STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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PASS CHRISTIAN HEALTH AND REHABILIATION CENTER	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

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F 000	INITIAL COMMENTS The State Agency (SA) conducted Complaint Investigations (CI) MS #27466 and CI MS #27500, at the facility from 2/5/25 to 2/7/25. During the investigations, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. CI MS # 27466 was investigated for resident rights and physical environment and there were no deficiencies cited regarding the complaint. The SA investigated CI MS #27500 regarding quality of care and medication administration. F726 and F760 were cited regarding the complaint. As a result of the survey, F727 was also cited. The facility had a census of 55 and was licensed for 60 beds.	F 000		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident	F 726		3/21/25

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

Electronically Signed | 02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 726	Continued From page 1 assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure staff competency in medication reconciliation, which resulted in a nurse accessing the wrong resident's records and transcribing incorrect medication orders into the system without verification. This failure led to the prolonged administration of incorrect medications for one (1) of four (4) sampled residents reviewed for medication administration. Resident #1. Findings include: A review of the facility's policy and procedures titled "Physician's Orders," revised on 03/03/2021, revealed, "The facility will ensure that physician orders are appropriately and timely documented in the medical record. Information received from the referring facility or agency must be reviewed, verified with the physician, and transcribed to the electronic medical record ... The nurse transcribing the order is responsible for ensuring accuracy and compliance with physician instructions ..."	F 726	This Plan of Correction does not constitute an admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared solely because of the provisions of State and Federal Laws. 1) Resident #1 was discharged on 01/13/2025 to Assisted Living Facility. 2) All Residents have the potential to be affected by this alleged deficient practice. 3) All Nursing Staff was inserviced on Physician Orders Policy and Medication Reconciliation on 02/27/2025 by the Director of Nursing. 4) An audit was conducted by the Director of Nursing for all admissions/readmissions for 30 days prior to 02/27/25, then starting on 02/28/25, medical records nurse will conducted an	

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F 726	Continued From page 2 A record review of the acute hospital's "Discharge Information," dated 11/22/2024, revealed Resident #1's "Your Medication List" included Acetaminophen 500 milligrams (mg) by mouth every six hours as needed for mild pain, Amoxicillin-clavulanate 875/125 mg by mouth in the morning and one tablet before bedtime for two (2) days, Aspirin 81 mg delayed-release by mouth in the morning, B Complex with Vitamin C by mouth in the morning, Bisacodyl 10 mg suppository rectally daily as needed for constipation, Diphenhydramine and Zinc Acetate Cream applied topically three times daily as needed for itching, Docusate Sodium 100 mg by mouth in the morning and one capsule before bed, Ergocalciferol 1250 micrograms (mcg) (50,000 units) by mouth daily, Fexofenadine 180 mg by mouth in the morning, Lasix 20 mg by mouth every morning, Hydralazine 10 mg in the morning and 10 mg before bedtime, Hydrocodone/Acetaminophen 5/325 mg by mouth every six hours as needed for moderate pain, Hydroxyzine 25 mg by mouth three times a day as needed for itching, Ipratropium/Albuterol 0.5 mg/3 mg/2.5 mg base/3 ml nebulizer solution every six hours for three (3) days, and Phenol 1.4% sore throat spray as needed, and Polyethylene glycol 17 gram packet take seventeen grams by mouth in the morning. A record review of Resident #1's "Medication Administration Record (MAR)," dated 11/01/2024 through 11/30/2024, revealed Resident #1 received Amlodipine Besylate 5 mg by mouth daily for six (6), Aspirin 81 mg by mouth daily for six (6) days, B Complex by mouth daily for six (6) days, Carbidopa/Levodopa/Entacapone 12.5-50-200 mg by mouth daily for eight (8) days;	F 726	audit on three to five (3-5) residents for three weeks, then it will be conducted monthly. All audits will be brought to the Quality Assurance Performance Improvement Committee meeting on 03/20/25, and continue monthly for three months to determine the effectiveness and make necessary changes.	

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F 726	Continued From page 3	F 726		

Cyanocobalamin injection 1000 mcg intramuscular every 30 days for one (1) day, Ergocalciferol 1.25 mg every Friday for one (1) day, Eye-Vites Oral Tablet daily for six (days), Hydrochlorothiazide 12.5 mg by mouth daily for eight (8) days, Lasix 20 mg by mouth daily for six (6) days, Levothyroxine 137 mcg by mouth daily for seven (7) days, Omega-3 fatty acids 1200 mg by mouth daily for eight (8) days, Omeprazole 40 mg by mouth daily for seven (7) days, Potassium Chloride ER 10 meq by mouth for six (6) days, Ropinirole HCL 1 mg by mouth daily for eight (8) days, Vitamin D3 by mouth daily for eight (8) days, Buspirone HCL 15 mg by mouth twice daily for nine (9) days, Gabapentin 600 mg by mouth twice daily for nine (9) days, Multivitamin Oral Tablet two times daily for nine (9) days, Norco 5/325 mg by mouth every six (6) hours as needed for one (1) day (2 doses given), Oxycodone 5 mg every six (6) hours as needed for one (1) day (1 dose given), and Sertraline HCL 100 mg by mouth twice daily for nine (9) days.

During an interview on 02/06/2025 at 9:00 AM, Registered Nurse (RN) #2 confirmed she received an email from the Marketer indicating Resident #1's information was available in the computer system. RN #2 admitted that she did not verify the physician's orders or confirm that the correct resident's information was uploaded before entering the orders into the facility's electronic health records (EHR) system. She no longer worked at the facility and was unaware that she had accessed another patient's chart and not the new admission (Resident #1) that was being discharged from the hospital. The nurse stated that she was trained in nursing school to follow the five rights when receiving a resident's information - the right patient, right

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	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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F 726	Continued From page 4 medication, right route, right dose and right time. RN #2 explained that she was admitting numerous residents and was "not thinking' at that time On 2/6/25 at 3:00 PM, the Administrator Assistant confirmed Resident #1 received the wrong medication for several days. She explained that RN #2 was the interim Director of Nursing (DON) at the time the medication error occurred. The Administrator Assistant stated that she was notified by RN#1 stating that the resident had received the wrong medication. A record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 11/21/2024 with current diagnoses including Fracture of the Manubrium. A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact.	F 726		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.	F 727		3/21/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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F 727	Continued From page 5 §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Registered Nurse (RN) was present at the facility for at least eight (8) consecutive hours a day for one (1) of eight (8) days reviewed. Findings included: A record review of the staffing grid revealed that a Registered Nurse (RN) did not work on 01/21/2025. A record review of the facility's "Facility Assessment Tool," dated 07/31/2024, revealed that the facility's staffing plan was based on the resident population and their needs for care and support. The assessment indicated licensed nurses providing direct care were adjusted based on residents' activities and care needs per shift, with two (2) to four (4) licensed nurses per shift and a nurse-to-resident ratio of 1:20 to 1:30. The document also listed other nursing personnel responsible for administrative duties, including the Director of Nursing (DON), two (2) unit managers, a wound care nurse, and one (1) Minimum Data Set (MDS) coordinator. On 02/06/2025 at 8:00 AM, during an interview, the Interim DON stated that she had only worked at the facility for one (1) month. She stated that she had served in this role for two (2) weeks and had been working night shifts all week due to staff shortage. The Interim DON reported that on 01/20/2025, she worked from 8:00 AM to 1:30	F 727	1) Executive Director conducted an audit for the prior 30 days prior to 02/27/25 and found that there was at least 8 hours of coverage daily. The Audit was conducted on 02/27/25. 2) All Residents have the potential to be affected by this alleged deficient practice. 3) Inservice was provided to the Executive Director by the Regional Director of Clinical Services on 02/24/25 regarding the requirement of 8 hours of Registered Nurse coverage daily. All nurses were inserviced on requirements of 8 hours of RN coverage daily. This was conducted by the Executive Director on 02/27/25. 4) On 02/28/25, the requirement of 8 hour RN coverage will be assured in the daily stand-up meetings by the Director of Nurses and/or the Executive Director. The weekend coverage will be monitored in every Friday's stand-up meeting. Executive Director conducted an audit for the prior 30 days from 02/27/25 for 8 hours of RN coverage, starting on 02/28/25 the Executive Director will audit daily for 3 weeks and then monthly. The Executive Director will present all audits to the Quality Assurance Performance Improvement Committee Meeting on 03/20/25, and continue to monthly for three months to determine the	

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F 727	Continued From page 6 PM. She further stated that a night shift nurse called in, and after going home for a few hours of rest, she returned to the facility at 6:00 PM and worked until 7:00 AM. She stated that she advised the Administrative Assistant to notify staff that they should prepare to stay overnight due to the weather and recommended that the maintenance department prepare rooms for staff to sleep in. The Interim DON reported that after working the full night shift, she needed to go home and rest. She further stated that the Administrator later called her to return to the facility on 1/21/25, but she was unable to drive due to severe weather conditions and did not return until the following day. On 02/06/2025 at 3:00 PM, during an interview, the Administrative Assistant confirmed that the facility did not have an RN on duty on 01/21/2025. She stated that the severe snowstorm prevented staff from coming in to assist and that two (2) Licensed Practical Nurses (LPNs) were available. The Administrative Assistant further stated that she and the LPNs remained at the facility to ensure the safety of the residents and the facility was actively recruiting RNs to fill the staffing gap.	F 727	effectiveness and make necessary changes.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and facility policy review, the facility failed to prevent significant medication errors, resulting in a resident receiving multiple unprescribed	F 760	1) Resident #1 discharged on 01/13/25. Resident #4 discharged to the hospital on 01/21/25.	3/21/25

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	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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F 760	Continued From page 7 medications for up to eight (8) consecutive days, causing excessive sedation and the inability to participate in therapy (Resident #1), and failed to administer prescribed intravenous (IV) antibiotics on multiple occasions (Resident #4) for two (2) of four (4) sampled residents. Findings included: A review of the facility's policy titled "Administering Medications," revised April 2019, revealed, " ...Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation ...4. Medications are administered in accordance with prescriber orders ...9. The individual administering medications verifies the resident's identity before giving the resident his/her medications ...22. The individual administering the medication initials the resident's Medication Administration Record (MAR) on the appropriate line after giving each medication and before administering the next ones ..." Resident #1 On 02/05/2025 at 9:30 AM, during an interview, Resident #1's daughter stated that Registered Nurse (RN) #1 notified her that Resident #1 had received ten (10) days of another resident's medications. She said that the nurse informed her that another nurse had gotten the wrong medication from the computer portal which caused her mother to receive someone else's medication. The daughter reported that she had been calling the facility repeatedly, questioning why her mother was sedated and unable to participate in therapy and that several family members came to visit the resident and reported	F 760	2) All Residents have the potential to be affected by this alleged deficient practice. 3) An inservice was conducted by the Director of Nurses to all nurses on 02/27/25 regarding Administering Medications. Two licensed nurses will verify transcription of physcian orders by reconciling orders entered into the electronic health records. The two licensed nurses will verify residents date of birth, social security number, and name to ensure correct physician orders were entered into the resident electronic health record. 4) The Director of Nurses or Medical Records Nurse will audit the Medication Administration Record for timely and accurate documentation beginning 02/28/25 for 3-5 Residents weekly for 3 weeks then 3-5 Residents monthly for 3 months. All audits will be brought to the Quality Assurance Performance Improvement Committee on 03/20/25 and continue monthly for three months to determine the effectiveness and make necessary changes.	

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	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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F 760	Continued From page 8	F 760		

that she was not alert and oriented as she had been while in the hospital.

During an interview on 2/5/25 at 10:00 AM, with RN #1, she explained that medications are sent to the nursing home from the hospital when a resident is discharged from the hospital. She stated that nurses were having to get Resident #1's medications from the Omnicell (a type of automated medication dispensing system) which alerted her to investigate further. RN #1 reported that she compared Resident #1's MAR and the physician's orders and noticed that the admitting physician's orders had another person's name on them, and not Resident #1. The nurse notified the Administrator, Medical Director (MD) and the Nurse Practitioner (NP). The nurse revealed she was told to delete all those medications and to input the correct medications from the correct discharge orders. The resident was assessed for negative adverse reactions. RN #1 revealed that Resident #1 was heavily sedated.

During an interview on 2/5/25 at 10:30 AM, the NP confirmed Resident #1 was administered the wrong medications. The NP stated that she notified the Medical Director and assessed the resident, as well as ordered some laboratory tests, which were normal. The NP stated Resident #1 was disoriented and sedated at that time. The NP explained that the facility notified the insurance company and asked for more covered days because Resident #1 had a slight delay in therapy due to being heavily sedated and unable to follow commands.

An interview on 2/5/25 at 10:45 AM, with the Speech Therapy (ST) Director revealed Resident #1 was evaluated on 11/22/24. The resident was

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	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

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F 760	Continued From page 9	F 760		

alert oriented, able to stand, and transfer with one person assist. The resident met criteria to receive physical and occupational therapy to be strengthened after her fracture. The ST Director also said she was told by the Physical Therapy Assistant (PTA) and Occupational Therapy Assistant (OTA) that on 11/25/24 the resident was heavily sedated and needed maximum assistance with transfers and standing.

An interview on 2/5/25 at 11:00 AM with the (PTA) and (OTA) revealed Resident #1 was lethargic and not following commands on Monday 11/25/24. The PTA and OTA said Resident #1 needed maximum assistance with two (2) person assistance because she was heavily sedated, and they could not provide therapy.

During an interview on 2/5/25 at 11:15 AM, the Admissions Director explained either the Marketer or herself will upload resident admission information into the computer system. The Marketer who uploaded the incorrect resident information for Resident #1 is no longer employed at the facility. She reported that after the information is uploaded, then the admitting nurse will download that information and put everything into the electronic health record (EHR) where it belongs.

On 2/6/25 at 9:00 AM, during an interview, RN #2 confirmed she received an email from the Marketer indicating Resident #1's information was available in the computer system. RN #2 admitted that she did not verify the physician's orders or confirm that the correct resident's information was uploaded before entering the orders into the facility's electronic health records (EHR) system. She no longer worked at the facility and was

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F 760	Continued From page 10	F 760		

unaware that she had accessed another patient's chart and not the new admission (Resident #1) that was being discharged from the hospital. RN #2 explained that she was admitting numerous residents and was "not thinking' at that time.

A record review of the acute hospital's "Discharge Information," dated 11/22/2024, revealed Resident #1's "Your Medication List" included Acetaminophen 500 milligrams (mg) by mouth every six hours as needed for mild pain, Amoxicillin-clavulanate 875/125 mg by mouth in the morning and one tablet before bedtime for two (2) days, Aspirin 81 mg delayed-release by mouth in the morning, B Complex with Vitamin C by mouth in the morning, Bisacodyl 10 mg suppository rectally daily as needed for constipation, Diphenhydramine and Zinc Acetate Cream applied topically three times daily as needed for itching, Docusate Sodium 100 mg by mouth in the morning and one capsule before bed, Ergocalciferol 1250 micrograms (mcg) (50,000 units) by mouth daily, Fexofenadine 180 mg by mouth in the morning, Lasix 20 mg by mouth every morning, Hydralazine 10 mg in the morning and 10 mg before bedtime, Hydrocodone/Acetaminophen 5/325 mg by mouth every six hours as needed for moderate pain, Hydroxyzine 25 mg by mouth three times a day as needed for itching, Ipratropium/Albuterol 0.5 mg/3 mg/2.5 mg base/3 ml nebulizer solution every six hours for three (3) days, and Phenol 1.4% sore throat spray as needed, and Polyethylene glycol 17 gram packet take seventeen grams by mouth in the morning.

A record review of Resident #1's "Medication Administration Record (MAR)," dated 11/01/2024 through 11/30/2024, revealed Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 760	Continued From page 11	F 760		

received Amlodipine Besylate 5 mg by mouth daily for six (6), Aspirin 81 mg by mouth daily for six (6) days, B Complex by mouth daily for six (6) days, Carbidopa/Levodopa/Entacapone 12.5-50-200 mg by mouth daily for eight (8) days; Cyanocobalamin injection 1000 mcg intramuscular every 30 days for one (1) day, Ergocalciferol 1.25 mg every Friday for one (1) day, Eye-Vites Oral Tablet daily for six (days), Hydrochlorothiazide 12.5 mg by mouth daily for eight (8) days, Lasix 20 mg by mouth daily for six (6) days, Levothyroxine 137 mcg by mouth daily for seven (7) days, Omega-3 fatty acids 1200 mg by mouth daily for eight (8) days, Omeprazole 40 mg by mouth daily for seven (7) days, Potassium Chloride ER 10 meq by mouth for six (6) days, Ropinirole HCL 1 mg by mouth daily for eight (8) days, Vitamin D3 by mouth daily for eight (8) days, Buspirone HCL 15 mg by mouth twice daily for nine (9) days, Gabapentin 600 mg by mouth twice daily for nine (9) days, Multivitamin Oral Tablet two times daily for nine (9) days, Norco 5/325 mg by mouth every six (6) hours as needed for one (1) day (2 doses given), Oxycodone 5 mg every six (6) hours as needed for one (1) day (1 dose given), and Sertraline HCL 100 mg by mouth twice daily for nine (9) days.

On 2/6/2025 at 3:00 PM, during an interview, the Administrative Assistant confirmed that Resident #1 had received the wrong medication. She stated that she was initially notified by Registered Nurse (RN) #1, who reported the medication error. The Administrative Assistant further stated that at the time of the incident, RN #2 was serving as the interim Director of Nursing (DON). She explained that upon reviewing the resident's medical records from the local hospital, she noticed discrepancies in the physician's orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255287	A. BUILDING _____ B. WING _____	C 02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PASS CHRISTIAN HEALTH AND REHABILIATION CENTER	538 MENGE AVENUE PASS CHRISTIAN, MS 39571

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F 760	Continued From page 12	F 760		

Additionally, the Administrative Assistant confirmed that there was no documentation for several days indicating whether Resident #4 had received her prescribed medication.

A record review of Resident #1's "Admission Record" revealed the facility admitted Resident #1 on 11/21/2024 with current diagnoses including Fracture of the Manubrium.

A record review of the Admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/28/2024 revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact.

Resident #4

A record review of the "Admission Record" revealed the facility admitted Resident #4 on 5/22/2024 and she had a diagnosis of Infection following a Procedure, Deep Incisional Surgical Site, with and "Onset Date" of 1/7/2025.

A record review of the MDS with an ARD of 01/12/2025 revealed Resident #4 had a BIMS score of 8, which indicated her cognition was moderately impaired. Section I revealed the resident had a hip fracture and wound infection, Section M revealed the resident had a surgical wound, and Section N revealed the resident was on antibiotic therapy.

A record review of the "Order Summary Report" revealed Resident #4 had a Physician's Order," dated 1/6/25 for Ceftriaxone (Rocephin) intravenously daily for a wound infection. Resident #4 also had a Physician's Order dated 1/6/25 for Vancomycin intravenous daily for a

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F 760	Continued From page 13	F 760		

wound infection.

A record review of Resident #4's "Medication Administration Record (MAR)," dated 01/11/2025 through 01/31/2025, revealed there was no documentation indicating that Vancomycin had been administered on 1/13/25, 1/16/25, or 1/21/25 or that Ceftriaxone had been administered on 01/16/2025 and 01/21/2025.

A record review of Resident #4's "Medication Administration Record (MAR)," dated 02/1/2025 through 2/28/2025, revealed there was no documentation indicating that Vancomycin had not been administered on 2/1/25 or 2/3/25 was coded "9".

On 2/5/25 @ 10:15 AM, during an interrview with Licensed Practical Nurse (LPN) #2 clarified that the code "9" indicated to see nurses notes.

Record review of the nurses notes revealed no documentation related to antibotics was in the nurses notes.

On 2/5/2025 at 1:00 PM, during an interview, LPN #1 confirmed that Resident #4 was receiving intravenous (IV) antibiotics, including Vancomycin and Bactrim, for a wound infection in the right hip. LPN #1 stated that she was unable to administer IV medications because only Registered Nurses (RNs) were permitted to do so. She explained that if a medication did not have a nurse's signature on the Medication Administration Record (MAR), it was because the RN had not signed it. LPN #1 stated that she could not confirm whether the medication had been given, as she was not responsible for administering it. She also mentioned that she often reminded RNs

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F 760	Continued From page 14 to administer IV antibiotics and to sign the MAR after administration. LPN #1 also confirmed the code "9" on the MAR would indicate to see nurses notes. On 02/06/2025 at 8:00 AM, during an interview, the Interim Director of Nursing (DON) stated that she had only worked at the facility for one (1) month and had been the Interim DON for two (2) weeks. She confirmed that Resident #4's antibiotics were scheduled for the day shift, however, she has had to work on night shift and was unable to administer the IV medication. She reported that if she is at the facility during the day, she administers the antibiotics.	F 760		