STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 03/30/21 to conduct an unannounced complaint investigation in conjunction with an on-site follow-up survey. The survey team was onsite 03/30/21. Additional information was obtained offsite on 03/31/21 through 04/05/21. Therefore, the exit date was 04/05/21. Tag F655 was corrected as of 04/05/21. A repeat tag (F842) was cited. New tags were also cited as a result of the complaint investigation survey. The facility is still out of compliance. Event ID #H9U011. 2 of 18 complaint allegations were substantiated with deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, physician assistant (PA) interview, staff interview, and record review the facility failed to provide bariatric transport for 1 of 1 sampled residents (Resident #15) with bariatric needs which resulted in the resident missing two follow-up medical appointments. Findings included: Record review revealed Resident #15 was admitted to the facility on 10/05/20. The resident's documented diagnoses included morbid obesity and malignant neoplasm (cancer)	F 558	1.Facility received fax note for resident #15. Bariatric transport arraigned for resident #15 appointments. 2.Appointments for the next 30 days will be reviewed by DHS (Director of Health Services)/ CCC (Clinical Competency Coordinator) for any special needs of resident. 3.Administrative Assistant will place appointment books at each Nurses	4/15/21

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

Electronically Signed | 04/14/2021

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 558	Continued From page 1 of the sigmoid colon. Resident #15's 10/07/20 admission minimum data set (MDS) documented his cognition was moderately impaired and he was dependent on 2+ staff for transfers. In her 11/12/20 2:11 PM progress note PA #2 documented, "He (Resident #15) is scheduled to follow up with (oncologist) on 11/4 --- (appointment) missed, requested reschedule." In her 11/16/20 2:59 PM progress note PA #1 documented, "Chemotherapy to be addressed post-rehab with (oncologist)....(Resident #15) had virtual (appointment) with (oncology) on Friday, 11/13, but no visit note received." During an observation of Resident #15 on 03/30/21 at 3:15 PM he was resting in a bariatric bed watching television. He stated he missed his first couple of appointments with his oncologist because the transport company did not have the proper equipment and the facility did not have enough staff to assist so he could attend in person. He reported he was anxious about his diagnosis, and the missed appointments caused him frustration. He commented everything worked out okay because he was able to participate in a telemedicine appointment shortly after his second missed appointment. During an interview with the facility's Administrative Assistant/Appointment Scheduler on 03/30/21 at 3:24 PM she stated she scheduled Resident #15 for transport to an oncology follow-up appointment at the end of October 2020. However, she reported she had not met or observed the resident and no staff members	F 558	station. Resident appointments will be placed in appointment book with date, time and special needs of resident. Administrative Assistant will check appointment book 2x/ day, arrange appropriate transportation and any special needs resident may require. Upcoming appoints will be reviewed in daily morning meeting 5x/week by Administrative Assistant and DHS/CCC for special needs. Appointments will be audited weekly x5, then 2x a week x4 weeks then monthly x 3 months 4.Licensed Nurses in serviced on appoint book and requirements for appointments on 4/13/21 by CCC. In service will be incorporated in the orientation process. 5.Findings will be presented in QAQI committee monthly x3 months by DHS/CCC. Compliance date 4/15/2021	

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F 558	Continued From page 2	F 558		

alerted her about the resident's bariatric needs prior to her setting up the appointment. She explained she set up the appointment with the facility's primary transport company, but when they arrived they informed the facility they did not have the capability of providing bariatric transport. She commented Resident #15 missed his oncology consult. According to the Appointment Scheduler, she rescheduled the appointment for early November 2020 with a company that was able to provide bariatric transport. However, she stated multiple facility staff members had to assist the transport staff in getting the bariatric stretcher up the hill. She reported the stretcher broke before the resident could be loaded in the van, and the resident missed his second oncology follow-up appointment.

During an interview with facility's Therapy Outcomes Coordinator on 03/30/21 at 4:25 PM she stated Resident #15 could not tolerate sitting up in his wheelchair for long, and the resident requested that he not be kept up in a wheelchair for greater than 30 minutes at a time. Therefore, she reported the resident had to be transported to appointments via stretcher. She commented the resident required bariatric transport which should have been relayed to the Appointment Scheduler by nursing.

During an interview with the facility's Social Worker (SW) on 03/30/21 at 5:20 PM she stated she only assisted with Resident #15's transportation needs by helping develop a list of possible transport companies that could provide bariatric transportation after the resident missed his first oncology follow-up.

During a telephone interview with PA #1 on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 558	Continued From page 3	F 558		

03/31/21 at 10:35 AM she stated she did not think missed follow-up appointments with the oncologist produced any negative health outcomes for Resident #15.

During a telephone interview with the facility's interim Director of Nursing (DON) on 03/31/21 at 11:52 AM she stated facility staff should have informed the facility's Appointment Scheduler that Resident #15 had bariatric needs before she scheduled the resident's first oncology appointment. She reported that requirements for bariatric transport should have been sought out so that the resident did not continue to miss medical appointments.

During a telephone interview with Nursing Assistant (NA) #1 on 03/31/21 at 2:35 PM she stated when the transport company arrived in the facility the first time to take Resident #15 to his appointment their stretcher was not big enough to provide a safe transport. She explained the belts necessary to keep the resident stable in the stretcher could not be buckled around the resident.

During a telephone interview with NA #2 on 03/31/21 at 2:42 PM she stated the second attempt to get Resident #15 to his oncologist was unsuccessful because the facility did know it had to send two of its own staff members to the appointment with the resident. She reported it took four facility staff members to transfer the resident out of bed to get him on a stretcher ready for transfer.

During a follow-up telephone interview with the facility's Administrative Assistant/Appointment Scheduler on 03/31/21 at 11:18 AM she stated

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	345009	A. BUILDING _____ B. WING _____	C 04/05/2021

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F 558	Continued From page 4	F 558		

she received training before she began her scheduling responsibilities about a year ago, but new things came up, and she had to learn some things as she went along. She reported on the second attempt to get Resident #15 to the oncologist the stretcher broke before the transport and facility staff could get him loaded in the van. She commented in subsequent conversation with the bariatric transport company she learned that the facility had to provide at least two of its own staff members to unload the resident at the doctor's office, reload the resident after his appointment, and get the resident back inside after transport back to the facility. The Appointment Scheduler stated she did not think the facility could have provided at least two staff members to accompany Resident #15 on his second appointment because she did not have advance notice to clear the departure of two staff members and still maintain enough staff in the building to take care of resident care needs.

During a telephone interview with the Administrator on 04/01/21 at 3:13 PM he stated Resident #15's first oncology follow-up was scheduled for 10/28/20, but had to be rescheduled for 11/04/20 so a bariatric transport company could take the resident to the appointment. He reported because of problems on 11/04/20 the resident was not able to see the oncologist, but he was assessed during a telemedicine appointment with oncology on 11/13/20.

During a telephone interview with Oncology Nurse #1 on 04/05/21 at 4:47 PM she stated in Resident #15's record it was documented the resident missed follow-up oncology consults on 10/28/20 and 11/04/20. She reported after two

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	345009	A. BUILDING _____ B. WING _____	C 04/05/2021

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F 558	Continued From page 5 appointments which had to be canceled Resident #15 had his first follow-up consult via a telemedicine appointment with oncology on 11/13/20. She commented the missed appointments delayed planning on the resident's treatment option, but did not affect the resident's medical outcome.	F 558		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and physician and staff	F 761	Nurse #1 and #11 were in serviced on	4/15/21

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F 761	Continued From page 6 interviews the facility failed to keep medications secured by leaving them on an overbed table in a resident's room for 1 of 1 rooms where an observation of catheter care was being conducted, failed to keep an unattended medication secured in a locked medication cart by leaving it on top of a medication cart for 1 of 4 medication carts observed (100 hall), and failed to keep unattended medications secured in a locked medication cart for 1 of 4 medication carts observed (Nursing Station 4). Findings included: 1. During an observation of catheter care on 03/30/21 at 11:45 AM two medication cups containing pills were seen on the bedside table in room 717. The medications were not labeled, and some were split in half. Nurse #1 verified she had left one of the cups containing medications at the bedside that morning and the other medication cup had been left at the bedside by the nurse on second shift the previous evening. On 03/30/21 at 11:45 PM both medication cups containing pills were carried out of the room by Nurse #1. She identified the pills she had left at the bedside as Neurontin, Eliquis, Glycopyrrolate (3 pieces cut in half), and Baclofen (2 tabs). She stated she could not identify the pills in the second medication cup. Both medications cups with pills were given to the Interim Director of Health Services (DHS) for identification. Nurse #1 stated she had documented in the electronic medication record that she had administered all the medications when she had not. She commented she knew she had falsified the medical record. She explained the resident had asked her to leave the medications and would not allow her to remain in the room until the	F 761	3/31/21 on proper medication administration, including staying with resident when administering medication to insure medication is taken without any negative outcome and documenting medications after consumption. Nurse #1 and #2 in serviced on medication cart is always to be locked, no medications are to be left on top of med cart or in resident□s rooms. Resident # 1, MD notified on 3/30/21 of medications not being administered, no new orders received. 2. Licensed nurses in serviced on the leaving medications at bedside and ensuring med carts are locked at all times. In service to be included in the orientation process. 3. Medication observation will be completed with all nurses by the DHS/CCC on 4/15/21, then2x/week x 4 weeks, then weekly x4 weeks, then monthly x3 months. Medication carts will be observed by the DHS/ CCC 5x/ week x 4 weeks, weekly x4 weeks, then monthly x3 months. 4. Findings will be presented to the QAQI committee monthly x3 months by the DHS/CCC. Compliance date 4/15/2021	

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F 761	Continued From page 7	F 761		

medications had been taken. She stated she knew not to leave medications in a room unattended and not to document that medications had been administered when they had not.

In an interview with the facility Medical Director on 03/30/21 at 12:05 PM he stated medication should not be left at a bedside and then documented as administered. He thought a resident might forget to take medications when left or a different resident could have accidentally ingested the unattended medications.

In an interview with the Interim Director of Health Services on 03/30/21 at 12:30 PM she stated she had identified the medications in the second cup that had been left on the bedside table by Nurse #11 the previous day as Glycopyrrolate (3 pieces split in half), Neurontin and Trazadone. She commented the medications should not have been left unattended on a bedside table and should not have been documented as administered when they were not. She explained any medications not administered should have been discarded and documented as not given.

In an interview with Nurse #11 on 04/01/21 at 9:39 AM she stated she had left medications at the bedside in room 717 on second shift on 03/29/21 and then inaccurately documented she had administered the medications in the electronic medical record. She commented she knew not to leave medication unattended at a bedside and she would not do it again. She also knew to document "refusal or withheld" in the electronic medical record if a medication had not been administered.

2. In a continuous observation on 03/30/21 from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345009	A. BUILDING _____ B. WING _____	C 04/05/2021

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THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 761	Continued From page 8	F 761		

10:20 AM to 10:22 AM a medication cart was outside room 124. The door to the room was pulled almost closed leaving about a one-inch gap between the door and the door frame. A stack of three medication cups was lying on its side on top of the cart and there was an orange capsule inside the top medication cup. Nurse #1 exited room 124 at 10:22 AM.

In an interview on 03/30/21 at 10:22 AM Nurse #1 confirmed that she left the medication cart unattended when she went into room 124 and that she could not see the medication cart from inside the room. She stated she had not seen the capsule because the medication cups had fallen over and did not realize she left the medication on top of the medication cart. Nurse #1 stated that medications should not be left on top of the medication cart because anyone could take them.

In an interview on 03/30/21 at 12:35 PM the interim DHS indicated that it was a safety issue to leave medications on top of medication carts unattended. She stated that anyone could remove the medications off the top of the cart and take them.

3. In a continuous observation on 03/30/21 from 1:16 PM to 1:19 PM the Station 4 medication cart assigned to hall 500 was located against the wall in the Station 4 dining room. The lock on the medication cart did not appear to be engaged. There were residents in the dining room and a staff member was observed removing a tablecloth from a table across from the medication cart. No nurses were at Nursing Station #4 or observed in the surrounding area. Nurse #2 approached the medication cart from around the corner at 1:19 PM and verified she

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THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 761	Continued From page 9	F 761		

was the nurse responsible for the medication cart.

In an interview on 03/30/21 at 1:19 PM Nurse #2 verified that the medication cart was unlocked by opening the drawers of the cart without having to use a key to unlock it. She stated that a medication cart should never be left unlocked and unattended because anyone could get into it and remove the medications.

In an interview on 03/30/21 at 1:30 PM the Interim DHS stated that she expected medication carts to be locked at all times if out of the line of sight of the nurse. She indicated that if the medication cart was not locked then anyone could get into the cart and take anything they wanted.

4. In a continuous observation on 03/30/21 from 4:18 PM to 4:20 PM the Station 4 medication cart assigned to hall 500 was located against the wall in the Station 4 dining room. The lock on the medication cart did not appear to be engaged. No staff was seen in the surrounding area. Nurse #2 approached the medication cart through a set of double doors from off the unit. She verified that she was still responsible for the medication cart.

In an interview on 03/30/21 at 4:20 PM Nurse #2 verified that the medication cart was unlocked by opening the drawers of the cart without having to use a key to unlock it. She again stated that a medication cart should never be left unlocked and unattended because anyone could get into it and remove the medications.

In an interview on 03/30/21 at 4:48 PM the Interim DHS stated that she expected medication carts to

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F 761	Continued From page 10 be locked at all times because if they were not someone could take the medication out of the cart.	F 761		
F 773 SS=D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is not met as evidenced by: Based on physician assistant (PA) interview, staff interview, and record review the facility failed to notify the physician or PA of a critical lab value as soon as it was received for 1 of 3 sampled residents (Resident #13) whose medications and labs were reviewed. The facility also failed to obtain a urine sample for a urinalysis ordered by the physician for 1 of 3 sampled residents (Resident #14) whose medications and labs were reviewed. Findings included: 1. A 10/30/20 hospital Discharge Summary documented Resident #13 was hospitalized from 10/26/20 until 10/30/20. "...(Magnesium) 1.2 (milligrams per deciliter) on admission, likely due to decreased oral intake related to altered diet from oropharyngeal dysphagia. Repleted and	F 773	1.Residents #13 and resident #14 are no longer in facility. 2.Audit was conducted on 4/9/21 by the DHS/CCC/Unit Manager for missed labs for the past 30 days. MD/NP/PA was notified of any missed labs and for further direction. Audit was conducted by DHS/CCC/Unit Manager for critical lab values and notification of MD/NP/PA for past 30 days. Audits for missed labs and critical labs will be completed by the DHS/CCC/Unit Manager 5x/ week x4 weeks, weekly x4 weeks and monthly x3 months. 3.Licensed nurses in serviced on	4/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 773	Continued From page 11 levels now improved..." Record review revealed Resident #13 was admitted to the facility on 10/30/20 . The resident's documented diagnoses included hypomagnesemia and disorientation. Resident #13's 11/02/20 admission minimum data set (MDS) documented his cognition was severely impaired. In her 11/04/20 8:03 PM nurse's note Nurse #3 documented, "Resident (#13) observed to have some confusion throughout shift. Observed walking in hallway multiple times with multiple items in hand and no oxygen on. Resident stating that he is going home and looking for the church. PA made aware and orders for blood work and urine to be collected on Friday (11/06/20)...." Lab results for Resident #13 documented they were reported on 11/06/20 at 4:06 PM. Review of the results revealed the resident had a critically low magnesium level of 1.3 milligrams per deciliter (mg/dL) with 1.8 - 2/5 mg/dL being within normal limits. Review of nurse's notes between 11/06/20 and 11/09/20 revealed there was no documentation that a physician or PA had been made aware of Resident #13's critical lab result. In her 11/09/20 12:15 PM progress note PA #1 documented, "...Patient seen to follow up on lab results, (magnesium) level low to 1.3....added supplement...." Review of physician orders revealed on 11/09/20	F 773	obtaining labs and lab results, and notification of critical labs to MD/NP/PA. In service to be included in the orientation process. 4.Findings will be presented to the QAQI committee by the DHS/CCC monthly. Compliance date 4/15/2021	

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	345009	A. BUILDING _____ B. WING _____	C 04/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT WHITAKER GLEN-MAYVIEW	513 EAST WHITAKER MILL ROAD RALEIGH, NC 27608

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F 773	Continued From page 12	F 773		

a physician order was entered into Resident #13's electronic medical record for magnesium oxide 500 mg twice daily at 9:00 AM and 9:00 PM. However, review of the resident's November 2020 medication administration record (MAR) documented Resident #13 did not receive any magnesium oxide during his stay in the facility.

In her 11/09/20 03:58 PM nurse's note Nurse #3 documented, "Resident (#13) discharged from facility AMA (against medical advice) at about (3:00 PM) with family to transport. Prescriptions given upon leaving facility. Residents family instructed to follow up with PCP (primary care physician) as soon as possible. (Family) stated (appointment) was set for tomorrow. Resident left in stable condition."

During an interview with Nurse #3 on 03/30/21 at 2:57 PM she stated she could not remember Resident #13. However, she reported it was facility policy to call a physician or PA immediately when critical lab results were obtained. She explained the nurse who received the report should have stopped what he/she was doing long enough to make a quick call relaying the results.

During a 03/31/21 10:35 AM telephone interview with PA #1, who wrote the 11/09/20 progress note in regard to Resident #13, she stated she did not remember Resident #13 or the circumstances which led to the discovery of his critically low magnesium. However, she reported she did not think she was notified of the magnesium level prior to her arrival in the facility on 11/09/20 because she would have begun magnesium supplementation as soon as she was notified. She explained since Resident #13's 11/06/20 potassium level was within normal limits, the

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F 773	Continued From page 13	F 773		

resident had a hospital history of hypomagnesemia, and the resident was not currently on any magnesium in the facility, she would have begun magnesium supplementation on the day the critical lab was received. According to PA #1, her expectation was that the facility notify herself or the physician as soon as critical lab values were received so appropriate interventions could be put in place quickly to prevent possible harm to residents.

During a telephone interview with the facility interim Director of Nursing (DON) on 03/31/21 at 11:52 PM she stated Nurse #11 cared for Resident #13 from 7:00 AM until 7:00 PM on 11/06/20 when the resident's lab results were available. The DON reported Nurse #11 no longer worked in the facility. She commented Nurse #5 cared for Resident #13 from 7:00 PM on 11/06/20 until 7:00 AM on 11/07/20. According to the DON, the nurse who reviewed lab results which contained a critical value or received a call from the lab about a critical lab would call the resident's physician or PA at once to obtain guidance.

During a telephone interview with Nurse #5 on 03/31/21 at 4:24 PM she stated she did not remember Resident #13, and she did not receive many lab results on her shift. She reported lab results were distributed to the nurses by care coordinators, and when she reviewed them if she found a critical lab value she immediately called the physician to let him/her know so a course of action could be determined. She explained critical labs were a priority, and the receiving nurse should call at once.

During a 04/01/21 10:28 AM telephone interview

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F 773	Continued From page 14	F 773		

with the Clinical Lab Director, for the company which processed Resident #13's lab work on 11/06/20, she stated a call was placed to the facility on 11/07/20 at 2:05 PM as a back up to alert them of the resident's critically low magnesium. She reported the nurse who received the call was Nurse #4.

A text sent by the facility's Staff Scheduler on 04/01/21 at 11:10 AM documented Nurse #4 no longer worked at the facility.

During a telephone conversation with Nurse #8, a Clinical Competency Coordinator (CCC), on 04/01/21 at 11:41 AM she stated lab results were sent to the facility via e-mail, and the CCC distributed them to the nurses who reviewed them. She reported the reviewing nurses were trained to call resident physicians or PA's as soon as they received critical lab results, even if it was on the weekend. She also commented when a resident went home AMA it was at the discretion of the provider to determine if medication or only a list of medications were sent home with the residents. According to Nurse #8, she was unsure whether Resident #13's family received the list or the actual medications.

2. Resident #14 was admitted to the facility on 10/26/20 and discharged to home on 11/13/20. Diagnoses included urinary tract infection (UTI) and urinary retention.

A physician's order was written by the Physician Assistant #1 on 11/12/20 for a urinalysis with urine culture laboratory test to be done on 11/13/20 because the family reported to nursing

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F 773	Continued From page 15	F 773		

the resident had experienced abdominal pain and burning on urination.

An admission Minimum Data Set assessment (MDS) completed on 10/28/20 revealed Resident #14 had moderately impaired cognition with a diagnosis of Alzheimer's disease. He required extensive assistance with all activities of daily living except eating. He was always incontinent of bowel and bladder and required intermittent urinary catheterization.

A care plan dated 11/06/2020 for Resident #14 included the following problem: At risk for recurrent UTI, resident with the use/order of in and out catheterization which he refuses at times and he refused to have indwelling catheter placed. A goal was for the resident to remain free from signs and symptom of at UTI x 90 days. One of the interventions was to follow physician orders for a urinalysis as ordered.

Review of laboratory reports revealed for Resident #14 a urinalysis with urine culture had not been collected as ordered by Physician Assistant #1 on 11/13/20.

An interview was conducted on 04/01/21 at 9:52 AM with Physician Assistant #1. She stated she had placed an order for a urinalysis with culture to be done on 11/13/20 for Resident #14 because 11/12/20 was a Thursday and labs only went out on Mondays, Wednesdays and Fridays. She knew the resident was due to be discharged on 11/13/20 and reported she had communicated to the family that she would call the results to them the following Monday when the report came back from the lab. She realized the sample had not been sent and called the family on Saturday,

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F 773	Continued From page 16	F 773		

11/14/20, and advised the family to take the resident to an urgent care facility to have the sample collected or offered to write a prescription to treat the UTI symptoms. She stated the family declined both options stating where they lived they had a concierge physician who would handle the matter.

An interview was conducted with the Interim Director of Health Services (DHS) on 04/01/21 at 10:00 AM. She stated she had no idea why the urine was not collected because there was no documentation. She reported it was the responsibility of the Nurse Manager on the unit to make sure all labs were collected and sent to the lab.

An interview was conducted with Nurse #10 on 04/01/21 at 11:02 AM. She stated she no longer worked at the facility. Although she had documented in a progress note on 11/13/20 that the resident was discharged to home, she could not remember discharging the resident or anything about an order for a urine culture.

An interview was conducted with Nurse #9 on 04/01/21 at 2:01 PM. He stated he became the Unit Manager sometime in December 2020. Prior to his promotion, he explained no one staff member was in charge of auditing physician orders for laboratory tests-it was the responsibility of each nurse on duty to ensure labs were collected. He reported since December 2020 when he began daily auditing of new orders fewer errors had occurred.