated the PPE for contact isolation was the use of gloves and gowns and, depending on what they are doing, a mask. The ICP/ADON stated for EBP, staff should use gloves and gowns for incontinence care. The ICP/ADON also stated the staff should be aware of what type of PPE to be used and precautions based on the door signage posted and the information received in report. If contact isolation signage is on the door, there should be a blue #6 over the bed which correlates with EBP. The ICP/ADON stated Resident #4 was on contact precautions due to ESBL in the wound, a surgical site with a lot of drainage. The ICP/ADON also stated Resident #5 was EBP only, due to having a g-tube and IV. The ICP/ADON stated the floor staff should not have long artificial nails due to infection control issues and they should be trimmed neatly.<br><br>Review of the facility policy titled Isolation Precautions - Categories of Transmission - Based Infections dated October 2021 showed under Policy, standard precautions shall be used when caring for residents regardless of their suspected or confirmed infection status. Transmission based precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. 1. Transmission-Based precautions will be used whenever measures more stringent than standard precautions are needed to prevent or control the spread of infection. In addition to standard precautions, implement contact precautions for residents known or suspected to be infected or colonized with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental services or resident - care items in the residence environment. Examples of infections requiring Contact Precautions include but are not limited to gastrointestinal, respiratory, skin, or wound infections or colonization with multi drug resistant organisms.<br><br>Review of the facility policy titled Progressive Discipline Policy dated April 2019, showed under Personal Hygiene, fingernails should be kept neat, clean, and of conservative length. Employees providing patient care must keep nails short so not to create safety or infection control issues. No artificial nails, appliques or studs on nails may be worn by any clinical staff who provide patient care. |