STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215299	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTGATE HILLS REHAB & HEALTHCARE CTR	10 N. ROCK GLEN ROAD BALTIMORE, MD 21229

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

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** Based on observation and record review and staff interview, there were no care plan interventions in place to turn and reposition a resident who had 16 wounds or to place splints on extremities for the resident that had severe contractures. This was evident for 1 out of 20 residents (Resident #15) reviewed for care planning. The findings include: Resident #15 was observed by the surveyor on 9/18/20 at 11:45 AM lying on his/her left side with knees bent and in the fetal position with hand and legs splints in place. The hand and leg splints were observed by the surveyor on the resident again on 9/18/2020 at 2 PM. Record review conducted on 9/18/20 at 1:45 PM revealed Resident #15 was admitted to the facility in February 2020 with a sacral wound and with contractures that became severe and orders for turning and positioning every 2 hours and as needed. Further record review revealed the resident had a care plan in place for contractures and wounds, however, there were no interventions listed for turning and positioning, nor any interventions for hand and leg splints for the contractures despite observation of splints worn by the resident. An interview was conducted with Physical Therapy Staff #18 and the Director of Nursing on 9/18/20 at 2PM who advised that Resident #15 was consulted on 3/10/20 while receiving rehabilitation services about the need to avoid the fetal position and to reduce contractures. Per the DON, the resident is turned and positioned, however resident prefers to be on the left side and will flip back over to the left side if placed on the right side. The resident had also been consulted about wearing a bilateral knee brace to help contractures from getting worse and the resident agreed to try leg splints. Per Staff #18, on May 18, 2020 a note was written by Staff #18 that resident had difficulty tolerating hip abduction cushion which was deferred at that time due to skin integrity issues, and also the bilateral knee extension brace was also deferred due to the same concerns.
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review the facility failed to provide Activities of Daily Living (ADL) care, medication administration, and treatments to Resident's #15, #16, #17, #18, #13, and #14. This was evident for 6 out of 20 residents reviewed during the complaint survey. 1. A record review conducted on 9/18/20 at 1:45 PM for Resident #15 revealed the resident was admitted to the facility in February 2020 with a history of contractures, muscle wasting, and poor eating and multiple wounds as well as other diagnoses. Resident #15 was documented as needing extensive assistance and remained in the fetal position with severe contractures and had an order to turn and reposition every 2 hours and as needed. Further review of the record and review of the activities of daily living documentation revealed the following: Turning and positioning was not done according to resident records on 9/5/20 day shift and 9/6, 9/7/20, 9/12/20 on night shift. Amount eaten was not recorded on 9/5/2020 at 8 AM and 12 noon. Personal Hygiene was not recorded as completed on 9/5/2020 day shift or 9/6/20, 9/7/20, or 9/12/20 night shift. Resident was not fed her ensure plus on 9/17/20 and 9/18/20, as it was observed by the surveyor on her bedside table unopened on both days. The resident was not capable of reaching to the bedside table to pick up anything and was not able put a straw into the Ensure supplement due to the resident's contractions of the extremities. Don was interviewed on 9/18/20 at 2PM and stated there would be a meeting held with the medical director, physical therapy, occupational therapy, social services, Unit manager and dietician on 9/24/20 to go over Resident # 15 medical plan and treatment per family request. 2. Review of complaint MD 546 regarding lack of activities of daily living performed for bathing, toilet use and personal hygiene and other concerns was reviewed on 9/17/20 at 12:14 PM. Record review of Resident #13's records and facility Geriatric Nursing Assistant (GNA) documentation on 9/17/2020 at 12:14 PM revealed the following: Resident #13 did not have ADL care for bathing recorded on 5/2 and 5/3/2020, toilet use was not recorded on 5/2/20, and 5/3/20, skin checks were not recorded as completed on 5/2/20 and 5/3/20. Additionally, Resident #13's record had no documentation of the resident being dressed on 5/2/2020 and personal hygiene was not recorded as provided on 5/2 and 5/3/2020. There was no record of Resident #13 being turned or repositioned on 5/2 and 5/3/2020. There was no documentation to state if resident refused attempts to provide care. Further record review revealed a nurse practitioner saw the resident on 5/2/20; 5/4/20; and on discharge 5/5/20. There was no documentation that the physician saw the resident upon admission or during his/her stay at the facility. The DON confirmed in interview on 9/17/20 at 2 PM that they physician/medical director never saw the resident in person or through teleconference. 3. Review of Complaint #MD 546 regarding care concerns for Resident #14 was reviewed on 9/17/20. Review of the medical record for Resident #14 on 9/17/20 and 9/18/20 at 2 PM revealed the following medications were not given to the resident: Aspirin 81 mg ordered 1 time per day for [MEDICAL CONDITION] measures; Aspirin was not given on the 5/5, 5/7, 5/20, and 5/30/2020 [MEDICATION NAME] ordered 1000 mcg per day for supplement was not given on 5/5, 5/7, 5/20, 5/30/2020 Donepezil HCL ordered 10 mg at bedtime for Alzheimer's was not given 5/2, 5/19/2020 [MEDICATION NAME] ordered 40 mg 1 time per day for HTN, not given on 5/5, 5/7, 5/20, 5/30/2020 [MEDICATION NAME] 20 mg at bedtime ordered, not given on 5/2, 5/19/2020 [MEDICATION NAME] ordered 2 times per day for HTN, Not given at 9 AM 5/5, 5/7, 5/20, 5/30/2020; PM dose not given on 5/19/2020. Moisturizing cream apply to both legs 2 times per day, not given 9 AM 5/17, 5/30/2020; and 5 PM dose not given 5/16 and 5/19/2020, Covid 19 evaluation not done on 5/4, 5/7, 5/17,5/20, 5/30/2020. Not evaluated for pain 5/4, 5/7, 5/17,5/20, 5/30/2020. Vital signs not done on 5/4, 5/7, 5/17,5/20, 5/30/2020 Not Fed: day shift 5/2, 5/3, 5/12, 5/16, 5/26 or evening on 5/2, 5/3, 5/12, 5/16, 5/26/2020. ADL Care: Day shift Resident was not provided care for Bladder 5/2, 5/ 3, 5/12, 5/16, 5/26/2020 and Evening shift on 5/5, 5/12/2020 and Night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30 Bowel care not given day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020 and evening shift on 5/5, 5/12/2020 and night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. No skin check recorded on day shift and evening shift on Eve 5/5, 5/12/2020, as well as night shift 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Personal Hygiene not done Day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Toilet use not recorded on day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Turn and reposition not recorded 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. There was no documentation in the record to indicate the resident had refused ADL care. The DON was interviewed on 9/17/2020 regarding the number of blanks there were in the Medication Administration Record [REDACTED]. The facility lost several staff or staff chose to stop working at the facility and there were also agency staff present during that time. The DON stated when she came back to the facility after having been on leave, many staff were terminated for not completing records or writing documentation. She stated she was aware of the lack of documentation and was discussing this in her monthly quality assurance meetings. 4. Record review was conducted for Complaint #MD 681 and the medical record for Resident #18 on 9/21/20 at 9 AM and revealed the resident was admitted to this facility in September of 2019 with a [DIAGNOSES REDACTED]. Further review of ADL records found that Resident #18 was

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) not bathed on 9/10/20 day shift nor night shift. S/he was also not changed on 9/6/20, 9/7/20 and 9/12/20. Resident had no skin check completed on 9/10/20 on day shift and there was no documentation that the resided was dressed and personal hygiene given on that day. There was no documentation noted on the activities of daily living facility record to determine if the resident refused or the if tasks were not done. The DON was made aware of the concerns throughout the survey and upon exit on 9/22/2020. 5. Review of Complaint #MD 681 regarding concerns related to oxygen tubing and the medical record of Resident #17 was completed on 9/18/2020 and revealed the resident had an order for [REDACTED].#17's oxygen was is use, however the oxygen tubing was not dated. Further record review revealed oxygen saturation levels were not taken on 9/8/20 and 9/10/20 evening shift. Resident #17 also has a history of diabetes mellitus (DM) type 2 with an order to check Blood Sugar levels before meals and call the physician if less than 60 or greater than 300. Further review of the record revealed the Blood Sugar was not checked on 9/7/20 at 1630 and 9/9/20 at 1630 and was also not checked on 9/11/20 at 6:30 AM. 6. Review of Complaint #MD 681 related to blood sugar levels being checked and the medical record for Resident #16 was conducted 9/21/20 at 10:29 AM and revealed Resident #16 had a history of [REDACTED]. an order for [REDACTED]. Review of the record revealed the injection was not given on 7/3/20 1700 hours. Another order for insulin: [MEDICATION NAME] solution pen injector Inject 12 units sub Q two times per day was noted but review of the record revealed the injection was not given on 7/17/20 at 0900 or 1700 hours nor on 7/25/20 at 1700 hours. Further record review revealed finger sticks were not done on 7/2/20 at 6:30 and 11:30 AM, 7/3/20 at 1630, 7/6/20 at 11:30 AM and [MEDICATION NAME] flex pen injects per sliding scale not done on 7/30/20 as ordered. The documentation concerns related to all 6 residents were reviewed throughout the survey and again during exit on 9/22/2020 with the DON and Administrator.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** Based on review of resident records, observation and staff interviews, the facility failed to provide activities of daily living (ADL) care to a resident who was dependent on staff for for all ADL care. This was evident for 1 of 20 residents (Resident #15) reviewed during a complaint survey. The findings include: Record review conducted on 9/18/20 at 1:45 PM revealed Resident #15 was admitted to the facility in February 2020 with a history of contractures, muscle wasting, and poor eating and multiple wounds as well as other diagnoses. Resident #15 was documented as needing extensive assistance including feeding of all meals and drinks and remained in the fetal position with severe contractures. Further record review revealed the following documentation regarding activities of daily living (ADL): 1. Turning and positioning was recorded as completed according to resident records on 9/5/20 day shift and 9/6, 9/7, and 9/12/2020 on night shift despite an order to turn and reposition every 2 hours and as needed. 2. Amount eaten was not recorded on 9/5/2020 at 8 AM and 12 noon. 3. Personal Hygiene was not recorded as completed on 9/5/2020 day shift or 9/6/20, 9/7/20, or 9/12/20 night shift. 4. Ensure Plus was not fed to Resident #15 on 9/17/20 and 9/18/20 as it was observed by surveyor as left unopened on bedside table both days. The resident was not capable of reaching the Ensure on the bedside table to drink the Ensure Plus independently based on observation of contractures to extremities. Observation of Resident #15 revealed the resident was not fed his/her Ensure plus supplement on 9/17/20 and 9/18/20, as it was observed on the resident's bedside table unopened on both days and the resident was not capable of reaching to his/her bedside table to pick up anything or put a straw into the Ensure drink. The Director of Nursing (DON) was interviewed on 9/18/20 at 2 PM and stated there would be a meeting held with the medical director, Physical therapy and occupational therapy, social services, Unit manager and dietician on 9/24/20 to go over Resident # 15's medical plan and treatment per family request. DON and administrator were made aware of the concerns on 9/18/20.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the review of pertinent medical records and interview with facility staff, it was determined that staff failed to complete documentation on the medication and treatment administration record (MAR/TAR); failed to ensure that residents received regular scheduled medications as prescribed, and failed to document in a progress note if the resident refused the medications or treatments. This was found evident through the review of 9 of 20 records (Resident #12, #10, #11, #15, #16, #17, #18, #13, and #14) reviewed during a complaint survey. The findings include: 1. Compliant #MD 232 was reviewed on 9/16/2020 through 9/22/2020 for a variety of concerns. Review of Resident #12's medical record on 9/22/2020 at 12:02 PM revealed the following: --COVID assessments not completed on the day shift of 6/17/20, 6/19/20 and the evening of 6/9/20, 6/12/20, 6/19/20, 6/23/20 and 6/25/20. --Pain assessments for Resident #12 were not completed on the day shift of 6/18/20, 6/19/20 and the evening shifts of 6/9/20, 6/12/20, 6/19/20, 6/23/20 and 6/25/20. --The wound treatment for [REDACTED].#12 was not signed off as completed on 6/10/20, 6/11/20, 6/13/20, 6/15/20, 6/19/20, 6/22/20, 6/24/20, 6/26/20, 6/29/20, 6/30/20. --Turning and positioning for Resident #12 was not signed off as completed for 6/23/20, 6/25/20 and 6/30/20. The concern related to the multiple incomplete entries on the MAR/TAR on consecutive days and shifts was reviewed throughout the survey with the Director of Nursing (DON) and the Administrator and again during exit on 9/22/2020. 2. Complaint #MD 213 was reviewed on 9/18/20 for multiple concerns. One of the concerns indicated that medications were not given as prescribed and that vital signs were to be taken every shift, but were taken weekly. Review of the medical record for Resident #10 on 9/18/2020 revealed that the following medications were not given to the resident: -[MEDICATION NAME] 500 mg IV one time a day for Osteomylitis (Bone Infection). There was a missing entry on 7/28/20 at 9:00 AM. - Implanted Ports (central line for liquid injection) when in use, flush after administration of a medication with 10 ml saline every shift. There was a missing entry on 7/28/20 dayshift. -Santyl Ointment 250 unit/gm ([MEDICATION NAME]). Apply to Right shin topically every day shift for wound care. There were missing entries for dayshift on 7/17/20, 7/27/20 and 7/28/20. -[MEDICATION NAME] Sodium Solution Inject 0.4 ml subcutaneous one time a day for [MEDICAL CONDITIONS]. There was a missing entry on 7/28/20 at 9:00 AM. -Cefepine HCL Solution 2 GM/100 ml. Use 100 ml Intravenously three times a day for Osteomylitis. There were missing entries on 7/24/20 2000 (PM) dose, 7/28/20 1400 (PM) dose and 7/31/20 1400 (PM) dose. -[MEDICATION NAME] tablet give 500 mg by mouth three times a day for wound infection. There were missing entries for 7/17/20 2000 (PM) dose, and 7/26/20 1400 (PM) dose. -Vital signs every shift- Review of the MAR indicated [REDACTED]. Further review of the resident medical record revealed there were no corresponding progress notes of the resident refusal to take any of the medications that were not given. 3. Complaint #MD 994 was reviewed on 9/18/20 for multiple concerns. One of the concerns was that the resident's port-a-cath (central line for liquid injections through the vein) was not flushed. Review of the Resident #11's medical record on 9/18/2020 revealed there were missing entries of the port being flushed on 8/12/20 and 8/14/20 evening shift. Additionally, on 8/8/20 (evening shift), 8/9/20 (evening and night shift) and on 8/10/20 night shift the resident received 15 ml of saline flush and not the prescribed dose of 10 ml. Further review of the medical record revealed there were no corresponding progress notes of the resident refusal of the port being flushed. An interview was conducted with the DON on 9/18/20 at 1:15 PM and she was made aware of the identified concerns for Resident #10 and Resident #11. The DON reviewed the MARs and TARs for each of the residents and confirmed that there were missing entries for scheduled routine medications for the residents. The DON was made aware that there were no corresponding progress note indicating resident refusals. The DON stated to the surveyor that she was out of the facility for the entire month of May 2020 and returned to the facility around June 20th, 2020 due to illness. She stated that upon her return it was made known to her that there were concerns of medications not signed off and given. She further stated that the facility has provided ADHOC (similar to QAPI) Training to the staff to correct these concerns. 4. A Record review was conducted on 9/18/20 at 1:45 PM for Resident #15 and revealed the resident was admitted to the facility in February of 2020 with a history of contractures, muscle wasting, and poor eating and multiple wounds as well as other diagnoses. The resident was documented as needing extensive assistance and remained in the fetal position with severe contractures. Further record review revealed the following: a. Turning and positioning was not done according to resident records on 9/5/20 day shift and 9/6/20, 9/7/20, 9/12/20 on night shift despite an order for [REDACTED]. Amount eaten was

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) not recorded on 9/5/2020 at 8 AM and 12 noon. c. Personal Hygiene was not done on 9/5/2020 day shift or 9/6/20, 9/7/20, or 9/12/20 night shift. Observation of Resident #15 revealed the resident was not fed his/her Ensure plus supplement on 9/17/20 and 9/18/20, as it was observed on the resident's bedside table unopened on both days and the resident was not capable of reaching to his/her bedside table to pick up anything or put a straw into the Ensure drink. DON and administrator were made aware during survey exit on 9/22/2020 5. Review of complaint MD 546 regarding lack of activities of daily living performed for bathing, toilet use and personal hygiene and other concerns was reviewed on 9/17/20 at 12:14 PM. Record review of Resident #13's records and facility Geriatric Nursing Assistant (GNA) documentation on 9/17/2020 at 12:14 PM revealed the following: Resident #13 did not have ADL care for bathing recorded on 5/2 and 5/3/2020, toilet use was not recorded on 5/2/20, and 5/3/20, skin checks were not recorded as completed on 5/2/20 and 5/3/20. Additionally, Resident #13's record had no documentation of the resident being dressed on 5/2/2020 and personal hygiene was not recorded as provided on 5/2 and 5/3/2020. There was no record of Resident #13 being turned or repositioned on 5/2 and 5/3/2020. There was no documentation to state if resident refused attempts to provide care. Further record review revealed a nurse practitioner saw the resident on 5/2/20; 5/4/20; and on discharge 5/5/20. There was no documentation that the physician saw the resident upon admission or during his/her stay at the facility. The DON confirmed in interview on 9/17/20 at 2 PM that they physician/medical director never saw the resident in person or through teleconference. 6. Review of Complaint #MD 546 regarding care concerns for Resident #14 was reviewed on 9/17/20. Review of the medical record for Resident #14 on 9/17/20 and 9/18/20 at 2 PM revealed the following medications were not given to the resident: Aspirin 81 mg ordered 1 time per day for [MEDICAL CONDITION] measures; Aspirin was not given on the 5/5, 5/7, 5/20, and 5/30/2020 [MEDICATION NAME] ordered 1000 mcg per day for supplement was not given on 5/5, 5/7, 5/20, 5/30/2020 Donepezil HCL ordered 10 mg at bedtime for Alzheimer's was not given 5/2, 5/19/2020 [MEDICATION NAME] ordered 40 mg 1 time per day for HTN, not given on 5/5, 5/7, 5/20, 5/30/2020 [MEDICATION NAME] 20 mg at bedtime ordered, not given on 5/2, 5/19/2020 [MEDICATION NAME] ordered 2 times per day for HTN, Not given at 9 AM 5/5, 5/7, 5/20, 5/30/2020; PM dose not given on 5/19/2020. Moisturizing cream apply to both legs 2 times per day, not given 9 AM 5/17, 5/30/2020; and 5 PM dose not given 5/16 and 5/19/2020, Covid 19 evaluation not done on 5/4, 5/7, 5/17,5/20, 5/30/2020. Not evaluated for pain 5/4, 5/7, 5/17,5/20, 5/30/2020. Vital signs not done on 5/4, 5/7, 5/17,5/20, 5/30/2020 Not Fed: day shift 5/2, 5/3, 5/12, 5/16, 5/26 or evening on 5/2, 5/3, 5/12, 5/16, 5/26/2020. ADL Care: Day shift Resident was not provided care for Bladder 5/2, 5/ 3, 5/12, 5/16, 5/26/2020 and Evening shift on 5/5, 5/12/2020 and Night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30 Bowel care not given day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020 and evening shift on 5/5, 5/12/2020 and night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. No skin check recorded on day shift and evening shift on Eve 5/5, 5/12/2020, as well as night shift 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Personal Hygiene not done Day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Toilet use not recorded on day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Turn and reposition not recorded 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. There was no documentation in the record to indicate the resident had refused ADL care. The DON was interviewed on 9/17/2020 regarding the number of blanks there were in the Medication Administration Record [REDACTED]. The facility lost several staff or staff chose to stop working at the facility and there were also agency staff present during that time. The DON stated when she came back to the facility after having been on leave, many staff were terminated for not completing records or writing documentation. She stated she was aware of the lack of documentation and was discussing this in her monthly quality assurance meetings. 7. Record review was conducted for Complaint #MD 681 and the medical record for Resident #18 on 9/21/20 at 9 AM and revealed the resident was admitted to this facility in September of 2019 with a [DIAGNOSES REDACTED]. Further review of ADL records found that Resident #18 was not bathed on 9/10/20 day shift nor night shift. S/he was also not changed on 9/6/20, 9/7/20 and 9/12/20. Resident had no skin check completed on 9/10/20 on day shift and there was no documentation that the resided was dressed and personal hygiene given on that day. There was no documentation noted on the activities of daily living facility record to determine if the resident refused or the if tasks were not done. The DON was made aware of the concerns throughout the survey and upon exit on 9/22/2020. 8. Review of Complaint #MD 681 regarding concerns related to oxygen tubing and the medical record of Resident #17 was completed on 9/18/2020 and revealed the resident had an order for [REDACTED].#17's oxygen was is use, however the oxygen tubing was not dated. Further record review revealed oxygen saturation levels were not taken on 9/8/20 and 9/10/20 evening shift. Resident #17 also has a history of diabetes mellitus (DM) type 2 with an order to check Blood Sugar levels before meals and call the physician if less than 60 or greater than 300. Further review of the record revealed the Blood Sugar was not checked on 9/7/20 at 1630 and 9/9/20 at 1630 and was also not checked on 9/11/20 at 6:30 AM. 9. Review of Complaint #MD 681 related to blood sugar levels being checked and the medical record for Resident #16 was conducted 9/21/20 at 10:29 AM and revealed Resident #16 had a history of [REDACTED]. an order for [REDACTED]. Review of the record revealed the injection was not given on 7/3/20 1700 hours. Another order for insulin: [MEDICATION NAME] solution pen injector Inject 12 units sub Q two times per day was noted but review of the record revealed the injection was not given on 7/17/20 at 0900 or 1700 hours nor on 7/25/20 at 1700 hours. Further record review revealed finger sticks were not done on 7/2/20 at 6:30 and 11:30 AM, 7/3/20 at 1630, 7/6/20 at 11:30 AM and [MEDICATION NAME] flex pen injects per sliding scale not done on 7/30/20 as ordered. The documentation concerns related to all 9 residents were reviewed throughout the survey and again during exit on 9/22/2020 with the DON and Administrator.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff, it was determined that the facility failed to: 1.) Follow-up and implement treatments regarding wounds identified on admission and through independent party assessments and 2.) Follow- up and implement recommend supplements needed for the treatment and healing of wounds recommend by the dietitian. This was true for 1 of 3 residents (Resident #12) reviewed for pressure ulcers during the complaint survey. The findings include: Medical record review of Resident #12 on 9/16/2020 8:30 AM revealed [DIAGNOSES REDACTED]. Resident was also noted as a long-term care resident of the facility. 1. A review of weekly skin assessments on 9/16/2020 at 10:37 AM revealed assessments completed on 4/8, 4/15 and 4/22/2020 that documented no skin issues or impairments. On 4/30/2020 staff on assessment documented a new facility acquired pressure ulcer, documented as unstageable on the sacrum. On 5/1/2020 Resident #12 was noted with a change in condition and was sent to the hospital. On 9/16/2020 at 2:04 PM the hospital records for Resident #12 were reviewed. Resident remained at the hospital from 5/1/2020 through 5/20/2020. Admission [DIAGNOSES REDACTED]. Resident was assessed in the hospital on [DATE] by the wound ostomy continence nurse (WOC) and was noted with the following skin areas: A sacral unstageable pressure injury that extended to the upper buttocks noted with moderate amount of serosanguinous (drainage that is yellowish with small amounts of blood) and is tender to touch. An area on the right lateral ankle documented as a deep tissue injury (DTI), (ulcers that are likely to deteriorate and bruises on bony prominences), that measured 2 cm x 2 cm documented as dark purple in color and with ecchymosis (discoloration of the skin resulting from bleeding underneath, typically caused by bruising) without drainage. Areas on the right medial foot and left medial ankle with dark scabbing and a right bunion with dark brown discoloration were also documented on the WOC assessment. The assessment also documented that at that time the bilateral heels, elbows, ears, lips, and nares were intact without breakdown. Discharge treatment recommendations included to paint the identified areas on the lower extremities with [MEDICATION NAME] and place in offloading boots. Resident #12's readmission record and assessment to the nursing home was reviewed on 9/16/2020 at 2:38 PM. The assessment noted the presence of the sacral wound, documented it as community acquired unstageable, a right lateral ankle area that was dark purple, measuring 2 cm x 2 cm and an area to the left medial ankle. A review of the physician orders [REDACTED]. However, nothing was ordered or put in place for the areas noted on the discharged assessment or the admission assessment regarding the resident's lower extremities. On 9/16/2020 the previous WOC nurse (Staff #7) for the facility was interviewed. She stated that she saw the resident the following week on 5/26/2020 after s/he was admitted on [DATE] to assess the sacral wound and adjust the orders. On 9/17/2020 at 1:16 PM, Staff #7 was interviewed again regarding the other wounds noted on Resident #12 on 5/20/2020. Staff #7 stated that she cannot confirm or deny the presence of any other wounds, that she was only there to do the weekly wound assessment on the sacral wound. Continued review of the facility weekly skin checks noted the following: On 5/25/2020 a weekly skin check was completed and noted no skin areas on Resident #12. The 6/15, 6/22 and 6/29/20 weekly skin checks noted that there were no skin areas on Resident #12, besides the sacral ulcer. On 6/22/2020 hospice services came in to evaluate Resident #12. The assessment noted the following wounds: sacral wound with palpable bone, DTI to the right and left ankle and right medial foot. Further

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F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 3) review of the MAR/TAR for Resident #12 failed to reveal consistent documentation of staff signing off that treatment and care of the sacral wound, including actual skin treatment and turning in positioning were completed. This was reviewed with the Director of Nursing on 9/17/2020 and throughout the survey. (Cross reference F 684) On 9/22/2020 at 10:02 AM an interview with Hospice Staff #14 and her Supervisor Staff #15 regarding Staff #14's admission assessment of Resident #12 that was completed on 6/22/2020 at 8:00 PM. Staff #14 was asked if she had completed a hands-on assessment of the resident or was this an assessment copied from a hospital discharge. She stated that no, she had completed this assessment with her own hands and eyes. She was asked next what the hand off procedure was with the nurse on duty caring for the resident at the facility. She stated she would report off to the nurse, however, he was unavailable even after waiting for a significant amount of time. She left the chart in an area he designated and flagged her report for his review. A review of the nursing notes from 6/22-6/23/20 and the MAR/TAR failed to note or address any of the findings related to wounds noted in the hospice assessment. Review on 9/22/2020 at 9:00 AM of a physician note completed on 7/1/2020 noted that the extremities had protective boots bilaterally, however, the MAR/TAR, nursing notes and physician orders [REDACTED]. An actual order to turn and reposition Resident #12 was not made until 6/19/2020, although the resident was re-admitted to the facility on [DATE]. Review of the facility Geriatric nursing assistance (GNA) documentation for turning and positing (T and P) only notes daily signing off that T and P was completed each shift, however it was not consistently signed off as completed by staff and it did not show that the frequency of the T and P only that it occurred at least 1 time on the staffs shift. There was a previous order to float heels that was implemented prior to 5/1/2020 for Resident #12 but was never re-ordered upon the resident's re-admission to the facility on [DATE]. There was no follow-up on the recommended preventative treatment orders from the resident's discharge from Hospital #1 on 5/20/2020 that could have been put in place to assist in the prevention or the delay in the development of the wounds such as turning as noted above. On 7/2/2020 Resident #12 was sent to the hospital again for noted with labored breathing using accessory muscles and oxygen was applied for comfort with the recommendation to transfer resident 911 to nearest hospital for further evaluation and treatment. On 9/16/2020 hospital records for Resident #12 were reviewed from Hospital #2 admission on 7/2/2020. Admitting and final [DIAGNOSES REDACTED]. Hospital skin assessments, completed on 7/2/2020 revealed the following: sacral stage 4, right medial knee unstageable, left foot partial thickness wound, right hip DTI, left ear stage 3 pressure injury and right ear healed DTI. 2. During the Resident #12's stay in Hospital #1 a registered dietitian was consulted and implemented the following: [MEDICATION NAME] (tube feeding as the resident was unable to eat orally initially) and ProSource 30gram of protein daily. Additionally, on 5/11/2020 magic cup and gelatin twice a day was added that added calories and protein to the resident's diet once the resident was able to eat with assistance. Staff #13, the facility dietitian, was interviewed on 9/16/2020 at 1:54 PM regarding dietary assessments of Resident #12 upon readmission to the facility on [DATE], as no assessment was found in the electronic health record (EHR). She was able to provide a paper assessment completed on 5/21/2020, as she was doing tele-visits at the time. The dietician assessment noted the resident's weight at 118 pounds (lbs.) It further noted only the presence of a sacral unstageable wound. The assessment plan included the recommendation to start prostat (liquid protein supplement)30 ml, three times a day, and health shakes once daily. The plan also noted that these were in place prior to the resident's discharge on 5/1/2020. A review concurrently with the dietitian of the MAR indicated [REDACTED].) That when it was in place previously that it was only ordered once a day. The assessment also noted that the dietitian would continue to follow the resident. No further documentation was noted in the chart or elsewhere that the dietitian continued to follow the resident regarding his/her diet. When Resident #12 was admitted to Hospital #2 the following labs were noted: sodium of 161 (normal 135-145) and an elevated white blood cell count 17.8 (normal 4.5-11). Resident #12's [MEDICATION NAME] was 3 gm/dl (normal 3.4-5.4 grams per deciliter), a low level can signal malnutrition or inflammation and the total protein was 8.0 gm/dl (normal range 6.0-8.3) Secondary to the residents decline and inability to take in food orally, at the request of family a gastrostomy tube was placed. The overall concern related to the facilities staff failure to identify wounds noted by different entities and further implement interventions for the treatment and potential prevention of further decline of identified wounds from the residents readmission on 5/20/2020 to discharge on 7/2/2020 was discussed throughout the survey and again at exit on 9/22/2020 with the DON and the Administrator.
F 0711 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff it was determined that the facility staff failed to: 1.) document an accurate overview and presentation of the resident during a physician Telehealth visits and 2.) failed to document individual assessments and recommendations on three different residents. This was evident during 3 of 3 physician record reviews. (Resident #1, #11 and #12) The findings include: 1. Medical record review of Resident #12 on 9/16/2020 revealed [DIAGNOSES REDACTED]. Resident was also noted as a long-term care resident of the facility. Resident #12's Minimum Data Set (MDS) was reviewed on 9/16/2020 at 8:36 AM. The MDS is a comprehensive assessment of the resident completed by the facility staff. Information on the MDS should reflect the seven days up to and including the Assessment Reference Date (ARD). Resident #12's quarterly MDS assessment completed on 5/27/2020 noted that s/he required total assistance of 2 staff to complete activities of daily living including bed mobility and transfers and walking in and out of the room did not occur. Additionally, the MDS assessment noted that his/her hearing was highly impaired and that s/he was rarely understood when speaking. The Director of Nursing (DON) was interviewed on 9/16/2020 at 10:05 AM. She stated regarding Resident #12 that the resident had severe dementia and a decline in oral intake. The resident was sent out to the hospital in early May 2020 related to the decline. Resident #12's psychiatrist notes were reviewed on 9/17/2020 at 10:00 AM. Staff #17 documented having Telehealth visits in lieu of face to face visits with Resident #12 on 5/28, 6/5, 6/12 and 6/25/2020. The note text of each encounter documented that Patient oral consent for virtual visit obtained. Patient identity confirmed. Additionally, the 5/20, 6/5 and 6/12/20 progress notes documented the following: the patient denies fever/chills, cough, sore throat, myalgias. Staff #17 documented on physical examination 4. psych able to answer questions appropriately. The 6/25/2020 progress note documented regarding Resident #12 patient reports having slept well. All 4 progress note recommendations included to encourage the patient to get out of bed to chair during daytime hours and ambulate with room to prevent [MEDICAL CONDITION] and other sequalae of prolonged bedrest/immobility. Discharge planning was addressed and noted as ongoing and pending progress with rehab and medical plans of care. The facility medical director, Staff #16 was interviewed along with the DON on 9/ 0 at 2:24 PM. Staff #16 stated that he was familiar with the resident as s/he was discussed in their risk meetings and s/he was non-verbal, bed bound and unable to get up. The tele-health progress notes completed by Staff #17 were reviewed and discussed. Staff #16 agreed that the assessments and documentation did not correlate and was not reflective of Resident #12's status. 2. Two other residents were reviewed for comparison and consistency (Resident #1 and #11) regarding Staff #17's Telehealth visits. Resident #1, although verbal was bed bound, receiving gastrostomy tube feeding and later was admitted to hospice and passed away in the facility. Resident #11 was admitted on antibiotic therapy, respiratory therapy and was active in physical therapy before being discharged home. However, the same wording in the documentation was noted regarding reason for visit, resident current functional status and recommendations post visit which included rehab, pain management and discharge planning for all three residents reviewed (Residents #12, #1 and #11). This concern was reviewed on 9/22/2020 with the DON prior to survey exit. The concerns related to the psychiatrist's notes were reviewed during the survey and again during exit on 9/22/2020.
F 0712 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that the resident and his/her doctor meet face-to-face at all required visits.** Based on resident record review and staff interview Resident #13 was not seen by a physician when admitted to this facility. This was evident for 1 out of 20 residents reviewed during the complaint survey. The findings include: Review of Resident #13's medical record on 9/17/20 at 12:14 PM revealed the resident was admitted to this facility in April of 2020 for rehab following back surgery. A nurse practitioner saw the resident on 5/2/2020, 5/4/2020, and did the discharge summary on 5/5/20, however there was no documentation of a physician visit to the resident upon admission or during the duration of the resident's stay. The Director of Nursing was asked to verify this information and stated in interview on 9/17/20 at 2 PM that the physician/medical director never saw the resident in person or through teleconference.
F 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Based on administrative record review and interviews with facility staff it was determined the facility failed to ensure that a resident's drug regimen was free from unnecessary drugs and that medications were administered as ordered. This was found to be evident for 1 Resident (#11) whose medications were reviewed during a complaint survey. The findings include: Complaint #MD 994 was reviewed on 9/18/20 for multiple concerns. One of the concerns indicated that Resident #11 had an implanted port-a-cath (which is a type of central venous catheter used to inject liquids directly into the vein) that was not flushed daily as prescribed. Review of the physician orders [REDACTED]. Further review of the medication administration records (MAR) for Resident #11 revealed the following: (when using a peripheral, midline, or PICC-Peripherally Inserted Central Catheter) flush catheter with 10 ml of saline after completing medication every shift. Start date 8/8/20. Further review revealed that the resident port was flushed with 15 ml saline on the following dates: 8/8/20 evening shift, 8/9/20 evening and night shift, and 8/10/20 night shift. An interview was conducted with the Director of Nursing (DON) on 9/18/20 at 1:50 PM and she was made aware that upon review of the MAR for Resident #11, it revealed the resident was administered 15 ml of saline multiple times and not the 10 ml dose that was ordered by the physician. The DON reviewed the documentation and confirmed that the staff did in fact give the wrong dose of the medication and should have given the medication according to the prescribed orders. The DON stated that the staff will be educated on giving medication according to physician orders.
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** Based on administrative record review and interviews with facility staff it was determined the facility failed to maintain complete and accurate records for residents. This was found to be evident for 8 of 20 residents (Resident #10, #11, #15, #16, #17, #18, #13, and #14) reviewed during a complaint survey. The findings include: 1. Complaint #MD 213 was reviewed on 9/18/20 for multiple concerns. One of the concerns indicated that medications were not given as prescribed and that his/her vital signs were to be taken every shift, but were taken weekly. Review of the medical record for Resident #10 revealed that the following ordered medications were not given to the resident: [MEDICATION NAME] 500 mg IV one time a day. There was a missing entry on 7/28/20 at 9:00 AM. When implanted ports (a central line for liquid injection) are in use, flush after administration of a medication with 10 ml saline every shift. There was a missing entry on 7/28/20 dayshift. Santyl Ointment 250 unit/gm ([MEDICATION NAME]). Apply to Right shin topically every day shift for wound care. There were missing entries for dayshift on 7/17/20, 7/27/20 and 7/28/20. [MEDICATION NAME] Sodium Solution Inject 0.4 ml subcutaneous one time a day for [MEDICAL CONDITIONS]. There was a missing entry on 7/28/20 at 9:00 AM. Cefepine HCL Solution 2 GM/100 ml. Use 100 ml Intravenously three times a day for Osteomylitis. There were missing entries on 7/24/20 2000 (PM) dose, 7/28/20 1400 (PM) dose and 7/31/20 1400 (PM) dose. [MEDICATION NAME] tablet give 500 mg by mouth three times a day for wound. There were missing entries for 7/17/20 2000 (PM) dose, and 7/26/20 1400 (PM) dose. Review of the MAR indicated [REDACTED]. 2. Complaint #MD 994 was reviewed on 9/18/20 for multiple concerns. One of the concerns was that the resident port-a-cath (central line for liquid injections through the vein) was not flushed. Review of Resident #11's medical record on 9/18/2020 revealed there were missing entries of the port being flushed on 8/12/20 and 8/14/20 evening shift. An interview was conducted with the Director of Nursing (DON) on 9/18/20 at 2:00 PM and she stated that this concern was brought to her attention when she returned to the facility in June 2020 after being out due to illness. The DON went on to say that she is currently providing education to the staff to address all of the identified concerns. 3. A Record review was conducted on 9/18/20 at 1:45 PM for Resident #15 and revealed the resident was admitted to the facility in February of 2020 with a history of contractures, muscle wasting, and poor eating and multiple wounds as well as other diagnoses. The resident was documented as needing extensive assistance and remained in the fetal position with severe contractures. Further record review revealed the following: a. Turning and positioning was not done according to resident records on 9/5/20 day shift and 9/6/20, 9/7/20, 9/12/20 on night shift despite an order for [REDACTED]. Amount eaten was not recorded on 9/5/2020 at 8 AM and 12 noon. c. Personal Hygiene was not done on 9/5/2020 day shift or 9/6/20, 9/7/20, or 9/12/20 night shift. Observation of Resident #15 revealed the resident was not fed his/her Ensure plus supplement on 9/17/20 and 9/18/20, as it was observed on the resident's bedside table unopened on both days and the resident was not capable of reaching to his/her bedside table to pick up anything or put a straw into the Ensure drink. DON and administrator were made aware during survey exit on 9/22/2020 4. Review of complaint MD 546 regarding lack of activities of daily living performed for bathing, toilet use and personal hygiene and other concerns was reviewed on 9/17/20 at 12:14 PM. Record review of Resident #13's records and facility Geriatric Nursing Assistant (GNA) documentation on 9/17/2020 at 12:14 PM revealed the following: Resident #13 did not have ADL care for bathing recorded on 5/2 and 5/3/2020, toilet use was not recorded on 5/2/20, and 5/3/20, skin checks were not recorded as completed on 5/2/20 and 5/3/20. Additionally, Resident #13's record had no documentation of the resident being dressed on 5/2/2020 and personal hygiene was not recorded as provided on 5/2 and 5/3/2020. There was no record of Resident #13 being turned or repositioned on 5/2 and 5/3/2020. There was no documentation to state if resident refused attempts to provide care. Further record review revealed a nurse practitioner saw the resident on 5/2/20; 5/4/20; and on discharge 5/5/20. There was no documentation that the physician saw the resident upon admission or during his/her stay at the facility. The DON confirmed in interview on 9/17/20 at 2 PM that they physician/medical director never saw the resident in person or through teleconference. 5. Review of Complaint #MD 546 regarding care concerns for Resident #14 was reviewed on 9/17/20. Review of the medical record for Resident #14 on 9/17/20 and 9/18/20 at 2 PM revealed the following medications were not given to the resident: Aspirin 81 mg ordered 1 time per day for [MEDICAL CONDITION] measures; Aspirin was not given on the 5/5, 5/7, 5/20, and 5/30/2020 [MEDICATION NAME] ordered 1000 mcg per day for supplement was not given on 5/5, 5/7, 5/20, 5/30/2020 Donepezil HCL ordered 10 mg at bedtime for Alzheimer's was not given 5/2, 5/19/2020 [MEDICATION NAME] ordered 40 mg 1 time per day for HTN, not given on 5/5, 5/7, 5/20, 5/30/2020 [MEDICATION NAME] 20 mg at bedtime ordered, not given on 5/2, 5/19/2020 [MEDICATION NAME] ordered 2 times per day for HTN, Not given at 9 AM 5/5, 5/7, 5/20, 5/30/2020; PM dose not given on 5/19/2020. Moisturizing cream apply to both legs 2 times per day, not given 9 AM 5/17, 5/30/2020; and 5 PM dose not given 5/16 and 5/19/2020, Covid 19 evaluation not done on 5/4, 5/7, 5/17,5/20, 5/30/2020. Not evaluated for pain 5/4, 5/7, 5/17,5/20, 5/30/2020. Vital signs not done on 5/4, 5/7, 5/17,5/20, 5/30/2020 Not Fed: day shift 5/2, 5/3, 5/12, 5/16, 5/26 or evening on 5/2, 5/3, 5/12, 5/16, 5/26/2020. ADL Care: Day shift Resident was not provided care for Bladder 5/2, 5/ 3, 5/12, 5/16, 5/26/2020 and Evening shift on 5/5, 5/12/2020 and Night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30 Bowel care not given day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020 and evening shift on 5/5, 5/12/2020 and night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. No skin check recorded on day shift and evening shift on Eve 5/5, 5/12/2020, as well as night shift 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Personal Hygiene not done Day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Toilet use not recorded on day shift 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. Turn and reposition not recorded 5/2, 5/3, 5/12, 5/16, 5/26/2020, and evening shift 5/5, 5/12, as well as night shift on 5/3, 5/5, 5/6, 5/8, 5/9, 5/10, 5/12, 5/30/2020. There was no documentation in the record to indicate the resident had refused ADL care. The DON was interviewed on 9/17/2020 regarding the number of blanks there were in the Medication Administration Record [REDACTED]. The facility lost several staff or staff chose to stop working at the facility and there were also agency staff present during that time. The DON stated when she came back to the facility after having been on leave, many staff were terminated for not completing records or writing documentation. She stated she was aware of the lack of documentation and was discussing this in her monthly quality assurance meetings. 6. Record review was conducted for Complaint #MD 681 and the medical record for Resident #18 on 9/21/20 at 9 AM and revealed the resident was admitted to this facility in September of 2019 with a [DIAGNOSES REDACTED]. Further review of ADL records found that Resident #18 was not bathed on 9/10/20 day shift nor night shift. S/he was also not changed on 9/6/20, 9/7/20 and 9/12/20. Resident had no skin check completed on 9/10/20 on day shift and there was no documentation that the resided was dressed and personal hygiene given on that day. There was no documentation noted on the activities of daily living facility record to determine if the resident refused or the if tasks were not done. The DON was made aware of the concerns throughout the survey and upon exit on 9/22/2020. 7. Review of Complaint #MD 681 regarding concerns related to oxygen tubing and the medical record of Resident #17 was completed on 9/18/2020 and revealed the resident had an order for [REDACTED].#17's oxygen was is use,

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F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5) however the oxygen tubing was not dated. Further record review revealed oxygen saturation levels were not taken on 9/8/20 and 9/10/20 evening shift. Resident #17 also has a history of diabetes mellitus (DM) type 2 with an order to check Blood Sugar levels before meals and call the physician if less than 60 or greater than 300. Further review of the record revealed the Blood Sugar was not checked on 9/7/20 at 1630 and 9/9/20 at 1630 and was also not checked on 9/11/20 at 6:30 AM. 8. Review of Complaint #MD 681 related to blood sugar levels being checked and the medical record for Resident #16 was conducted 9/21/20 at 10:29 AM and revealed Resident #16 had a history of [REDACTED]. an order for [REDACTED]. Review of the record revealed the injection was not given on 7/3/20 1700 hours. Another order for insulin: [MEDICATION NAME] solution pen injector Inject 12 units sub Q two times per day was noted but review of the record revealed the injection was not given on 7/17/20 at 0900 or 1700 hours nor on 7/25/20 at 1700 hours. Further record review revealed finger sticks were not done on 7/2/20 at 6:30 and 11:30 AM, 7/3/20 at 1630, 7/6/20 at 11:30 AM and [MEDICATION NAME] flex pen injects per sliding scale not done on 7/30/20 as ordered. The documentation concerns related to all 9 residents were reviewed throughout the survey and again during exit on 9/22/2020 with the DON and Administrator.