STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145449	A. BUILDING _____ B. WING _____	08/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ACCOLADE PAXTON SENIOR LIVING	450 FULTON STREET PAXTON, IL 60957

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement pressure relieving interventions, administer pressure ulcer treatments as ordered, and measure pressure ulcers weekly for three of three residents (R1, R4, R5) reviewed for pressure ulcers in the sample list of 15. Findings include: 1.) R1's Face Sheet dated 8/19/20 documents R1 admitted to the facility on [DATE] and R1's [DIAGNOSES REDACTED]. R1's Admission Minimum Data Set ((MDS) dated [DATE] documents R1 is moderately impaired with cognition, uses extensive assistance of two staff for bed mobility and toileting, and is dependent on two staff for transfers. This MDS documents R1 is frequently incontinent of bowel and bladder and admitted to the facility with two stage one pressure ulcers. This MDS documents R1 is at risk for pressure ulcers, uses a pressure relieving device for bed/chair and uses a turning/repositioning program. R1's Care Plan revised on 8/14/20 does not document R1's pressure ulcers or pressure relieving interventions. R1's Pressure Ulcer Risk assessment dated [DATE] documents a total score of 16, indicating R1 is at risk for developing pressure ulcers. R1's Hospital Discharge Orders dated 7/15/20 documents orders to apply a [MEDICATION NAME] dressing to R1's bilateral medial metatarsal heads/left lateral ankle and right medial heel change every 3 to 5 days, an adherent foam dressing to R1's coccyx and right lateral ankle and change every 5 to 7 days, and apply Silver [MEDICATION NAME] 1 % cream topically daily to R1's ankle wound until debridement. R1's Order Summary Report dated 7/15-8/18/20 documents a daily treatment order to cleanse R1's right heel and right ankle wounds, apply a skin protectant around the wound beds, apply calcium alginate to the wound beds and cover with a nonstick pad and gauze wrap. R1's July 2020 (TAR) Treatment Administration Record does not document R1's [MEDICATION NAME] treatment to the bilateral medial metatarsal heads/left lateral ankle and right medial heel was administered as ordered on 7/16 and 7/23. This TAR does not document that Silver [MEDICATION NAME] cream was administered as ordered to R1's ankle wound on 7/16, 7/17, 7/25, and 7/27. This TAR does not document R1's treatment for [REDACTED]. R1's August 2020 TAR does not document that R1's right heel and right ankle wound treatment for [REDACTED]. R1's Admission Skin assessment dated [DATE] documents R1 had a right heel pressure sore that measured 4 cm (centimeters) by 1 cm and a right ankle bone sore that measured 2 cm by 2 cm. This form is incomplete and the area to document preventative interventions is left blank. R1's Weekly Skin Assessments dated 7/23/20 and 7/30/20 document R1 had a right heel pressure sore and a right ankle bone sore. This assessment does not document a description, the stages, or measurements for the wounds to R1's right heel and right ankle. There are no documented measurements in R1's medical record of R1's wounds until 8/4/20. R1's Initial Wound Evaluation and Management Summary dated 8/4/20 by V21 Wound Physician documents R1 had an Unstageable (due to necrosis) wound to the right heel that measured 2 cm long by 3 cm wide with no measurable depth. This summary documents R1's right heel wound was 100 % covered by black necrotic (dead) tissue and documents recommendations for the use of pressure relieving boots when in bed and to float R1's heels. This summary documents R1 had an abrasion wound to the right lateral ankle that measured 1 cm long by 1 cm wide by 0.1 cm deep that was covered by 100 % slough (devitalized tissue) and required debridement (removal of dead tissue.) This summary documents R1 had an abrasion wound to the left medial foot that measured 0.5 cm long by 0.5 cm wide. On 8/18/20 at 5:11 PM V2 Director of Nursing stated the nurses should be documenting on the resident's TAR when they administer treatment orders. V2 confirmed there was no documentation that R1's wound treatments were administered on 7/16, 7/17, 7/25, 7/27, 7/28, and 8/2/20. V2 stated the facility is unable to provide any documentation of pressure relieving interventions for R1 and confirmed R1's Care Plan does not document R1's impaired skin integrity. On 8/19/20 at 10:26 AM,V21 Wound Physician stated R1's right heel wound on 8/4/20 was unstageable due to necrosis, and R1's right heel wound could have been a Deep Tissue Injury upon admission rather than a Stage 1 pressure ulcer. V21 stated R1 had abrasions to the left and right ankles that were likely due to rubbing or being pulled across a sheet and sheering would have been a contributing factor. On 8/19/20 at 11:00 AM, Assistant Director of Nursing stated V3 oversees wounds in the facility. V3 stated V3 did not assess or measure R1's wounds until R1 was seen by V21 Wound Physician on 8/4/20. V3 stated V3 only sees residents who have referrals to see V21. V3 confirmed there were no documented wound measurements for R1's right heel, right ankle, and left ankle wounds after 7/15 until 8/4/20. V2 Director of Nursing stated the floor nurses should have documented weekly measurements on R1's wounds. 2.) R4's Face Sheet dated 8/19/20 documents R4 admitted to the facility on [DATE] and R4's [DIAGNOSES REDACTED]. R4's MDS dated [DATE] documents R4 has moderate cognitive impairment, is frequently incontinent of bowel, uses extensive assistance of two staff for bed mobility, and is totally dependent upon two staff for toileting and transfers. This MDS documents R4 admitted to the facility with one stage 2 and three stage 3 pressure ulcers, and R4 uses a pressure relieving device for bed/chair and a turning/repositioning program. R4's Care Plan revised on 5/20/20 documents R4 has a pressure ulcer with interventions to provide skin care per facility guidelines, provide wound care per treatment orders, and refer to specialized practitioner for wound management. R4's Pressure Ulcer Risk assessment dated [DATE] documents a total score of 13 indicating R4 is at moderate risk of developing pressure ulcers. R4's Order Summary Report dated 3/1-4/30/20 documents an order to cleanse R4's buttock wounds with wound cleanser, apply skin protectant to surrounding wound, and apply hydrogel twice daily. R4's Initial Wound Evaluation & Management Summary dated 3/5/20 by V21 Wound Physician documents R4 had a Stage 3 pressure wound of the right heel that measured 1.5 cm long by 1.5 cm wide by no measurable depth and required debridement. This summary documents recommendations to offload the wound, float R4's heels when in bed, and use pressure relieving boots when in bed. This summary documents R4 had a Deep Tissue Injury to R4's left heel that measured 2 cm long by 3 cm wide and no measurable depth and documents recommendations to offload the wound and elevate R4's legs. This summary documents R4 had a Stage 3 pressure wound of the sacrum that measured 2 cm long by 1 cm wide by 0.1 cm deep and a Stage 3 pressure wound of the coccyx that measured 2.5 cm long by 1.5 cm wide by 0.1 cm deep that both required surgical debridement. This summary documents R4 had a Stage 3 wound to the left buttock that measured 1 cm by 1 cm with orders to apply a [MEDICATION NAME] dressing daily. This summary documents recommendations to reposition per facility protocol, use of a low air loss mattress, and the use of a pressure relieving wheelchair cushion. R4's March 2020 TAR documents R4's left buttock wound treatment for [REDACTED]. This MAR indicated [REDACTED]. R4's April 2020 TAR documents R4's skin protectant to bilateral heels, and calcium alginate treatment to sacrum/coccyx/buttock was not administered as ordered on 4/2 and 4/6/20. R4's Wound Care Telemedicine Follow Up Evaluation dated 4/15/20 by V21 documents R4's Stage 3 right heel wound measured 1.7 cm by 1.9 cm, Stage 3 sacral wound measured 3 cm by 2.4 cm by 0.1 cm, Stage 3 coccyx wound measured 2.5 cm by 1.4 cm by 0.1 cm, Stage 3 left upper buttock wound measured 1 cm by 0.7 cm, Stage 3 right buttock wound measured 3.9 cm by 2.7 cm. R4's Wound Care Telemedicine Follow Up Evaluation dated 4/23/20 by V21 documents R4's Stage 3 right heel wound measured 1.5 cm by 0.9 cm, Stage 3 sacral wound measured 3 cm by 2.4 cm by 0.1 cm, Stage 3 coccyx wound measured 2.7 cm by 1.4 cm by 0.1 cm, Stage 3 left upper buttock wound measured 1 cm by 1 cm, and Stage 3 right buttock wound 2 cm by 2 cm. This evaluation documents R4 had an Unstageable Deep Tissue Injury of the left lower buttock that measured 1.7 cm by 1 cm and an Unstageable Deep Tissue Injury of the left buttock that measured 5.3 cm by 0.8 cm. This summary documents recommendations to reposition per facility protocol, off load wounds, use a low air loss mattress, not to place an impermeable mattress pad beneath R4, use of a pressure relieving

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

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.

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) wheelchair cushion, use of a draw sheet, and to limit R4's sitting time to 30 minutes. There is no documentation in R4's medical record that V21's recommendations for the use of a low air loss mattress, pressure relieving boots and wheelchair cushion, elevation of R4's legs, limiting R4's sitting time, and offloading of R4's wounds were implemented. On 8/18/20 at 5:11 PM V2 Director of Nursing stated the nurses should be documenting treatment administrations on the TAR and if the treatment is not signed out, then there is no documentation that the order was administered. Confirmed R4 admitted on ,[DATE] with coccyx/buttock/sacral wounds and R4's March 2020 MAR indicated [REDACTED]. V2 confirmed V21's order for [MEDICATION NAME] to R4's left buttock wound was not implemented on 3/6/20 as ordered. V2 stated V2 was unable to provide documentation of pressure relieving interventions that were implemented for R4. 3. R5's Face Sheet dated August 19, 2020 documents R5 has [DIAGNOSES REDACTED]. R5's Initial Weekly Skin assessment dated [DATE] documents that R5 has no pressure ulcers. R5's Pressure Ulcer Risk Assessment, dated February 3, 2020 documents R5 is at risk for pressure ulcer and recommends elevation of head of bed, position changes in the wheelchair and position changes while in bed. R5's Medical Record does not document initiation of elevation of head of bed, position changes in the wheelchair or position changes while in bed. R5's Initial Wound Evaluation and Management Summary dated February 20, 2020 by V21 Wound Physician documents a stage two shearing wound on the right buttock, 7 centimeters (cm) x 4cm x not measurable and a stage two shearing wound on the left buttock, 6cm x 4cm x not measurable. Recommendations: reposition per facility protocol, off-load wound and Pressure reducing relief cushion. R5's Initial Wound Evaluation and Management Summary dated February 20, 2020 by V21 documents an order for [REDACTED]. There was no treatment documented on R5's Right or Left Wound on February 23, 2020, February 25, 2020 or February 27, 2020. R5's Wound Evaluation and Management dated March 31, 2020 by V21 documents orders for a dressing to Right Buttock wound size 6cm x 2cm x 1cm, of strength Dakin solution on gauze daily for 25 days, Hydrogel to Left Buttock Wound, size 1.5cm x 1cm x not measurable for 25 days and Hydrogel to Left Great Toe for 30 days. R5's Treatment Record dated April 2020 documents dressing order of strength Dakin solution on gauze daily for 25 days on Right Buttock Wound, Hydrogel to Left Buttock Wound for 25 days and Hydrogel to Left Great Toe for 30 days. No treatment was documented on the Right Buttock Wound, Left Buttock Wound or Left Great Toe on April 2, 2020. R5's Wound Evaluation and Management dated June 16, 2020 by V21 documents orders for a dressing of Alginate Calcium applied once daily for 23 days to Right Buttock Wound 3cm x 4cm x 2.5 cm. Order for skin prep to newly acquired left heel wound measuring .3cm x .4cm x not measurable. Order for Left Great Toe measuring .5cm x .7cm x not measurable, skin prep for 16 days. R5's Treatment Record dated June 2020 documents dressing order of Alginate Calcium applied once daily for 23 days to Right Buttock Wound. On June 20, 2020 no treatment was documented on the Right Buttock Wound. R5's Progress Note dated June 29, 2020 at 12:49 PM by V13 Registered Nurse documents R5 was transferred to a local hospital for wound management and [DIAGNOSES REDACTED]. R5's Wound Evaluation and Management dated July 21, 2020 by V21 documents orders dressing of Alginate Calcium applied once daily for 30 days to Right Buttock Wound size 3cm x 4cm x 2 cm. Order for Skin Prep to Left Great Toe Wound size .5cm x .7 cm x not measurable for 30 days and Order for Skin Prep to Unstageable (Due to Necrosis) of the Left Heel, size .3cm x .4 cm x not measurable for 30 days. R5's Treatment Record dated July 2020 documents dressing order of Alginate Calcium to be applied once daily for 30 days to Right Buttock, Hydrogel to Left Buttock Wound and Hydrogel to Left Great Toe. On July 25, 2020 no treatment was documented on the Left Great Toe and the Left Heel. On July 28, 2020 no treatment was documented on the Left Great Toe, the Left Heel, or the Right Buttock. On 8/17/20 at 1:00 PM V8 Registered Nurse entered R5's room to complete R5's sacral wound treatment. V8 removed R5's brief and there was no dressing covering R5's sacral wound. The wound bed was pink. V8 cleansed R5's wound and applied calcium alginate with a bordered dressing. V8 applied a skin protectant to R5's left heel. R5's heel was red with skin intact. On 8/18/20 at 3:05 PM, V2 (Director of Nursing) confirmed that there is no documentation in R5's medical record of interventions to prevent pressure ulcers for R5. On 8/18/20 at 3:20 PM, V2 confirmed that an empty box in the Medication Administration Record [REDACTED]. On 8/24/20 at 8:21 AM,V2 Director of Nursing confirmed that interventions were not in place to prevent R5's pressure ulcers. The facility's Pressure Ulcer Prevention, Identification, and Treatment policy with a revision date of February 2020 documents Prevention program will be utilized for all residents who have been identified as being at risk for developing pressure ulcers. The facility will initiate an aggressive treatment program for those residents who have pressure ulcers. This policy documents the Charge Nurse is to care for pressure areas, provide treatments as ordered, and measure and document on the pressure ulcers weekly. This policy documents that pressure ulcer assessments will include prevention techniques.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to monitor a resident for dehydration by failing to monitor and document urinary catheter output, obtain physician ordered laboratory results, and notify a physician of a change in condition for one of five residents (R4) reviewed for dehydration in the sample list of 15. Findings include: R4's Face Sheet dated 8/19/20 documents R4's [DIAGNOSES REDACTED]. R4's Minimum (MDS) data set [DATE] documents R4 has moderate cognitive impairment and uses setup and supervision for eating assistance. R4's Care Plan revised on 5/20/20 documents R4 is at risk for altered nutritional status with interventions to obtain labs and diagnostic work as ordered, report the results to the physician, and follow up as indicated. R4's Care Plan documents R4 has an indwelling urinary catheter with an intervention to observe and document intake and output per facility policy. R4's Care Plan documents R4 has an Activity of Daily Living self care deficit with interventions for setup/supervision for eating. R4's Order Listing Report dated 3/1/20-4/30/20 documents an order for [REDACTED]. Pt (R4) evaluated and appears to be a little dry. This note documents orders to obtain a urinalysis, administer 1 liter of Normal Saline intravenously, and recheck CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) on 4/1/20. R4's Laboratory Report dated 3/30/20 documents R4's BUN (Blood Urea Nitrogen) was 43 (reference range is 7-18 milligrams/deciliter) and R4's Creatinine was 1.46 (reference range is 0.60-1.30 milligrams/deciliter.) R4's Laboratory Report dated 4/8/20 documents R4's BUN was 28 and R4's Creatinine was 1.33. There is no documentation in R4's medical record that a CBC and BMP was drawn as ordered on [DATE]. R4's March 2020 TAR (Treatment Administration Record) does not document urinary catheter output on the evening shift for 3/19-3/21, 3/29 and 3/30, and on the night shift for 3/23 and 3/29/20. R4's April 2020 TAR does not document urinary catheter output on the day shift on 4/2, 4/6, and 4/13, on the evening shift on 4/1, 4/3, 4/5, 4/10-4/13, 4/16, 4/19, and 4/21, and on the night shift on 4/3, 4/5, 4/6, 4/8, 4/12-4/14, 4/16, 4/18, and 4/19/20. R4's Progress Note dated 4/24/20 at 7:52 PM by V2 Nurse Practitioner documents R4 was evaluated for an unresponsive episode. This note documents R4 has had an intermittent cough and diarrhea for several days. This note documents R4 was transferred to the hospital for further evaluation. There is no documentation in R4's medical record that V2 was notified of R4 having diarrhea prior to 4/24/20. On 8/18/20 at 5:11 PM V2 Director of Nursing/Nurse Practitioner stated V2 had been monitoring R4's labs for dehydration and R4 was given IV (Intravenous) fluids. V2 confirmed V2 had ordered a CBC and BMP to be drawn on 4/1/20, and stated R4 had labs drawn on 4/8/20. V2 confirmed there was no documentation that R4 had a CBC and BMP drawn on 4/1/20 as ordered. V2 stated V2 was notified of R4's change in condition on 4/24/20, and nursing staff had reported to V2 that R4 had diarrhea for several days. V2 stated that V2 should have been notified of R4's diarrhea prior to 4/24/20. V2 stated urinary catheter output should be documented and monitored as ordered and confirmed R4's March and April 2020 TAR documented R4 was missing documentation of R4's urinary output. The facility's Hydration and Prevention of Dehydration policy dated August 2017 documents The facility will endeavor to provide adequate hydration and to prevent and treat dehydration. The Dietitian, nursing staff, and the physician will assess factors that may contribute to inadequate fluid intake and will assure all residents will receive adequate hydration. This policy documents nursing will assess for signs or symptoms of dehydration during daily care and laboratory tests may be ordered to assess for dehydration. The facility's Catheter Care Handling and Observation policy with a revision date of September 2018 documents Certified Nursing Assistants are to observe and report any changes to the Charge Nurse, and the Charge Nurse is to report any changes to the physician. This policy documents to monitor the resident's urine level, maintain an accurate record of the resident's daily output, and if the level increases rapidly to report to the Charge Nurse. This policy documents
F 0760 **Level of harm** - Actual harm **Residents Affected** - Few	**Ensure that residents are free from significant medication errors.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to protect residents from significant medication errors for two of three residents (R2, R6) reviewed for intravenous antibiotic administration in the sample list of 15. This failure resulted in recurrence of pain, swelling/[MEDICAL CONDITION], and additional surgical procedures and hospitalization to treat exacerbation of an infection for R2. Findings include: The facility's Medication Errors policy dated August 2017 documents

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F 0760 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Medication/Treatment Errors shall be documented on the Nursing Home Incident Reporting Form. An error shall be defined as any variation in administration of medication from the physician's orders [REDACTED]. 1.) R2's Face Sheet dated 8/18/20 documents R2 admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R2's Care Plan dated 3/4/19 documents R2 has an infection of the right internal knee with an intervention to administer antibiotics per physician orders. R2's Progress Note dated 4/11/2019 at 3:07 PM, V2 Nurse Practitioner documents R2 had a right total knee replacement in December 2018 and had complications with an infected total knee that had to be removed. R2 has an antibiotic cement spacer in R2's right knee, and is being followed by R2's orthopedic surgeon (V12). This note documents R2 was recently sent back to the hospital after increased pain and swelling and was admitted to the hospital on [DATE]. This note documents R2 had a repeat irrigation and debridement of R2's right knee and an antibiotic cement spacer was inserted. This note documents on 4/8 and 4/9 there was concern that there may be an infection migrating into the soft tissues of R2's thigh. R2 was discharged from the hospital and back to the facility on [DATE] on intravenous antibiotics. R2's Hospital Progress Note dated 4/7/19 at 9:37 AM, V12 Orthopedic Surgeon documents, (R2) is doing some better. We did talk about (R2's) knee and the infection. It certainly appeared as if the infection was still there. We talked about the fact that we have to cure this. We even mentioned the possibility of an amputation as an end result if we cannot cure it. This note also documents R2's [MEDICAL CONDITION] Arthritis affects R2's immune system. R2's Hospital Discharge Orders dated 4/11/19 documents orders for [MEDICATION NAME] (Antibiotic) 2 grams intravenously every 8 hours and [MEDICATION NAME] (Antibiotic) 1500 mg (milligrams) intravenously every 12 hours. R2's Aerobic Culture of the right knee dated 4/10/19 documents the presence of one colony of Coagulase negative Staphylococcus (bacteria.) R2's April 2019 Medication Administration Record [REDACTED]. This MAR indicated [REDACTED]. R2's Progress Note dated 4/11/19 at 8:41 PM, V4 LPN (Licensed Practical Nurse) documents intravenous [MEDICATION NAME] 2 grams was not on hand. R2's Progress Note dated 4/12/2019 at 5:12 AM by V4 documents intravenous [MEDICATION NAME] 2 grams Meds (medications) not on hand, not an rn (Registered Nurse.) R2's Progress Note dated 4/15/2019 at 1:51 PM, V2 Nurse Practitioner documents R2 has had increased leg pain and swelling, and R2 was concerned that did not receive all of R2's scheduled doses of antibiotics. R2's Progress Note dated 4/18/2019 at 12:28 PM, V2 documents R2 reported having a fever of 101.1 degrees Fahrenheit last night. R2 had returned from the hospital a week ago after having a second antibiotic knee spacer placed and R2's knee irrigated. This note documents R2 reported missing antibiotics to V2 on 4/15/19. R2 is to be seen today in V12's office. This note documents an addendum that V2 spoke with V6 (Physician's Assistant at V12's office) regarding R2's missed doses of intravenous antibiotics. This note documents Discussed with (V6) that upon chart review it appeared pt (R2) did not have 2 doses of the [MEDICATION NAME], one the night of return and one the morning after. Also, discussed with (V6) that (R2) arrived at facility at 2:45 PM so this provider not sure if (R2) received the 2pm dose at the hospital and may have missed that dose as well. (R2) also did not have her vanc ([MEDICATION NAME]) the night of (R2's) return. This provider was notified by the pt (R2) on 4/15 that (R2) missed doses of (R2's) antibiotic. This was discussed with the facility at that time. (V6) is discussing readmitting (R2) to the hospital and may need more surgery vs (versus) aspiration, ID (Infectious Disease) consult, and stressed this is a limb threatening situation. R2's Hospital Progress note dated 4/16/19 at 4:33 PM, V6 Physician Assistant documents R2 had an irrigation and debridement of R2's right knee, deep cultures, and placement of an antibiotic cement spacer on 4/5/19. This note documents R2 was discharged six days ago to an extended care facility to receive regular Intravenous antibiotics. This note documents, Apparently there were two and a half to three days where (R2) was getting either no antibiotics or not the complete intended ordered antibiotics. This note documents Plan: Obviously an interruption and (in) antibiotics like this is not at all acceptable. It sounds like (R2's) antibiotics have resumed appropriately, but I am very concerned about the interruption. R2's Hospital Procedure Summary Note dated 4/21/19 at 12:47 PM, V12 Orthopedic Surgeon documents Preoperative Diagnosis: [REDACTED]. Indication for surgery: Missed antibiotic doses with recurrence of pain, swelling and [MEDICAL CONDITION]. On 8/18/20 11:44 AM V2 Director of Nursing/Nurse Practitioner confirmed R2 had missed doses of intravenous [MEDICATION NAME] and [MEDICATION NAME] on 4/11 and 4/12/19. V2 stated V2 had spoken with V6 and R2 was admitted to the hospital for surgical intervention for R2's right knee infection. V2 stated it is hard to determine if the missed doses of antibiotics contributed to R2's infection since R2 had a history of [REDACTED]. V2 stated if a medication is unavailable then the nurses should check the facility's emergency medication supply, or notify the after hours pharmacy which can deliver the medication in 4 hours. V2 stated at the time R2's antibiotics were due, the nurses should have contacted V13 to obtain orders on how to proceed. On 8/21/20 at 4:04 PM, V6 Physician Assistant stated There were problems when (R2) returned to the facility in April where (R2) did not receive (R2's) IV antibiotics. It was a big deal because we were trying to eradicate (R2's) infection. It is possible that missing the doses of the IV antibiotics made (R2) more vulnerable to requiring additional surgery. 2.) The undated Nursing Home Incident Reporting Form documents R2 received two doses of intravenous (IV) [MEDICATION NAME] (antibiotic) administered intravenously through a CADD (Continuous Ambulatory Delivery Device). This report documents V11 Physician was notified, labs were ordered, and R2's [MEDICATION NAME] was held. R2's Physician order [REDACTED]. This RN (V5) hung the bag of [MEDICATION NAME] 5/6 at 2300 (11:00 PM) and ran the whole bag of fluid. The bag was suppose to be for two doses using a cad (CADD) pump. The AM nurse also hung an entire bag of [MEDICATION NAME] (2 doses). This RN (V5) called Pharmacy on 5/6 x 2 asking how the CAD (CADD) pump worked and it was never explained that there was two doses in one bag. MD (V11) called and notified of the med (medication) error and MD (medical doctor) (V11) said to hold the dose tonight and tomorrow am (morning) and draw the Vanco ([MEDICATION NAME]) lab (laboratory test) in the am. Resident (R2) has had increased stool and is slightly nauseated. VS (Vital Signs) WNL (Within Normal Limits.) Will continue to monitor. R2's [MEDICATION NAME] Trough (laboratory test) dated 5/8/19 documents an elevated level of 23.8, with the reference range of 15.0 - 20.0 micrograms/milliliter. On 8/18/20 10:21 AM V5 stated the pharmacy had sent the [MEDICATION NAME] premixed in a bag to administer intravenously to R2 through a CADD pump. V5 stated V5 was not aware that each bag of [MEDICATION NAME] was meant to be used for two doses of the medication. V5 stated that on 5/6/19 at 11:00 PM V5 administered the entire bag of [MEDICATION NAME] (2 doses) and the following morning another nurse administered an additional bag of [MEDICATION NAME] (2 doses). V5 stated V5 had not received any training from the facility on the use of the CADD pump prior to administering R2's [MEDICATION NAME]. On 8/18/20 11:39 AM, V9 Pharmacist stated administering double doses of the ordered [MEDICATION NAME] could cause a person to develop Redman's Syndrome, including a rash and itching. V9 stated [MEDICATION NAME] is dosed renally and could also have an affect on kidney function. V9 stated V9 would consider R2 receiving double the ordered dose of [MEDICATION NAME] would be considered a significant medication error. 3.) R6's Face Sheet dated July 19, 2020 documents R6 has [DIAGNOSES REDACTED]. R6's Discharge Hospital Orders dated July 29, 2020 document orders for Ertapenem (Antibiotic) one gram intravenous, every 24 hours for five days. R6's Medication Administration Record [REDACTED]. On 8/18/20 at 3:20 PM, V2 Director of Nursing confirmed that the Ertapenem one gram was not given on July 30, 2020 or July 31, 2020 and should have been given on July 30, 2020 and July 31, 2020. The facility's Administration of Medications policy revised on 11/21/18 documents Residents shall receive their medications on a timely basis in accordance with state and federal guidelines, and within established facility policies. The facility's Drug Orders from Pharmacy policy revised on September 2018 documents The purpose of this policy is to provide necessary to the pharmacy to assure accurate dispensing and prompt delivery of medications. The facility will provide information to the pharmacy when new medication or a change in medication order is received. This policy documents D. If possible new drug orders should be ordered before the pharmacy makes late afternoon delivery. E. If new drug orders have been received after the usual late delivery, the pharmacists are available for 24 hour emergency call.