STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375094	A. Building B. Wing	04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Tulsa	2425 South Memorial Tulsa, OK 74129

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 39772 Based on interview and record review, it was determined the facility failed to ensure a resident's wheelchair accessibility needs were accommodated during dialysis transportation for one (#8) of three residents who were reviewed for dialysis. The facility identified five residents who received dialysis and utilized a wheelchair for mobility. Findings: Resident #8 had diagnoses which included morbid obesity, chronic obstructive pulmonary disease, acute kidney failure, and dependence on renal dialysis. A care plan, dated 07/21/20, documented, .Focus .Dialysis .Interventions .Establish means of communication between dialysis facility .arrange transportation to and from dialysis . A nurse's note, dated 08/15/20, documented, .resident was unable to fit on to the vehicle ramp for transportation to Dialysis. Driver stated that she would not be able to fit with the current wheel chair and would need to reschedule appointment. Aides tried to use smaller wheel chair originally and resident could not fit comfortably and requested larger chair .Will f/u with [name withheld] for scheduling . A Medicare 5-Day assessment, dated 08/26/20, documented the resident was cognitively intact and utilized a wheelchair for mobility. On 01/26/21 at 12:45 p.m., the ADON (assistant director of nursing) stated dialysis residents were transported to dialysis by a private transport company and the admissions coordinator was responsible to ensure the vehicle could accommodate the resident's needs. She stated the transport company should have been contacted to send another vehicle as soon as it was determined the vehicle provided could not accommodate the resident's wheelchair.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 On 01/25/21 at 5:05 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to report results of laboratory data to the ordering practitioner for resident #10, which indicated the need to alter treatment for the resident. On 03/16/20, the physician ordered a urinalysis and a culture and sensitivity of the urine. On 03/17/20, the resident was started on an antibiotic for a urinary tract infection. The results of the culture and sensitivity revealed that the organism causing the infection, Proteus Mirabilis, was not sensitive to the antibiotic the resident was receiving. The physician was not notified of the results of the urine culture and sensitivity. Resident #10 was hospitalized on [DATE] with sepsis, and subsequently passed away on 03/26/20. The immediate cause for death was septic shock due to Proteus Mirabilis. On 01/25/21 the IJ situation was verified with the Oklahoma State Department of Health. On 01/25/21 at 5:05 p.m., the administrator and the assistant director of nurses were notified of the IJ situation related to failures in communicating pertinent lab results to the ordering physician. On 01/26/21 at 11:30 a.m., the plan of removal for the Immediate Jeopardy pertaining to notification of the physician was accepted. The plan of Removal for the Immediate Jeopardy documented: Plan of Removal 1. Facility licensed Nurses will be educated on the facility antibiotic and lab protocol. a. Current and outstanding labs will be addressed immediately by the Licensed Nurse. b. Abnormal labs will be called into the physician by the Licensed Nurse by the end of the shift for abnormal results. With critical abnormal results; the Licensed Nurse will notify the Primary Care Physician immediately upon receiving the results. c. When receiving the results of a Culture and Sensitivity; the Licensed Nurse is to call the Primary Care Physician and provide results to ensure the resident is on the proper antibiotic therapy. d. Documentation will be completed listing the contact time and orders given by the Licensed Nurse. e. If antibiotic is ordered, the Licensed Nurse will fax and call new order into pharmacy and request it be sent out immediately within 4 hours, in the event that the medication is not received in that time frame, the ordering physician will be notified and a hold order will be obtained until the medication is available and in the facility to administer. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Upon receipt of the antibiotic the receiving nurse will document arrival and initial dose will be given. g. Licensed Nurse should document on the antibiotic each shift for the duration of the order. h. Any adverse reaction will be reported to the ordering practitioner by Licensed Nurse. i. Policies and procedures will be updated, and all CMA's and Licensed Nursing staff will be educated to reflect the above noted protocols. 2. Current facility residents' labs for the previous 30 days will be reviewed to ensure the Primary Care Physician has been notified of the results. Lab results that have a Culture and Sensitivity will be reviewed with the Primary Care Physician to ensure resident is on the proper antibiotic. This will be completed by the Nurse Management Team. 3. During the morning Clinical Meeting the Nurse Managers will review current orders for Labs and Antibiotics to ensure the resident is receiving the appropriate antibiotic. 4. The Nurse Managers will call the Primary Care Physician if the resident is not on the antibiotic that the Culture and Sensitivity shows sensitivity to. 5. This plan of removal will be in compliance January 26, 2021 by 5pm On 01/27/21 interviews were conducted with the nursing staff regarding education in-services pertaining to antibiotic and lab protocol for immediate jeopardy removal. The staff stated an in-service was provided on 01/26/21. The staff was able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. On 01/27/21 at 12:30 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at an isolated level. Based on observation, interview, and record review, it was determined the facility failed to report results of lab data to the ordering practitioner for three (#4, #10 and #11) of five sampled residents. The facility failed to notify the physician of significant laboratory results. The physician was not notified of urinary culture and sensitivity lab results for resident #10, which indicated the infection the resident had was resistant to the antibiotic prescribed. The resident developed urinary sepsis, was hospitalized , and subsequently passed away. The facility identified 10 residents who currently received antibiotic therapy. Findings: The facility policy for Laboratory Services documented, the facility will notify the physician promptly of laboratory results. The policy documented laboratory results would be reviewed by the physician on a timely basis. The policy documented the facility would have a system to reconcile physician orders, labs ordered, the time labs were drawn, when the results were received, and when the physician was notified. The policy documented reports would be filed in the medical record. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included resistance to multiple antibiotics and a stage 4 pressure ulcer of the sacral region. The care plan, dated 10/30/19, documented a resident goal was to remain free from complications related to urinary tract infections (UTIs) over the next 90 days. Care plan interventions included observing for signs and symptoms of UTI such as complaint of burning with urination, flank pain, presence of blood in urine, discharge, elevated temperature, increased confusion and agitation, or decreased level of consciousness. The care plan documented staff were to alert the charge nurse of any signs and symptoms so the physician could be notified. The admission assessment, dated 12/24/19, documented the resident was moderately impaired for daily decision-making, required extensive assistance with activities of daily living (ADLs), and had a urinary catheter. A progress note, dated 03/16/20 at 8:19 a.m., documented the urinary catheter was patent to bedside drainage with pale yellow urine and a large amount of sediment. The note documented the resident reported a sensation of urinary urgency. The note documented the urinary catheter was irrigated with 100 cubic centimeters (cc) of sterile saline and continued to drain pale urine with sediment. The note documented the physician was contacted regarding urine for analysis and they were waiting for a return call. A progress note, dated 03/16/20 at 9:42 a.m., documented a physician order to change the urinary catheter and obtain a urinalysis with culture and sensitivity. A progress note, dated 03/16/20 at 10:57 a.m., documented laboratory (lab) called to pick up the stat urinalysis. A progress note, dated 03/16/20 at 5:05 p.m. documented the stat urinalysis results were faxed to the physician's office. A urinalysis lab report, dated 03/16/20, documented the resident had a UTI. A physicians order, dated 03/17/20, documented the resident was to receive Bactrim DS tablet 800-160 milligram (MG) two times a day for 7 days. A progress note, dated 03/18/20 at 10:15 a.m., documented the resident continued on Bactrim DS for a UTI his temperature was 98.1 degrees Fahrenheit (F). The note documented the resident denied any pain or burning. A urine culture and sensitivity report, dated 03/19/20 at 9:23 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. The progress notes for March 2020 did not document the physician was notified of the culture and sensitivity results. The physician orders for March 2020 did not document the discontinuation of Bactrim, or an order for an antibiotic in which the bacteria was sensitive. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The medication administration record (MAR) dated March 2020 documented the resident continued to receive Bactrim for a UTI. A progress note, dated 03/19/20 at 10:16 a.m., documented the resident continued on Bactrim DS for a UTI, his temperature was 97.9 degrees (F) and had no signs or symptoms of an adverse reaction. The note documented the resident complained of pressure to the abdominal area on the previous shift but had no complaints on this shift. A progress note, dated 03/24/20 at 1:15 p.m., documented the resident complained of the catheter leaking and the feeling of pain and pressure when moving. The note documented the nurse was unable to flush the catheter. The note documented the catheter was replaced and the resident tolerated it well. A progress note, dated 03/24/20 at 10:46 p.m., documented the nurse was called into the resident's room by a certified medication aid (CMA). The note documented the resident had uncontrollable tremors, his oxygen saturation was 68 percent on room air, and the resident had a temperature of 99.5 degrees F. The note documented staff were not able to obtain a blood pressure due to the tremors. The note documented the resident's face was flushed and his nail beds were blue. The note documented an ambulance arrived and transported the resident to the hospital for evaluation and treatment per doctor orders. The note documented the daughter, the director or nurses (DON), and the assistant director of nurses (ADON) were notified. An emergency medicine note, dated 03/24/20, documented clinical impressions of septic shock and acute respiratory failure with hypoxia. A details of hospital stay report, dated 03/26/20 at 3:18 p.m., documented the patient was treated for sepsis. The report documented the patient had proteus bacteria in his blood, was being treated with a broad spectrum antibiotic, and had a history of multi drug resistant organisms (MDRO). The report documented on the previous night the patient had labored breathing and became acutely hypotensive. The report documented a chest X-ray showed a probable aspiration pneumonia. The report documented the patient required multiple medications to maintain his blood pressure. The report documented the patient was placed on comfort measures after consulting with family and passed away at 1:35 p.m. on 03/26/20. A death certificate, dated 03/30/20, documented the immediate cause for death was septic shock due to Proteus Mirabilis. On 01/22/21 at 10:10 a.m., the assistant director of nurses (ADON) stated the process for lab orders was to put the order into the medical record, then order the lab through the laboratory website. The requisition would then be put in the lab book and the lab would be called for pick-up. She stated the charge nurse would check the lab website for the results and should notify the physician of any abnormal results. On 01/25/21 at 2:02 p.m., physician #1 was interviewed regarding lab results. He stated that he expected to be made aware of abnormal lab results. He stated that the lab company will call the facility and the physician with critical results, but culture and sensitivity results were not critical labs. Physician #1 stated the facility did not notify him of the culture and sensitivity results for resident #10. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/27/21 at 10:25 a.m., licensed practical nurse (LPN) #3 stated that it was the responsibility of the charge nurse to monitor the lab website for results and to report abnormal results to the physician. On 01/27/21 at 10:30 a.m. LPN #4 stated the physician should be notified of culture and sensitivity reports and the charge nurse was responsible for monitoring and reporting lab results. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection. The annual assessment, dated 10/27/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter and received antibiotics. A progress note, dated 01/13/21 at 3:02 p.m., documented the resident's urine was thick and the tube required milking and flushing for urine to flow adequately. The note documented the resident denied painful, urination, other symptoms, and was afebrile. The note documented water was available and accepted after prompting. A progress note, dated 01/14/21 at 7:36 a.m., documented the resident's urine continued to be thick and mucus like in consistency. The note documented the urine did not want to flow through tubing and it was slow at times with a cloudy appearance. The note documented a urinalysis was collected at that time to rule out UTI. The note documented the resident was afebrile and fluids were within reach. A final urinalysis report, dated 01/14/21 at 9:33 p.m., documented the urine had elevated protein, elevated blood, elevated white blood cell count and elevated red blood cell count. The progress notes for January 2020 did not document the physician was notified of the urinalysis report from 01/14/21 until 01/20/21. A final culture and sensitivity report, dated 01/16/21 at 8:34 a.m., documented probable collection contamination with skin flora and no susceptibility test was performed. The progress notes for January 2020 did not document the physician was notified of the culture and sensitivity report from 01/16/21 until 01/20/21. A progress note, dated 01/20/21 at 11:02 a.m., documented the suprapubic catheter was found on the floor beside the bed with a large amount of leaking urine to the abdominal region. The note documented the suprapubic catheter was replaced per physicians order, was draining to gravity and the the resident tolerated the procedure well. A progress note, dated 01/20/21 at 4:38 p.m., documented the urinalysis results were received, and were positive for a UTI. The note documented the physician was notified and orders were received for Rocephin intramuscular (IM) once a day for five days for UTI. The note documented the medication administration record (MAR) was updated and the power of attorney was made aware. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 01/21/21 at 12:32 p.m., documented the resident continued on an intramuscular (IM) antibiotic for a UTI. The note documented the resident has had no signs or symptoms of an adverse reaction. The note documented the resident was afebrile and the suprapubic catheter was patent and draining to gravity, and received catheter care every two hours and as needed. A progress note, dated 01/24/21 at 2:37 a.m., documented the resident had only received one dose of Rocephin on or about 01/21/21. The note documented the medication appeared on the medication administration record (MAR) and not the treatment administration record (TAR). The note documented the medication was being checked off as administered by the medication aids who were not actually giving the medication or notifying the nurse. The note documented the nurse administered the second dose on 01/23/21 and the order was updated on the TAR. On 01/26/21 at 12:45 p.m., the assistant director of nurses (ADON) stated she was aware of the missed doses of Rocephin. The ADON stated she interviewed the nurse who discovered the medication had not been given and that nurse told her the physician was not contacted. She stated the nurse should have been notified the medication was on the MAR and not the TAR. She stated the physician should have been notified. On 01/27/21 at 10:10 a.m., physician #1 stated he expected to be notified by the facility when medication he had ordered was not administered. On 01/27/21 at 10:10 a.m., certified medication aid (CMA) #2 stated that IM meds should be on the TAR. She stated if she noticed an IM med on the MAR and not the TAR she would notify the charge nurse so the medication could be administered. 3. Resident #11 had diagnosis which included urinary tract infection. The admission assessment, dated 12/11/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter. A progress note, dated 12/23/20 at 2:47 p.m., documented cloudy urine was noted in the catheter bag; a urine analysis was obtained per primary care physician, and a new order was received for Bactrim DS one time a day for five days until results of urinalysis were received. A physician's order, dated 12/23/20, documented to obtain a urinalysis with culture and sensitivity to rule out urinary tract infection. A final urinalysis report, dated 12/24/20 at 8:20 p.m., documented the result was abnormal with protein, leukocyte estrace (A screening test used to detect a substance that suggests there are white blood cells in the urine; this may mean you have a urinary tract infection.) bacteria and yeast, and the specimen was sent for culture. A final culture and sensitivity report, dated 12/26/20 at 11:11 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. The TAR documented the resident was administered Bactrim DS one time a day for five days on 12/23/20 through 12/27/20. No other antibiotic was documented as administered. (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The progress notes did not document the physician was notified of the culture and sensitivity results and did not document an antibiotic effective to treat the bacteria was ordered or administered to the resident. On 01/26/21 at 12:51 p.m., the ADON stated the antibiotic the resident was administered was resistant to the bacteria and was not the correct antibiotic. She reviewed the progress notes and stated the facility did not notify the physician of the culture and sensitivity results. The ADON stated the physician should have been notified of the culture and sensitivity results and a different antibiotic should have been ordered.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on interview and record review, it was determined the facility failed to provide complete admission orders to meet the immediate care needs for one (#9) of four sampled residents reviewed for quality of care. The facility identified 30 residents that were admitted to the facility in August of 2020. Findings: Resident #9 was admitted to the facility on [DATE] with diagnoses which included critical illness myopathy, and type II diabetes with a foot ulcer. A discharge summary report from the acute care facility, dated 08/17/2020, documented the resident had an active diabetic foot ulcer and was on diabetic renal diet. The admission orders, dated 08/17/2020, did not document orders for insulin, finger stick blood sugars (FSBS), or wound care. An admission note, dated 08/17/2020, documented the resident had a dialysis port on the left side of her chest, redness under both breasts, and redness to her coccyx area. It did not document other skin issues. A skin assessment, dated 08/18/2020 at 2:51 p.m., documented the resident had a diabetic foot ulcer to the right foot measuring 2.5 cm x 2.3 cm x undetermined. The assessment also documented a scab to the left breast measuring 7.5 cm x 0.5 cm x 0 cm. The nurse notes, dated 08/18/2020 at 10:02 p.m., documented the resident informed staff that she was a diabetic and received scheduled insulin at home. On 04/15/2021 at 11:58 a.m. LPN #3 was asked what should be done if the admission orders do not include orders needed to meet the needs of the resident. She stated that the physician should be notified immediately.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 On 01/25/21 at 5:05 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to ensure resident's physicians were notified of laboratory data which indicated the need to change treatments, and ensure residents received antibiotic therapy that was effective to treat their infection for resident #10. On 03/16/20, the physician ordered a urinalysis and a culture and sensitivity of the urine. On 03/17/20, the resident was started on an antibiotic for a urinary tract infection. The results of the culture and sensitivity revealed that the organism causing the infection, Proteus Mirabilis, was not sensitive to the antibiotic the resident was receiving. The physician was not notified of the results of the urine culture and sensitivity. Resident #10 was hospitalized on [DATE] with sepsis, and subsequently passed away on 03/26/20. The immediate cause for death was septic shock due to Proteus Mirabilis. On 01/25/21 the IJ situation was verified with the Oklahoma State Department of Health. On 01/25/21 at 5:05 p.m., the administrator and the assistant director of nurses were notified of the IJ situation related to failures in communicating pertinent lab results to the ordering physician. On 01/26/21 at 11:30 a.m., the plan of removal for the Immediate Jeopardy pertaining to notification of the physician was accepted. The plan of Removal for the Immediate Jeopardy documented: Plan of Removal 1. Facility licensed Nurses will be educated on the facility antibiotic and lab protocol. a. Current and outstanding labs will be addressed immediately by the Licensed Nurse. b. Abnormal labs will be called into the physician by the Licensed Nurse by the end of the shift for abnormal results. With critical abnormal results; the Licensed Nurse will notify the Primary Care Physician immediately upon receiving the results. c. When receiving the results of a Culture and Sensitivity; the Licensed Nurse is to call the Primary Care Physician and provide results to ensure the resident is on the proper antibiotic therapy. d. Documentation will be completed listing the contact time and orders given by the Licensed Nurse. e. If antibiotic is ordered, the Licensed Nurse will fax and call new order into pharmacy and request it be sent out immediately within 4 hours, in the event that the medication is not received in that time frame, the ordering physician will be notified and a hold order will be obtained until the medication is available and in the facility to administer. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	f. Upon receipt of the antibiotic the receiving nurse will document arrival and initial dose will be given. g. Licensed Nurse should document on the antibiotic each shift for the duration of the order. h. Any adverse reaction will be reported to the ordering practitioner by Licensed Nurse. i. Policies and procedures will be updated, and all CMA's and Licensed Nursing staff will be educated to reflect the above noted protocols. 2. Current facility residents' labs for the previous 30 days will be reviewed to ensure the Primary Care Physician has been notified of the results. Lab results that have a Culture and Sensitivity will be reviewed with the Primary Care Physician to ensure resident is on the proper antibiotic. This will be completed by the Nurse Management Team. 3. During the morning Clinical Meeting the Nurse Managers will review current orders for Labs and Antibiotics to ensure the resident is receiving the appropriate antibiotic. 4. The Nurse Managers will call the Primary Care Physician if the resident is not on the antibiotic that the Culture and Sensitivity shows sensitivity to. 5. This plan of removal will be in compliance January 26, 2021 by 5pm On 01/27/21 interviews were conducted with the nursing staff regarding education in-services pertaining to antibiotic and lab protocol for immediate jeopardy removal. The staff stated an in-service was provided on 01/26/21. The staff was able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. On 01/27/21 at 12:30 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at an isolated level. Based on observation, interview, and record review, it was determined the facility failed to: ~ report results of lab data to the ordering practitioner which indicated the need to change treatments, and/or ensure residents received antibiotic therapy that was effective to treat their infection for three (#4, #10 and #11) of five sampled residents who required antibiotic treatment; and ~ failed to provide wound care and diabetic care for one (#9) of four sampled residents who were reviewed for quality of care issues. The physician was not notified of urinary culture and sensitivity lab results for resident #10, which indicated the infection the resident had was resistant to the antibiotic prescribed. The resident developed urinary sepsis, was hospitalized , and subsequently passed away. The facility identified 10 residents who currently received antibiotic therapy. The facility identified 21 residents who had wounds and 14 residents who had diabetes. Findings: (continued on next page)

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	375094	A. Building B. Wing	04/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Care Center Tulsa	2425 South Memorial Tulsa, OK 74129

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy for Laboratory Services documented, the facility will notify the physician promptly of laboratory results. The policy documented laboratory results would be reviewed by the physician on a timely basis. The policy documented the facility would have a system to reconcile physician orders, labs ordered, the time labs were drawn, when the results were received, and when the physician was notified. The policy documented reports would be filed in the medical record. 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included resistance to multiple antibiotics and a stage 4 pressure ulcer of the sacral region. The care plan, dated 10/30/19, documented a resident goal was to remain free from complications related to urinary tract infections (UTIs) over the next 90 days. Care plan interventions included observing for signs and symptoms of UTI such as complaint of burning with urination, flank pain, presence of blood in urine, discharge, elevated temperature, increased confusion and agitation, or decreased level of consciousness. The care plan documented staff were to alert the charge nurse of any signs and symptoms so the physician could be notified. The admission assessment, dated 12/24/19, documented the resident was moderately impaired for daily decision-making, required extensive assistance with activities of daily living (ADLs), and had a urinary catheter. A progress note, dated 03/16/20 at 8:19 a.m., documented the urinary catheter was patent to bedside drainage with pale yellow urine and a large amount of sediment. The note documented the resident reported a sensation of urinary urgency. The note documented the urinary catheter was irrigated with 100 cubic centimeters (cc) of sterile saline and continued to drain pale urine with sediment. The note documented the physician was contacted regarding urine for analysis and they were waiting for a return call. A progress note, dated 03/16/20 at 9:42 a.m., documented a physician order to change the urinary catheter and obtain a urinalysis with culture and sensitivity. A progress note, dated 03/16/20 at 10:57 a.m., documented laboratory (lab) called to pick up the stat urinalysis. A progress note, dated 03/16/20 at 5:05 p.m. documented the stat urinalysis results were faxed to the physician's office. A urinalysis lab report, dated 03/16/20, documented the resident had a UTI. A physicians order, dated 03/17/20, documented the resident was to receive Bactrim DS tablet 800-160 milligram (MG) two times a day for 7 days. A progress note, dated 03/18/20 at 10:15 a.m., documented the resident continued on Bactrim DS for a UTI his temperature was 98.1 degrees Fahrenheit (F). The note documented the resident denied any pain or burning. A urine culture and sensitivity report, dated 03/19/20 at 9:23 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The progress notes for March 2020 did not document the physician was notified of the culture and sensitivity results. The physician orders for March 2020 did not document the discontinuation of Bactrim, or an order for an antibiotic to which the bacteria was sensitive. The medication administration record (MAR) dated March 2020 documented the resident continued to receive Bactrim for a UTI. A progress note, dated 03/19/20 at 10:16 a.m., documented the resident continued on Bactrim DS for a UTI, his temperature was 97.9 degrees (F) and had no signs or symptoms of an adverse reaction. The note documented the resident complained of pressure to the abdominal area on the previous shift but had no complaints on this shift. A progress note, dated 03/24/20 at 1:15 p.m., documented the resident complained of the catheter leaking and the feeling of pain and pressure when moving. The note documented the nurse was unable to flush the catheter. The note documented the catheter was replaced and the resident tolerated it well. A progress note, dated 03/24/20 at 10:46 p.m., documented the nurse was called into the resident's room by a certified medication aid (CMA). The note documented the resident had uncontrollable tremors, his oxygen saturation was 68 percent on room air, and the resident had a temperature of 99.5 degrees F. The note documented staff were not able to obtain a blood pressure due to the tremors. The note documented the resident's face was flushed and his nail beds were blue. The note documented an ambulance arrived and transported the resident to the hospital for evaluation and treatment per doctor orders. The note documented the daughter, the director or nurses (DON), and the assistant director of nurses (ADON) were notified. An emergency medicine note, dated 03/24/20, documented clinical impressions of septic shock and acute respiratory failure with hypoxia. A details of hospital stay report, dated 03/26/20 at 3:18 p.m., documented the patient was treated for sepsis. The report documented the patient had proteus bacteria in his blood, was being treated with a broad spectrum antibiotic, and had a history of multi drug resistant organisms (MDRO). The report documented on the previous night the patient had labored breathing and became acutely hypotensive. The report documented a chest X-ray showed a probable aspiration pneumonia. The report documented the patient required multiple medications to maintain his blood pressure. The report documented the patient was placed on comfort measures after consulting with family and passed away at 1:35 p.m. on 03/26/20. A death certificate, dated 03/30/20, documented the immediate cause for death was septic shock due to Proteus Mirabilis. On 01/22/21 at 10:10 a.m., the assistant director of nurses (ADON) stated the process for lab orders was to put the order into the medical record, then order the lab through the laboratory website. The requisition would then be put in the lab book and the lab would be called for pick-up. She stated the charge nurse would check the lab website for the results and should notify the physician of any abnormal results. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/25/21 at 2:02 p.m., physician #1 was interviewed regarding lab results. He stated that he expected to be made aware of abnormal lab results. He stated that the lab company will call the facility and the physician with critical results, but culture and sensitivity results were not critical labs. Physician #1 stated the facility did not notify him of the culture and sensitivity results for resident #10. On 01/27/21 at 10:25 a.m., licensed practical nurse (LPN) #3 stated that it was the responsibility of the charge nurse to monitor the lab website for results and to report abnormal results to the physician. On 01/27/21 at 10:30 a.m. LPN #4 stated the physician should be notified of culture and sensitivity reports and the charge nurse was responsible for monitoring and reporting lab results. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection. The annual assessment, dated 10/27/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter and received antibiotics. A progress note, dated 01/13/21 at 3:02 p.m., documented the resident's urine was thick and the tube required milking and flushing for urine to flow adequately. The note documented the resident denied painful, urination, other symptoms, and was afrebrile. The note documented water was available and accepted after prompting. A progress note, dated 01/14/21 at 7:36 a.m., documented the residents urine continued to be thick and mucus like in consistency. The note documented the urine did not want to flow through tubing and it was slow at times with cloudy appearance. The note documented a urinalysis was collected at that time to rule out UTI. The note documented the resident was afebrile and fluids were within reach. A final urinalysis report, dated 01/14/21 at 9:33 p.m., documented the urine had elevated protein, elevated blood, elevated white blood cell count and elevated red blood cell count. The progress notes for January 2020 did not document the physician was notified of the urinalysis report from 01/14/21 until 01/20/21. A final culture and sensitivity report, dated 01/16/21 at 8:34 a.m., documented probable collection contamination with skin flora and no susceptibility test was performed. The progress notes for January 2020 did not document the physician was notified of the culture and sensitivity report from 01/16/21 until 01/20/21. A progress note, dated 01/20/21 at 11:02 a.m., documented the suprapubic catheter was found on the floor beside the bed with a large amount of leaking urine to the abdominal region. The note documented the suprapubic catheter was replaced per physicians order, was draining to gravity and the the resident tolerated the procedure well. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 01/20/21 at 4:38 p.m., documented the urinalysis results were received, and were positive for a UTI. The note documented the physician was notified and orders were received for Rocephin intramuscular (IM) once a day for five days for UTI. The note documented the medication administration record (MAR) was updated and the power of attorney was made aware. A progress note, dated 01/21/21 at 12:32 p.m., documented the resident continued on an intramuscular (IM) antibiotic for a UTI. The note documented the resident has had no signs or symptoms of an adverse reaction. The note documented the resident was afebrile and the suprapubic catheter was patent and draining to gravity, and the resident received catheter care every two hours and as needed. A progress note, dated 01/24/21 at 2:37 a.m., documented the resident had only received one dose of Rocephin on or about 01/21/21. The note documented the medication appeared on the medication administration record (MAR) and not the treatment administration record (TAR). The note documented the medication was being checked off as administered by the medication aids who were not actually giving the medication or notifying the nurse. The note documented the nurse administered the second dose on 01/23/21 and the order was updated on the TAR. On 01/26/21 at 12:45 p.m., the assistant director of nurses (ADON) stated she was aware of the missed doses of Rocephin. The ADON stated she interviewed the nurse who discovered the medication had not been given and that nurse told her the physician was not contacted. She stated the nurse should have been notified the medication was on the MAR and not the TAR. She stated the physician should have been notified. On 10/27/21 at 10:10 a.m., physician #1 stated he expected to be notified by the facility when medication he had ordered was not administered. On 01/27/21 at 10:10 a.m., certified medication aid (CMA) #2 stated that IM meds should be on the TAR. She stated if she noticed an IM med on the MAR and not the TAR she would notify the charge nurse so the medication could be administered. 3. Resident #11 had diagnosis which included urinary tract infection. The admission assessment, dated 12/11/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter. A progress note, dated 12/23/20 at 2:47 p.m., documented cloudy urine was noted in the catheter bag; a urine analysis was obtained per primary care physician, and a new order was received for Bactrim DS one time a day for five days until results of urinalysis were received. A physician's order, dated 12/23/20, documented to obtain a urinalysis with culture and sensitivity to rule out urinary tract infection. A final urinalysis report, dated 12/24/20 at 8:20 p.m., documented the result was abnormal with protein, leukocyte estrace (A screening test used to detect a substance that suggests there are white blood cells in the urine; this may mean you have a urinary tract infection.) bacteria and yeast, and the specimen was sent for culture. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A final culture and sensitivity report, dated 12/26/20 at 11:11 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. The TAR documented the resident was administered Bactrim DS one time a day for five days on 12/23/20 through 12/27/20. No other antibiotic was documented as administered. The progress notes did not document the physician was notified of the culture and sensitivity results and did not document an antibiotic susceptible to the bacteria was ordered or administered to the resident. On 01/26/21 at 12:51 p.m., the ADON stated the antibiotic the resident was administered was resistant to the bacteria and was not the correct antibiotic. She reviewed the progress notes and stated the facility did not notify the physician of the culture and sensitivity results. The ADON stated the physician should have been notified of the culture and sensitivity results and a different antibiotic should have been ordered. 4. a. Resident #9 was admitted to the facility on [DATE] with diagnoses which included critical illness myopathy, and type II diabetes with foot ulcer. The admission orders, dated 08/17/20 did not document the resident was receiving insulin or finger stick blood sugars (FSBS). A nurse's note, dated 08/18/20 at 10:02 p.m., documented the resident informed staff that she was a diabetic and received scheduled insulin at home. A physician's order, dated 08/20/20 at 9:27 a.m., documented the resident was to be given 18 units of Lantus Solo Star (a type of long-acting insulin) subcutaneously every morning. A physician's order, dated 08/20/20 at 9:29 a.m., documented the resident was to be given Humalog insulin on a sliding scale. The order documented the resident was to be given 2 units Humalog insulin for a blood sugar between 151-200, 4 units for a blood sugar between 201-250, 6 units for a blood sugar between 251-300, 8 units for a bloodsugar between 301-350, and 10 units for a blood sugar between 351-400. The order documented the physician was to be notified if the residents blood sugar was above 400. The admission assessment, dated 08/24/20, documented the resident was cognitively intact for daily decision-making and required limited assistance with activities of daily living (ADLs). On 04/15/21 at 11:58 a.m. LPN #3 was asked what should be done if you suspect a resident is diabetic and is not receiving treatment. She stated that the physician should be notified immediately. b. An admission note, dated 08/17/20, documented resident #9 had a dialysis port on the left side of her chest, redness under both breasts, and redness to her coccyx area. It did not document other skin issues. A skin assessment, dated 08/18/20 at 2:51 p.m., documented the resident had a diabetic foot ulcer to the right foot measuring 2.5 cm x 2.3 cm x undetermined. The assessment also documented a scab to the left breast measuring 7.5 cm x 0.5 cm x 0 cm. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A physician's order, dated 08/18/20 at 2:56 p.m., documented the wound to the right foot was to be cleansed with wound cleanser, patted dry, medi honey was to be applied to the wound bed, it was to be covered with gauze 4 x 4 and secured with tape every day on day shift. A review of the treatment administration record (TAR) did not document wound care to the right foot was provided on 08/18/20. A nurse's note, dated 08/23/20 at 7:43 p.m., documented the resident was complaining of discomfort to the left breast. The note documented upon assessment there was an open area on the left breast with drainage. It documented the physician was notified and an order for wound care was received. A physician's order, dated 08/23/20 at 7:54 p.m., documented the wound to the left breast was to be cleansed with normal saline, patted dry, and a wet to dry dressing was to be applied. The order also documented the wound physician would evaluate the wound when he was in the facility on 08/24/20. A review of the treatment administration record (TAR) did not document wound care to the left breast was provided on 08/23/2020. A nurse's note, dated 08/24/20 at 9:01 a.m., documented the resident refused to see the wound care physician because she was leaving the facility against medical advice (AMA). The note documented the wound to the foot looked the same as it did upon admission and the scab on the left breast was now open. The note documented the nurse re-dressed both wounds and let the charge nurse know the resident was possibly leaving AMA. The admission assessment, dated 08/24/20, documented the resident was cognitively intact for daily decision-making and required limited assistance with activities of daily living (ADLs).

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 36191 Based on interview and record review, it was determined the facility failed to ensure the services of a registered nurse were used for at least eight consecutive hours a day, seven days a week. This had the potential to affect all 69 residents residing at the facility. Findings: On 01/26/21 at 11:46 a.m., licensed practical nurse (LPN) #2 stated the registered nurse (RN) in the building was a nurse practitioner (NP) who worked for [name-deleted] and had an office in the building. When the NP was asked about providing RN coverage, she stated she was a mid-level provider and not an RN. She did not acknowledge she was the facility's RN coverage. The schedule for 01/10/21 through 01/25/21 was reviewed with LPN #3. The LPN verified on 10 of the 16 days the facility did not have an RN. She stated she thought the NP qualified as the RN coverage. The LPN did not provide documentation the facility attempted to get an RN to cover the days they did not have an RN in the building.

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 On 01/25/21 at 5:05 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to notify the physician of results of a urine culture and sensitivity test that revealed the organism causing the infection was resistant to the antibiotic being used for resident #10. On 03/16/20, the physician ordered a urinalysis and a culture and sensitivity of the urine. On 03/17/20, the resident was started on an antibiotic for a urinary tract infection. The results of the culture and sensitivity revealed that the organism causing the infection, Proteus Mirabilis, was not sensitive to the antibiotic the resident was receiving. The physician was not notified of the results of the urine culture and sensitivity. Resident #10 was hospitalized on [DATE] with sepsis, and subsequently passed away on 03/26/20. The immediate cause for death was septic shock due to Proteus Mirabilis. On 01/25/21 the IJ situation was verified with the Oklahoma State Department of Health. On 01/25/21 at 5:05 p.m., the administrator and the assistant director of nurses were notified of the IJ situation related to failures in communicating pertinent lab results to the ordering physician. On 01/26/21 at 11:30 a.m., the plan of removal for the Immediate Jeopardy pertaining to notification of the physician was accepted. The plan of Removal for the Immediate Jeopardy documented: Plan of Removal 1. Facility licensed Nurses will be educated on the facility antibiotic and lab protocol. a. Current and outstanding labs will be addressed immediately by the Licensed Nurse. b. Abnormal labs will be called into the physician by the Licensed Nurse by the end of the shift for abnormal results. With critical abnormal results; the Licensed Nurse will notify the Primary Care Physician immediately upon receiving the results. c. When receiving the results of a Culture and Sensitivity; the Licensed Nurse is to call the Primary Care Physician and provide results to ensure the resident is on the proper antibiotic therapy. d. Documentation will be completed listing the contact time and orders given by the Licensed Nurse. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	e. If antibiotic is ordered, the Licensed Nurse will fax and call new order into pharmacy and request it be sent out immediately within 4 hours, in the event that the medication is not received in that time frame, the ordering physician will be notified and a hold order will be obtained until the medication is available and in the facility to administer. f. Upon receipt of the antibiotic the receiving nurse will document arrival and initial dose will be given. g. Licensed Nurse should document on the antibiotic each shift for the duration of the order. h. Any adverse reaction will be reported to the ordering practitioner by Licensed Nurse. i. Policies and procedures will be updated, and all CMA's and Licensed Nursing staff will be educated to reflect the above noted protocols. 2. Current facility residents' labs for the previous 30 days will be reviewed to ensure the Primary Care Physician has been notified of the results. Lab results that have a Culture and Sensitivity will be reviewed with the Primary Care Physician to ensure resident is on the proper antibiotic. This will be completed by the Nurse Management Team. 3. During the morning Clinical Meeting the Nurse Managers will review current orders for Labs and Antibiotics to ensure the resident is receiving the appropriate antibiotic. 4. The Nurse Managers will call the Primary Care Physician if the resident is not on the antibiotic that the Culture and Sensitivity shows sensitivity to. 5. This plan of removal will be in compliance January 26, 2021 by 5pm On 01/27/21 interviews were conducted with the nursing staff regarding education in-services pertaining to antibiotic and lab protocol for immediate jeopardy removal. The staff stated an in-service was provided on 01/26/21. The staff was able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. On 01/27/21 at 12:30 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at an isolated level. Based on observation, interview, and record review, it was determined the facility failed to notify the physician of significant laboratory results for five (#2, 4, 6, 10 and #11) of five sampled residents reviewed for laboratory services. The physician was not notified of urinary culture and sensitivity lab results for resident #10, which indicated the infection the resident had was resistant to the antibiotic prescribed. The resident developed urinary sepsis, was hospitalized , and subsequently passed away. The facility identified 63 residents who received laboratory services. Findings: (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility policy for Laboratory Services documented, the facility will notify the physician promptly of laboratory results. The policy documented laboratory results would be reviewed by the physician on a timely basis. The policy documented the facility would have a system to reconcile physician orders, labs ordered, the time labs were drawn, when the results were received, and when the physician was notified. The policy documented reports would be filed in the medical record. 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included resistance to multiple antibiotics and a stage 4 pressure ulcer of the sacral region. The care plan, dated 10/30/19, documented a resident goal was to remain free from complications related to urinary tract infections (UTIs) over the next 90 days. Care plan interventions included observing for signs and symptoms of UTI such as complaint of burning with urination, flank pain, presence of blood in urine, discharge, elevated temperature, increased confusion and agitation, or decreased level of consciousness. The care plan documented staff were to alert the charge nurse of any signs and symptoms so the physician could be notified. The admission assessment, dated 12/24/19, documented the resident was moderately impaired for daily decision-making, required extensive assistance with activities of daily living (ADLs), and had a urinary catheter. A progress note, dated 03/16/20 at 8:19 a.m., documented the urinary catheter was patent to bedside drainage with pale yellow urine and a large amount of sediment. The note documented the resident reported a sensation of urinary urgency. The note documented the urinary catheter was irrigated with 100 cubic centimeters (cc) of sterile saline and continued to drain pale urine with sediment. The note documented the physician was contacted regarding urine for analysis and they were waiting for a return call. A progress note, dated 03/16/20 at 9:42 a.m., documented a physician order to change the urinary catheter and obtain a urinalysis with culture and sensitivity. A progress note, dated 03/16/20 at 10:57 a.m., documented laboratory (lab) called to pick up the stat urinalysis. A progress note, dated 03/16/20 at 5:05 p.m. documented the stat urinalysis results were faxed to the physician's office. A urinalysis lab report, dated 03/16/20, documented the resident had a UTI. A physicians order, dated 03/17/20, documented the resident was to receive Bactrim DS tablet 800-160 milligram (MG) two times a day for 7 days. A progress note, dated 03/18/20 at 10:15 a.m., documented the resident continued on Bactrim DS for a UTI his temperature was 98.1 degrees Fahrenheit (F). The note documented the resident denied any pain or burning. A urine culture and sensitivity report, dated 03/19/20 at 9:23 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The progress notes for March 2020 did not document the physician was notified of the culture and sensitivity results. The physician orders for March 2020 did not document the discontinuation of Bactrim, or an order for an antibiotic in which the bacteria was sensitive. The medication administration record (MAR) dated March 2020 documented the resident continued to receive Bactrim for a UTI. A progress note, dated 03/19/20 at 10:16 a.m., documented the resident continued on Bactrim DS for a UTI, his temperature was 97.9 degrees (F) and had no signs or symptoms of an adverse reaction. The note documented the resident complained of pressure to the abdominal area on the previous shift but had no complaints on this shift. A progress note, dated 03/24/20 at 1:15 p.m., documented the resident complained of the catheter leaking and the feeling of pain and pressure when moving. The note documented the nurse was unable to flush the catheter. The note documented the catheter was replaced and the resident tolerated it well. A progress note, dated 03/24/20 at 10:46 p.m., documented the nurse was called into the resident's room by a certified medication aid (CMA). The note documented the resident had uncontrollable tremors, his oxygen saturation was 68 percent on room air, and the resident had a temperature of 99.5 degrees F. The note documented staff were not able to obtain a blood pressure due to the tremors. The note documented the resident's face was flushed and his nail beds were blue. The note documented an ambulance arrived and transported the resident to the hospital for evaluation and treatment per doctor orders. The note documented the daughter, the director or nurses (DON), and the assistant director of nurses (ADON) were notified. An emergency medicine note, dated 03/24/20, documented clinical impressions of septic shock and acute respiratory failure with hypoxia. A details of hospital stay report, dated 03/26/20 at 3:18 p.m., documented the patient was treated for sepsis. The report documented the patient had proteus bacteria in his blood, was being treated with a broad spectrum antibiotic, and had a history of multi drug resistant organisms (MDRO). The report documented on the previous night the patient had labored breathing and became acutely hypotensive. The report documented a chest X-ray showed a probable aspiration pneumonia. The report documented the patient required multiple medications to maintain his blood pressure. The report documented the patient was placed on comfort measures after consulting with family and passed away at 1:35 p.m. on 03/26/20. A death certificate, dated 03/30/20, documented the immediate cause for death was septic shock due to Proteus Mirabilis. On 01/22/21 at 10:10 a.m., the assistant director of nurses (ADON) stated the process for lab orders was to put the order into the medical record, then order the lab through the laboratory website. The requisition would then be put in the lab book and the lab would be called for pick-up. She stated the charge nurse would check the lab website for the results and should notify the physician of any abnormal results. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/25/21 at 2:02 p.m., physician #1 was interviewed regarding lab results. He stated that he expected to be made aware of abnormal lab results. He stated that the lab company will call the facility and the physician with critical results, but culture and sensitivity results were not critical labs. Physician #1 stated the facility did not notify him of the culture and sensitivity results for resident #10. On 01/27/21 at 10:25 a.m., licensed practical nurse (LPN) #3 stated that it was the responsibility of the charge nurse to monitor the lab website for results and to report abnormal results to the physician. On 01/27/21 at 10:30 a.m. LPN #4 stated the physician should be notified of culture and sensitivity reports and the charge nurse was responsible for monitoring and reporting lab results. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection. The annual assessment, dated 10/27/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter and received antibiotics. A progress note, dated 01/13/21 at 3:02 p.m., documented the resident's urine was thick and the tube required milking and flushing for urine to flow adequately. The note documented the resident denied painful, urination, other symptoms, and was afrebrile. The note documented water was available and accepted after prompting. A progress note, dated 01/14/21 at 7:36 a.m., documented the residents urine continued to be thick and mucus like in consistency. The note documented the urine did not want to flow through tubing and it was slow at times with cloudy appearance. The note documented a urinalysis was collected at that time to rule out UTI. The note documented the resident was afebrile and fluids were within reach. A final urinalysis report, dated 01/14/21 at 9:33 p.m., documented the urine had elevated protein, elevated blood, elevated white blood cell count and elevated red blood cell count. The progress notes for January 2020 did not document the physician was notified of the urinalysis report from 01/14/21 until 01/20/21. A final culture and sensitivity report, dated 01/16/21 at 8:34 a.m., documented probable collection contamination with skin flora and no susceptibility test was performed. The progress notes for January 2020 did not document the physician was notified of the culture and sensitivity report from 01/16/21 until 01/20/21. A progress note, dated 01/20/21 at 11:02 a.m., documented the suprapubic catheter was found on the floor beside the bed with a large amount of leaking urine to the abdominal region. The note documented the suprapubic catheter was replaced per physicians order, was draining to gravity and the resident tolerated the procedure well. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 01/20/21 at 4:38 p.m., documented the urinalysis results were received, and were positive for a UTI. The note documented the physician was notified and orders were received for Rocephin intramuscular (IM) once a day for five days for UTI. The note documented the medication administration record (MAR) was updated and the power of attorney was made aware. A progress note, dated 01/21/21 at 12:32 p.m., documented the resident continued on an intramuscular (IM) antibiotic for a UTI. The note documented the resident has had no signs or symptoms of an adverse reaction. The note documented the resident was afebrile and the suprapubic catheter was patent and draining to gravity, and the resident received catheter care every two hours and as needed. A progress note, dated 01/24/21 at 2:37 a.m., documented the resident had only received one dose of Rocephin on or about 01/21/21. The note documented the medication appeared on the medication administration record (MAR) and not the treatment administration record (TAR). The note documented the medication was being checked off as administered by the medication aids who were not actually giving the medication or notifying the nurse. The note documented the nurse administered the second dose on 01/23/21 and the order was updated on the TAR. On 01/26/21 at 12:45 p.m., the assistant director of nurses (ADON) stated she was aware of the missed doses of Rocephin. The ADON stated she interviewed the nurse who discovered the medication had not been given and that nurse told her the physician was not contacted. She stated the nurse should have been notified the medication was on the MAR and not the TAR. She stated the physician should have been notified. On 10/27/21 at 10:10 a.m., physician #1 stated he expected to be notified by the facility when medication he had ordered was not administered. On 01/27/21 at 10:10 a.m., certified medication aid (CMA) #2 stated that IM meds should be on the TAR. She stated if she noticed an IM med on the MAR and not the TAR she would notify the charge nurse so the medication could be administered. 3. Resident #11 had diagnosis which included urinary tract infection. The admission assessment, dated 12/11/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter. A progress note, dated 12/23/20 at 2:47 p.m., documented cloudy urine was noted in the catheter bag; a urine analysis was obtained per primary care physician, and a new order was received for Bactrim DS one time a day for five days until results of urinalysis were received. A physician's order, dated 12/23/20, documented to obtain a urinalysis with culture and sensitivity to rule out urinary tract infection. A final urinalysis report, dated 12/24/20 at 8:20 p.m., documented the result was abnormal with protein, leukocyte estrace (A screening test used to detect a substance that suggests there are white blood cells in the urine; this may mean you have a urinary tract infection.) bacteria and yeast, and the specimen was sent for culture. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A final culture and sensitivity report, dated 12/26/20 at 11:11 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. The TAR documented the resident was administered Bactrim DS one time a day for five days on 12/23/20 through 12/27/20. No other antibiotic was documented as administered. The progress notes did not document the physician was notified of the culture and sensitivity results and did not document an antibiotic susceptible to the bacteria was ordered or administered to the resident. On 01/26/21 at 12:51 p.m., the ADON stated the antibiotic the resident was administered was resistant to the bacteria and was not the correct antibiotic. She reviewed the progress notes and stated the facility did not notify the physician of the culture and sensitivity results. The ADON stated the physician should have been notified of the culture and sensitivity results and a different antibiotic should have been ordered. 39772 4. Resident #2 was admitted to the facility 07/01/20 with diagnoses which included chronic kidney disease, dependence on renal dialysis, anemia, type two diabetes mellitus, hypothyroidism, hyperlipidemia, hemiplegia and hemiparesis following cerebral infarction, and secondary hyperparathyroidism of renal origin. A review of laboratory reports revealed the following laboratory tests were completed: 07/07/20: ~ Basic Metabolic Panel; ~ Lipid Panel; ~ TSH (thyroid stimulating hormone); ~ Vitamin B-12; ~ Complete Blood Count /Auto Diff (differential): and ~ Hemoglobin A1C. 01/08/21: ~ Complete Blood Count; and ~ CMP (comprehensive metabolic panel). A review of the medical record revealed there was no documentation to support the facility had notified the physician of the laboratory results. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A quarterly assessment, dated 01/08/21, documented the resident was cognitively intact, received dialysis, and received a diuretic seven out of seven days of the look back period. On 01/25/21, the assistant director nurses (ADON) provided the surveyor copies of the 01/08/21 laboratory reports. The reports documented they had been reviewed by the physician's nurse on 01/08/21. A review of the nurse's notes dated 01/25/21, revealed the ADON contacted the physician's office regarding the laboratory reports for 01/08/21. 5. Resident #6 was admitted to the facility on [DATE] with diagnoses which included hemiplegia and hemiparesis following cerebral infarction. A review of the nurse's notes, dated 10/12/20, revealed a physician's verbal order for a stat BUN (blood urea nitrogen) and a creatinine laboratory test. A review of laboratory reports revealed a stat BUN and creatinine had been completed on 10/13/20. A review of the progress notes for 10/12/20-10/21/20 revealed there was no documentation to support the facility had notified the physician of the stat laboratory results. A quarterly assessment, dated 11/10/20, documented the resident was modified independent in cognition for daily decision making, required extensive assistance with hygiene, totally dependent on staff for bathing, and always incontinent of bowel and bladder. On 01/22/21 at 10:10 a.m., the ADON was interviewed regarding laboratory services. She stated they had switched the company that provided laboratory services in November 2020. She stated the lab process consisted of the following: ~ Receive physician orders for lab tests; (Note: if the physician ordered stat lab tests, the nurse would call [name withheld] to inform them of the stat lab order) ~ Nurse would enter the lab order into [name withheld]'s electronic lab system and the facility's electronic health care system; ~ Nurse would print the lab requisition and place it in the lab book; ~ On lab visit, [name withheld] would retrieve the lab requisition from the lab book; ~ Charge nurses were responsible for accessing [name withheld]'s electronic lab system to obtain lab results; ~ Lab would notify charge nurse, by phone, of any critical lab results; ~ Charge nurses were responsible for notifying the physician, by phone and fax, of abnormal lab results. (continued on next page)

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F 0773 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	She was asked how the physician was informed of laboratory test results. She stated the physician had access to [name withheld]'s electronic lab system but the charge nurse was responsible for notifying the physician of abnormal test results. On 01/22/21 at 10:20 a.m., LPN (licensed practical nurse) #6 was interviewed regarding laboratory services. She stated when the physician ordered lab tests she would enter the order in the electronic medical record then access the lab's electronic system to complete a requisition. She stated if the order was for stat lab, she contacted the lab by phone. She stated at least once during her shift she would access [name withheld]'s electronic lab system to check for lab results. She stated she would check the system for stat lab results every one to one and a half hours. She stated if stat lab results had not been accessed in the lab system by the end of her shift, she would report the pending stat lab to the next shift's charge nurse. On 01/26/21 at 12:45 p.m., the ADON was asked where it would be documented that the physician had been notified of a resident's laboratory results. She stated in the progress notes. She was asked who was responsible for notifying the physician of laboratory results. She stated the charge nurse was responsible.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 Based on interview and record review, it was determined the facility failed to maintain complete and accurate medical records by failing to document pre and post dialysis assessments for two (#2 and #5) of three sampled residents reviewed for dialysis care. The facility census and condition report documented five residents in the facility were receiving dialysis. Findings: 1. Resident #5 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease and dependence on renal dialysis. The annual assessment, dated 12/29/20, documented the resident was independent for daily decision-making, required extensive assistance with activities of daily living, and received dialysis. The physician's orders for January 2021 documented an order to chart post dialysis vital signs and weight upon return from dialysis. Review of the treatment administration record (TAR) and progress notes for January 2021 did not document post-dialysis vital signs or weights. On 01/26/21 at 10:50 a.m., the assistant director of nurses (ADON) was asked for additional records documenting post-dialysis vital signs and weights. No additional documentation was provided. She was asked where documentation of post-dialysis vital signs and weights were located and she stated in the TAR or progress notes. 39772 2. Resident #2 had diagnoses which included chronic kidney disease and dependence on renal dialysis. A quarterly assessment, dated 01/08/21, documented the resident was cognitively intact and received dialysis. The TAR, dated January 2021, documented, .vital signs and weight before dialysis and upon return of dialysis two times a day every Tue, Thu, Sat for dialysis treatment .Start date 10/20/2020 0700 . Review of the January 2021 TAR, 01/01/2021 through 01/23/2021 revealed 20 opportunities for Tuesday, Thursday, Saturday pre and post dialysis vital sign and weight entries with 13 documented. On 01/26/21 at 12:45 p.m., the ADON was interviewed about documentation of pre and post dialysis assessments. She stated the charge nurse was responsible for assessing the resident before they leave for dialysis and when they return from dialysis. She was asked where the pre and post dialysis assessments were documented. She stated in the TAR. She was asked if she could ensure dialysis resident's pre and post assessments were completed if they were not documented in the TAR. She stated no.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 36191 Based on observation, interview, and record review, it was determined the facility failed to implement infection prevention and control practices to prevent the development and transmission of COVID-19. The facility failed to ensure: ~ staff were screened before each shift for one (CMA #1) of three sampled staff who were reviewed for screening; ~ the floors and non-dedicated non-disposable resident care equipment was disinfected with an Environmental Protection Agency (EPA) registered disinfectant for use against SARS-CoV-2; ~ ice and water were obtained and delivered to residents in a manner in which infection control was maintained; and ~ the staff wore the correct personal protective equipment when entering the residents' rooms. Findings: The CDC guidance titled, Preparing for COVID-19 in Nursing Homes, documented, .Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19 .Actively take their temperature and document absence of symptoms consistent with COVID-19 .Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning .and shared resident care equipment . 1. On 01/26/21 at 3:06 p.m., licensed practical nurse (LPN) #3 stated all employees entered through the main entrance and were screened prior to going to their assigned area. She looked through the screening logs for the prior week (01/18/21 to 01/22/21) and stated she could not find screening forms for certified medication aide (CMA) #1. The LPN stated the CMA worked Monday through Friday. 2. On 01/25/21 at 9:45 a.m., housekeeper #1 stated he cleaned the floor with QC 34 floor neutralizer. The bottle did not have an EPA registration number. The housekeeping supervisor stated she could not find the EPA registration number for the product. The product was not found on the EPA-N list of approved disinfectants to use against SARS-Co V-2. At 10:43 a.m., certified nurse aide (CNA) #3 stated she used a pink liquid with Hand Sanitizer written on the bottle to disinfect a blood pressure cuff. She stated she also used it to disinfect the shower chair. At 11:50 a.m., the bottle was taken to the housekeeping supervisor by the administrator. The housekeeping supervisor stated she did not know what was in the bottle labeled as hand sanitizer. At 2:05 p.m., CNA #2 assisted resident #15 out of bed. She used a mechanical lift. The CNA did not disinfect the lift after it was used. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. On 01/25/21 at 9:00 a.m. to 9:30 a.m., CNA #1, #2 and #3 entered resident rooms on the halls with negative and quarantined residents without wearing eye protection. During a facility COVID-19 outbreak. At 10:16 a.m., a CNA in training (Aide) #6 was in resident #2's room, she removed her isolation gown and gloves; she did not use hand sanitizer or wash her hands, she picked up the resident's water pitcher and left the room. The aide took the pitcher to medication cart, removed the lid with bare hands, poured the water from the medication cart into the resident's water pitcher and then returned to the resident's room and placed the water pitcher on the isolation cart outside the room, she then donned a gown and gloves and delivered the water to the resident. She did not wear eye protection when entering the room and did not perform hand hygiene after touching the resident's water pitcher and before touching the water on the medication cart. Aide #6 stated she thought she had used hand sanitizer. She stated she was training to be a certified nurse aide. The aide stated she did not wear eye protection unless she provided direct care to the resident. At 10:22 a.m., CNA# 7 left the quarantine hall through the double doors with a resident's water pitcher. Upon return she stated she went to the dining room to fill the water pitcher with ice because she did not have ice on the hall. The CNA did not wear eye protection when she entered the resident's room to deliver the water pitcher. At 10:44 a.m., housekeeper #2 stated she did not wear an isolation gown when she cleaned the rooms of the residents who were on quarantine. She stated she thought she was just supposed to wear a gown when she cleaned in the rooms of the residents who tested positive for COVID-19. At 10:53 a.m., LPN #5 stated she was trained as an infection preventionist. The LPN stated the staff should not remove the residents' water pitchers from the quarantine area. She stated the water should not be obtained from the medication cart. The LPN stated she was not aware the staff needed to wear eye protection when entering the residents' rooms who were negative for COVID-19 and were not on quarantine. She stated the staff should wear full personal protective equipment (PPE) (gowns, gloves, mask, booties, and eye protection) when entering a resident's room who was on quarantine and change PPE in between each resident who was on quarantine unless delivering medications or meal trays. She stated the housekeeper should wear PPE when cleaning the resident rooms who were on quarantine.

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42171 On 01/25/21 at 5:05 p.m., an Immediate Jeopardy (IJ) situation was determined to exist due to the facility's failure to develop and implement an antibiotic use protocol which included reporting results of laboratory data to the ordering practitioner for resident #10. Resident #10 was hospitalized and subsequently passed away. On 01/25/21 the IJ situation was verified with the Oklahoma State Department of Health. On 01/25/21 at 5:05 p.m., the administrator and the assistant director of nurses were notified of the IJ situation related to failures in communicating pertinent lab results to the ordering physician. On 01/26/21 at 11:30 a.m., the plan of removal for the Immediate Jeopardy pertaining to notification of the physician was accepted. The plan of Removal for the Immediate Jeopardy documented: Plan of Removal 1. Facility licensed Nurses will be educated on the facility antibiotic and lab protocol. a. Current and outstanding labs will be addressed immediately by the Licensed Nurse. b. Abnormal labs will be called into the physician by the Licensed Nurse by the end of the shift for abnormal results. With critical abnormal results; the Licensed Nurse will notify the Primary Care Physician immediately upon receiving the results. c. When receiving the results of a Culture and Sensitivity; the Licensed Nurse is to call the Primary Care Physician and provide results to ensure the resident is on the proper antibiotic therapy. d. Documentation will be completed listing the contact time and orders given by the Licensed Nurse. e. If antibiotic is ordered, the Licensed Nurse will fax and call new order into pharmacy and request it be sent out immediately within 4 hours, in the event that the medication is not received in that time frame, the ordering physician will be notified and a hold order will be obtained until the medication is available and in the facility to administer. f. Upon receipt of the antibiotic the receiving nurse will document arrival and initial dose will be given. g. Licensed Nurse should document on the antibiotic each shift for the duration of the order. h. Any adverse reaction will be reported to the ordering practitioner by Licensed Nurse. (continued on next page)

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	375094	A. Building B. Wing	04/15/2021

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	i. Policies and procedures will be updated, and all CMA's and Licensed Nursing staff will be educated to reflect the above noted protocols. 2. Current facility residents' labs for the previous 30 days will be reviewed to ensure the Primary Care Physician has been notified of the results. Lab results that have a Culture and Sensitivity will be reviewed with the Primary Care Physician to ensure resident is on the proper antibiotic. This will be completed by the Nurse Management Team. 3. During the morning Clinical Meeting the Nurse Managers will review current orders for Labs and Antibiotics to ensure the resident is receiving the appropriate antibiotic. 4. The Nurse Managers will call the Primary Care Physician if the resident is not on the antibiotic that the Culture and Sensitivity shows sensitivity to. 5. This plan of removal will be in compliance January 26, 2021 by 5pm On 01/27/21 interviews were conducted with the nursing staff regarding education in-services pertaining to antibiotic and lab protocol for immediate jeopardy removal. The staff stated an in-service was provided on 01/26/21. The staff was able to verbalize understanding of the information provided in the in-service pertaining to the plan of removal. On 01/27/21 at 12:30 p.m., the IJ was removed when all components of the plan of removal had been completed. The deficiency remained at a level of actual harm at an isolated level. Based on observation, interview, and record review, it was determined the facility failed to develop and implement an antibiotic use protocol which included reporting results of lab data to the ordering practitioner for three (#4, #10 and #11) of five sampled residents reviewed for implementation of an antibiotic use protocol. The facility failed to notify the physician of significant laboratory results. The physician was not notified of urinary culture and sensitivity lab results for resident #10. The resident developed urinary sepsis, was hospitalized , and subsequently passed away. The facility identified 10 residents who currently received antibiotic therapy. Findings: The facility policy for Laboratory Services documented, the facility will notify the physician promptly of laboratory results. The policy documented laboratory results would be reviewed by the physician on a timely basis. The policy documented the facility would have a system to reconcile physician orders, labs ordered, the time labs were drawn, when the results were received, and when the physician was notified. The policy documented reports would be filed in the medical record. 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included resistance to multiple antibiotics and a stage 4 pressure ulcer of the sacral region. (continued on next page)

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan, dated 10/30/19, documented a resident goal was to remain free from complications related to urinary tract infections (UTIs) over the next 90 days. Care plan interventions included observing for signs and symptoms of UTI such as complaint of burning with urination, flank pain, presence of blood in urine, discharge, elevated temperature, increased confusion and agitation, or decreased level of consciousness. The care plan documented staff were to alert the charge nurse of any signs and symptoms so the physician could be notified. The admission assessment, dated 12/24/19, documented the resident was moderately impaired for daily decision-making, required extensive assistance with activities of daily living (ADLs), and had a urinary catheter. A progress note, dated 03/16/20 at 8:19 a.m., documented the urinary catheter was patent to bedside drainage with pale yellow urine and a large amount of sediment. The note documented the resident reported a sensation of urinary urgency. The note documented the urinary catheter was irrigated with 100 cubic centimeters (cc) of sterile saline and continued to drain pale urine with sediment. The note documented the physician was contacted regarding urine for analysis and they were waiting for a return call. A progress note, dated 03/16/20 at 9:42 a.m., documented a physician order to change the urinary catheter and obtain a urinalysis with culture and sensitivity. A progress note, dated 03/16/20 at 10:57 a.m., documented laboratory (lab) called to pick up the stat urinalysis. A progress note, dated 03/16/20 at 5:05 p.m. documented the stat urinalysis results were faxed to the physician's office. A urinalysis lab report, dated 03/16/20, documented the resident had a UTI. A physicians order, dated 03/17/20, documented the resident was to receive Bactrim DS tablet 800-160 milligram (MG) two times a day for 7 days. A progress note, dated 03/18/20 at 10:15 a.m., documented the resident continued on Bactrim DS for a UTI his temperature was 98.1 degrees Fahrenheit (F). The note documented the resident denied any pain or burning. A urine culture and sensitivity report, dated 03/19/20 at 9:23 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. The progress notes for March 2020 did not document the physician was notified of the culture and sensitivity results. The physician orders for March 2020 did not document the discontinuation of Bactrim, or an order for an antibiotic in which the bacteria was sensitive. The medication administration record (MAR) dated March 2020 documented the resident continued to receive Bactrim for a UTI. (continued on next page)

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 03/19/20 at 10:16 a.m., documented the resident continued on Bactrim DS for a UTI, his temperature was 97.9 degrees (F) and had no signs or symptoms of an adverse reaction. The note documented the resident complained of pressure to the abdominal area on the previous shift but had no complaints on this shift. A progress note, dated 03/24/20 at 1:15 p.m., documented the resident complained of the catheter leaking and the feeling of pain and pressure when moving. The note documented the nurse was unable to flush the catheter. The note documented the catheter was replaced and the resident tolerated it well. A progress note, dated 03/24/20 at 10:46 p.m., documented the nurse was called into the resident's room by certified medication aid (CMA). The note documented the resident had uncontrollable tremors, his oxygen saturation was 68 percent on room air, and the resident had a temperature of 99.5 degrees F. The note documented staff were not able to obtain a blood pressure due to the tremors. The note documented the resident's face was flushed and his nail beds were blue. The note documented the ambulance arrived and transported resident to the hospital for evaluation and treatment per doctor orders. The note documented the daughter, the director or nurses (DON), and the assistant director of nurses (ADON) were notified. An emergency medicine note, dated 03/24/20, documented clinical impressions of septic shock and acute respiratory failure with hypoxia. A details of hospital stay report, dated 03/26/20 at 3:18 p.m., documented the patient was treated for sepsis. The report documented the patient had proteus bacteria in his blood, was being treated with a broad spectrum antibiotic, and had a history of multi drug resistant organisms (MDRO). The report documented on the previous night the patient had labored breathing and became acutely hypotensive. The report documented a chest X-ray showed a probable aspiration pneumonia. The report documented the patient required multiple medications to maintain his blood pressure. The report documented the patient was placed on comfort measures after consulting with family and passed away at 1:35 p.m. on 03/26/20. A death certificate, dated 03/30/20, documented the immediate cause for death was septic shock due to Proteus Mirabilis. On 01/22/21 at 10:10 a.m., the assistant director of nurses (ADON) stated the process for lab orders was to put the order into the medical record, then order the lab through the laboratory website. The requisition would then be put in the lab book and the lab would be called for pick-up. She stated the charge nurse would check the lab website for the results and should notify the physician of any abnormal results. On 01/25/21 at 2:02 p.m., physician #1 was interviewed regarding lab results. He stated that he expected to be made aware of abnormal lab results. He stated that the lab company will call the facility and the physician with critical results, but culture and sensitivity results were not critical labs. Physician #1 stated the facility did not notify him of the culture and sensitivity results for resident #10. (continued on next page)

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/27/21 at 10:25 a.m., licensed practical nurse (LPN) #3 stated that it was the responsibility of the charge nurse to monitor the lab website for results and to report abnormal results to the physician. On 01/27/21 at 10:30 a.m. LPN #4 stated the physician should be notified of culture and sensitivity reports and the charge nurse was responsible for monitoring and reporting lab results. 2. Resident #4 was admitted to the facility on [DATE] with diagnoses which included urinary tract infection. The annual assessment, dated 10/27/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter and received antibiotics. A progress note, dated 01/13/21 at 3:02 p.m., documented the resident's urine was thick and the tube required milking and flushing for urine to flow adequately. The note documented the resident denied painful, urination, other symptoms, and was afrebrile. The note documented water was available and accepted after prompting. A progress note, dated 01/14/21 at 7:36 a.m., documented the residents urine continued to be thick and mucus like in consistency. The note documents the urine does not want to flow through tubing and it is was slow at times with cloudy appearance. The note documented a urinalysis was collected at that time to rule out UTI. The note documented the resident was afebrile and fluids were within reach. A final urinalysis report, dated 01/14/21 at 9:33 p.m., documented the urine had elevated protein, elevated blood, elevated white blood cell count and elevated red blood cell count. The progress notes for January 2020 did not document the physician was notified of the urinalysis report from 01/14/21 until 01/20/21. A final culture and sensitivity report, dated 01/16/21 at 8:34 a.m., documented probable collection contamination with skin flora and no susceptibility test was performed. The progress notes for January 2020 did not document the physician was notified of the culture and sensitivity report from 01/16/21 until 01/20/21. A progress note, dated 01/20/21 at 11:02 a.m., documented the suprapubic catheter was found on the floor beside the bed with a large amount of leaking urine to the abdominal region. The note documented the suprapubic catheter was replaced per physicians order, was draining to gravity and the the resident tolerated the procedure well. A progress note, dated 01/20/21 at 4:38 p.m., documented the urinalysis results were received, and were positive for a UTI. The note documented the physician was notified and orders were received for Rocephin intramuscular (IM) once a day for five days for UTI. The note documented the medication administration record (MAR) was updated and the power of attorney was made aware. (continued on next page)

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A progress note, dated 01/21/21 at 12:32 p.m., documented the resident continued on an intramuscular (IM) antibiotic for a UTI. The note documented the resident has had no signs or symptoms of an adverse reaction. The note documented the resident is afebrile and the suprapubic catheter was patent and draining to gravity, and received catheter care every two hours and as needed. A progress note, dated 01/24/21 at 2:37 a.m., documented the resident had only received one dose of Rocephin on or about 01/21/21. The note documented the medication appeared on the medication administration record (MAR) and not the treatment administration record (TAR). The note documented the medication was being checked off as administered by the medication aids who were not actually giving the medication or notifying the nurse. The note documented the nurse administered the second dose on 01/23/21 and the order was updated on the TAR. On 01/26/21 at 12:45 p.m., the assistant director of nurses (ADON) stated she was aware of the missed doses of Rocephin. The ADON stated she interviewed the nurse who discovered the medication had not been given and that nurse told her the physician was not contacted. She stated the nurse should have been notified the medication was on the MAR and not the TAR. She stated the physician should have been notified. On 10/27/21 at 10:10 a.m., physician #1 stated he expected to be notified by the facility when medication he had ordered was not administered. On 01/27/21 at 10:10 a.m., certified medication aid (CMA) #2 stated that IM meds should be on the TAR. She stated if she noticed an IM med on the MAR and not the TAR she would notify the charge nurse so the medication could be administered. 36191 3. Resident #11 had diagnosis which included urinary tract infection. The admission assessment, dated 12/11/20, documented the resident was cognitively intact for daily decision-making and required extensive assistance with activities of daily living (ADLs). The assessment documented the resident had a catheter. A progress note, dated 12/23/20 at 2:47 p.m., documented cloudy urine was noted in the catheter bag; a urine analysis was obtained per primary care physician, and a new order was received for Bactrim DS one time a day for five days until results of urinalysis were received. A physician's order, dated 12/23/20, documented to obtain a urinalysis with culture and sensitivity to rule out urinary tract infection. A final urinalysis report, dated 12/24/20 at 8:20 p.m., documented the result was abnormal with protein, leukocyte estrace (A screening test used to detect a substance that suggests there are white blood cells in the urine; this may mean you have a urinary tract infection.) bacteria and yeast, and the specimen was sent for culture. A final culture and sensitivity report, dated 12/26/20 at 11:11 a.m., documented the presence of the bacteria Proteus Mirabilis. The urine culture documented the bacteria was resistant to Bactrim. (continued on next page)

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F 0881 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The TAR documented the resident was administered Bactrim DS one time a day for five days on 12/23/20 through 12/27/20. No other antibiotic was documented as administered. The progress notes did not document the physician was notified of the culture and sensitivity results and did not document an antibiotic susceptible to the bacteria was ordered or administered to the resident. On 01/26/21 at 12:51 p.m., the ADON stated the antibiotic the resident was administered was resistant to the bacteria and was not the correct antibiotic. She reviewed the progress notes and stated the facility did not notify the physician of the culture and sensitivity results. The ADON stated the physician should have been notified of the culture and sensitivity results and a different antibiotic should have been ordered.

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F 0885 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Report COVID19 data to residents and families. 36191 Based on interview and record review, it was determined the facility failed to ensure residents/resident representatives and/or family members were provided cumulative updates of positive COVID-19 cases in the facility at least weekly for three (#2, #3 and #14) of four residents who were reviewed for notification. This had the potential to affect all 69 residents who resided in the facility. Findings: Review of the facility's line list revealed new positive COVID-19 cases in the building on the following dates: 01/07/21, 01/11/21, 01/14/21, 01/18/21, and 01/21/21. The facility had 12 residents on their COVID-19 positive unit. Review of resident #2 and #3's clinical record did not document the residents, resident representatives and/or families had been given cumulative weekly updates of the COVID-19 status in the building. On 01/25/21 at 10:42 a.m., resident #14 stated she did not know if there were any COVID-19 cases in the facility. She stated she thought they had cases because there was a plastic barrier up in the hall. On 01/26/21 at 2:54 p.m., the administrator stated he did not provide weekly cumulative updates of the COVID-19 status in the building because he thought the facility did not need to notify the resident, resident representative or families unless the facility had three or more cases of COVID-19.