Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, resulted from the State Veterans Home (SVH) Survey as a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or applicable Life Safety Code Identifying Information.) Title 38 Code of Federal Regulations Part 51 is applied for SVHs applicable by level of care.

General Information:

Facility Name: Emory L Bennett Memorial Nursing Home

Location: 1920 Mason Ave., Daytona Beach, FL 32117

Onsite / Virtual: Onsite

Dates of Survey: 7/12/22-7/15/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 120

Census on First Day of Survey: 81

VA Regulation Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from July 12, 2022, through July 15, 2022, at the Emory L Bennett Memorial Nursing Home. The survey revealed the facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§ 51.120 (j) Nutrition. Based on a resident's comprehensive assessment, the facility management must ensure that a resident— (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when a nutritional deficiency is identified. Level of Harm – Actual Harm that is not immediate jeopardy Residents Affected – Few	Based on observation, record review, and interview, the facility failed to maintain acceptable parameters of nutritional status. Resident #4 had a five (5) % weight loss in one (1) month from [DATE] that was not addressed. Supplements recommended by Dietary Staff A were not ordered for Resident #4. Resident #12 had significant weight loss with a five (5) % weight loss in one (1) month from [DATE] and an eight (8) % weight loss in one (1) month from [DATE] that was not addressed for two (2) of two (2) residents reviewed for weight loss. The findings include: 1) A facility policy for weight loss was requested and not provided. Resident #4 was admitted to the facility in 2022 with diagnoses including, but not limited to, neoplasm of unspecified behavior of brain, unspecified intracranial injury with loss of consciousness

	of unspecified duration, dysphagia oropharyngeal phase, history of heart failure, esophageal obstruction, history of malignant neoplasm of the prostate. A review of Resident #4's medical record revealed the resident weighed 196.4 pounds on [DATE] and pounds on [DATE], representing an 11.4-pound weight loss. Further review of the medical record revealed no nutritional assessment and no Dietary Staff notes to address the five (5) % weight loss in 32 days. A Review of Resident #4's nutritional review dated [DATE] revealed, "Recommend: 1. Magic Cup BID [twice a day] w/ [with] lunch and dinner r/t [related to] poor PO intake and Resident reported preference for sweet foods RD will monitor and follow PRN [as needed]." A review of Resident #4's provider orders revealed no nutritional supplements had been ordered. During an interview on 7/14/22 at 4:36 p.m., Administrative Nurse B verified that the Dietary Staff A's recommendation for a Magic Cup with lunch and dinner that was made in the [DATE] nutritional review was not ordered. They stated that Dietary Staff A made the recommendation in their assessment but did not write an order for it. The recommendation in Dietary Staff A's assessment was not identified by the nursing staff. Administrative Nurse B verified that the resident had no orders for dietary supplements. During an interview on 7/14/22 at 4:49 p.m., Administrative Nurse B stated that the Certified Nurse Aides have until the 10th of every month to put in resident weights into the system. After the 10th, Administrative Nurse B ran a report for the whole facility. Then they would have a weight meeting to address weight loss. Administrative Nurse B verified that Resident #4 was weighed on [DATE] and that as of [DATE], they had not addressed their five (5) % weight loss. During an interview on 7/15/22 at 8:22 a.m., Certified Nurse Aide A stated that they worked with Resident #4 frequently. Resident #4 received a pureed diet with honey thick liquids. They stated that they did not get supplements with their meals. 2) Review of the medical record for Resident #12 revealed an admission date of 2018. Resident #12's primary medical diagnosis was Chronic Obstructive Pulmonary Disease (COPD). Review of the most recent comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for

	Mental Status score of 13, indicating intact cognition. Resident #12 required varying levels of assistance with Activities of Daily Living (ADLs), including supervision with eating. On 7/12/22 at 12:22 p.m. Resident #12 was observed lying in bed with their eyes closed. Their bed was flat and low to the ground. Their meal tray was observed on the over-bed table which was positioned over the resident. The meal was on a regular plate and was covered. Resident #12 was not eating. The room lights were off, and the blinds were closed. Review of Resident #12's Physician Order revealed an order dated [DATE] for a regular diet with pureed texture. The order directed staff to provide food in separate bowls for all meals and to give one (1) at a time. A second order, dated [DATE], was noted for a Magic Cup (nutritional supplement) to be provided daily at lunch. On 7/14/22 at 12:02 p.m. Resident #12 was observed in their Broda chair sitting in the hallway near their room with an over-bed table positioned in front of them. There were several food bowls on the table. The was no Magic Cup on the tray. On 7/14/22 at 12:15 p.m. an interview was conducted with Licensed Nurse A. They confirmed that they were assigned to care for Resident #12 and that they were familiar with their care. Licensed Nurse A was asked to review Resident #12's Physician Order. Licensed Nurse A confirmed that Resident #12 should be provided one (1) bowl of food at a time and stated that they would instruct the Certified Nurse Aide). Licensed Nurse A also confirmed Resident #12's order for a Magic Cup and confirmed that it was not provided with their lunch. Regarding Resident #12's weight loss, Licensed Nurse A confirmed Resident #12 had lost weight over the recent months but stated that they were not sure of the cause. Review of Resident #12's Comprehensive Care Plan revealed a focus area for nutrition risk. Care Plan approaches included supervision during meals and providing Resident #12 with a puree diet and their supplements as ordered. The Care Plan also directed staff to provide Resident #12's food in bowls, monitor and document meal intake percentages, and to provide "maroon spoon" (adaptive equipment) during meals. Additionally, staff were directed to monitor Resident #12's weights and notify Dietary Staff A or the Physician of significant weight loss or gain as needed. Resident #12's weight history was reviewed from [DATE]. On [DATE] a weight of 252 pounds was documented. On [DATE], a subsequent weight of 239 pounds (a weight loss of 5.16% over a thirty-day period) was documented. Additional weights for

	subsequent months were 236.8 pounds on [DATE], 232.8 pounds on [DATE], 229 pounds on [DATE], and 210.4 pounds on [DATE]. Review of Resident #12's Physician Order and Care Plan revealed no nutritional interventions resulting from the documented weight loss. There were no nutritional assessments documented for the period of weight loss. An annual nutritional assessment dated [DATE] indicated Resident #12's nutritional risk factors were a texture modified diet, adaptive equipment with meals, abnormal labs, multiple chronic medical conditions, and poor PO (by mouth) intake. The assessment read, "PO intakes reviewed and appear poor, <50%. Spoke to resident in courtyard, noted resident does not stop moving/fidgeting and is likely constantly expending energy. Discussed weight loss w/resident, [they] stated [they] can tell [they've] lost weight, [they] denied any recent changes in eating habits, stated [they] eat ~50% and feels full/satisfied." Recommendations were made for a Magic Cup daily at lunch for weight stabilization and 90 milliliters (ml) of Med Pass (nutritional supplement) at night. A third recommendation was made to liberalize Resident #12's diet. On 7/14/22 at 4:47 p.m., a telephone call was placed to Dietary Staff A. A message was left requesting a call back. No return call was received. A facility policy for excessive weight loss was requested but was not provided. Administrative Nurse B explained that the facility did not have a specific policy for weight loss.
§ 51.120 (n) Medication Errors. The facility management must ensure that— (1) Medication errors are identified and reviewed on a timely basis; and (2) strategies for preventing medication errors and adverse reactions are implemented. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observations, interviews, and record reviews, the facility failed to 1. Implement strategies to prevent medication errors by failing to verify the medication order against the medication label prior to administration for one (1) of four (4) (Resident #14) residents observed during medication administration, and 2. Prevent medication errors by failing to accurately transcribe hospital discharge orders for one (1) resident of 18 sampled residents reviewed during the survey. The findings include: 1) On 7/14/22 at 8:58 a.m. an observation of medication administration was conducted for Resident #14 with Licensed Nurse A. At the beginning of the encounter, Licensed Nurse A stated, "I have to write down the medications from this computer and take them around the corner to the other computer. I think that computer is encrypting, and it doesn't have a mouse." Licensed Nurse A accessed the resident's Medication Administrator Record (MAR), wrote the name and dose of

	medications on a yellow sticky note, and proceeded around the corner and down the hall to a second medication cart near the resident's room. They began pouring the medications while referencing the yellow sticky note. The nurse prepared and administered six (6) medications for Resident #14 without comparing each medication's label with the Physician Order. On 7/14/22 at 9:05 a.m. Licensed Nurse A left the medication cart unlocked and unattended while they went down the hall and around the corner to a second medication cart to prepare and administer medications to Resident #14. On 7/14/22 at 9:10 a.m., Licensed Nurse A left the medication cart unlocked and unattended while they walked to Resident #14's room and administered their medications. On 7/14/22 at 4:25 p.m., an interview was conducted with Administrative Nurse B. They stated, "the nurse should have had another computer with [them]. [They] should not be writing down medication orders and preparing them from a sticky note." The facility's policy titled, "Medication Administration" dated 12/31/21, was reviewed. Section seven (7) of the policy read, "The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route of administration) prior to giving the medication." Section 15 of the policy read, "During administration of medications, the medication cart will be kept closed and locked when out of sight of the personnel administering medication." 2) Resident #1 was admitted to the facility in 2019 with diagnoses including, but not limited to, anxiety and psychotic disorder with delusions due to known physiological condition. A review of Resident #1's hospital discharge papers revealed the Resident was discharged in 2022 with orders for Buspar 15 mg (milligrams) t.i.d. (three (3) times a day). A review of Resident #1's Physician Order revealed an order dated [DATE] for buspirone [Buspar] tablet; 15 mg; amt [amount]: 15mg, via gastric tube three (3) times a day. A review of Resident #1's Medication Administration Record (MAR) revealed buspirone tablet; 15 mg; amt: 15mg; gastric tube three (3) times a day at 2:00 p.m. and 10:00 p.m. During an interview on 7/14/22 at 3:22 p.m., Administrative Nurse B stated the hospital discharge paperwork was given to the nursing supervisor. The nursing supervisor put in the orders

	for the provider to sign off on. Administrative Nurse B stated that they do not have a policy for transcribing orders. During an interview on 7/14/22 at 3:27 p.m., Administrative Nurse C stated that they reviewed the hospital discharge papers for Resident #1 and were responsible for putting the orders in the system for the provider to sign. They stated that for Resident #1's buspirone order, they thought the system calculated three (3) times a day, but it did not.
§ 51.140 (h) Sanitary conditions. The facility must: (1) Procure food from sources approved or considered satisfactory by Federal, State, or local authorities; (2) Store, prepare, distribute, and serve food under sanitary conditions; and (3) Dispose of garbage and refuse properly. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Many	Based on facility observations and staff interviews, the facility kitchen failed to ensure that food was stored, prepared, distributed, and served under sanitary conditions for facility - wide service. The facility failed to ensure 1) Kitchen areas were clean and sanitary, 2) Hair was properly secured during food preparation, and 3) Food was dated, labeled, and stored appropriately in the pantry and kitchen. The findings include: Review of facility policy number 3102 titled, "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices," effective date of 6/13/17, was provided on 7/15/22. The policy stated in pertinent part: "Hairnets, caps and/or beard restraints must be worn to prevent hair from contacting exposed food, clean equipment, utensils, and linens." Review of facility policy number 3103 titled, "Preventing Foodborne Illness-Food Handling," effective date 11/27/17, was provided on 7/15/22 and stated in pertinent part: "Food will be stored, prepared, handled and served to prevent the risk of foodborne illness. This facility recognizes that the critical factors implicated in foodborne illness are: a. Poor personal hygiene; b. Inadequate cooking and improper holding temperatures; c. Contaminated equipment; and d. Unsafe food sources." Review of facility policy number 3108 titled, "Cleaning Guidelines," effective date 11/20/17, was provided on 7/15/22. The policy stated in pertinent part: "I. STANDARD The food service area shall be maintained in a clean and sanitary manner. II. PROCEDURES 1. All kitchens, kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from pest infestations. 2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks,

	corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners will be kept in good repair. 7. Cutting boards (acrylic or hardwood) will be washed and sanitized between uses. 15. Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime." 1. Clean and sanitary kitchen On 7/13/2022 at 9:58 a.m. the kitchen was observed to have a serving window near the dishwasher unit. A large, blackened, splattered area of debris was observed to extend to a width of approximately six (6) to eight (8) inches wide and run down to a height of approximately 36 inches to the floor, on the right side of the window. The baseboard area below the serving window was covered in additional darkened black debris along the trim that extended vertically near the floor for approximately 30 inches. The opposite side of the serving window also had the same blackened debris down the wall in a similar manner. The dishwasher was also noted to have extensive blackened debris along the wall behind the unit. During an observation on 7/13/22 at 10:18 a.m., seven (7) large, color-coded cutting boards were observed with heavily scored markings across the cutting surfaces. Dietary Staff B was not sure how old they were or how often they would be replaced, but they thought they would be replaced about every two (2) years. Dietary Staff C was also observed at this time preparing lunch and was not observed wearing a hair net. On 7/15/22 at 9:48 a.m. the unsanitary walls were still observed along the wall behind the dishwasher, and along the sides and floors near the serving window. Dietary Staff B was interviewed on 7/15/22 at 9:55 a.m., while reviewing the assignment log that identified the daily cleaning schedule for both the cooks and the dietary aides. They said that the cooks and aides were each assigned duties to review each day. They said that the deep cleaning schedule that was currently posted for the week of 7/13/22 to 7/23/22 was for the staff to look at and monitor each day. The posted daily cleaning schedule for 7/10/22 through 7/16/22 was also reviewed. It had no staff names for identified cleaning assignments. Staff members had initialed in large letters across the entire scheduled day, with a downward arrow, indicating reviewed only. Some of the identified cleaning areas included:

	toaster, slicer, pot rack, cook preparation box, shelf above sinks, behind the dish machine, floors, walls behind the serving line, and the corner wall by the fire extinguisher. An interview was conducted on 7/15/22 at 2:18 p.m. with Dietary Staff D. They said that they had to sign off on the kitchen cleaning log for the items assigned to the dietary staff during the seven (7)-day period. They said that they needed to sign off at least once during the assigned week that they completed them, but that it was not a daily sign-off log. An interview was conducted on 7/15/22 at 2:22 p.m. with Dietary Staff E. They said that the cooks were assigned things to clean in the kitchen each week, and they also needed to sign off on them once completed. They said that they were not documented daily, but they needed to do the cleaning during the assigned week. 2. Food storage Observation on 7/15/22 at 9:50 a.m. revealed the dry storage room with five (5) large dry goods bins on the floor containing sugar, flour, rice, breadcrumbs, and cornstarch. There was a paper log identifying the items on the wall behind the bins. The log recorded “dry storage-ingredient bins.” Each food item was identified with a place to notate “dates: received” and “dates: exp (expiration).” -The sugar was documented as being received on 1/10/22, with no noted expiration date. -The flour was documented as being received on 6/1/21 with no expiration date. -The rice was documented with multiple dates. There was a received date of 6/10/21 and expiration of “5/23,” received date of 7/12/21 with no expiration date, received 10/23/21 with the expiration of “3/26,” received 11/24/21 and expired “11/23,” and received 1/20/22 and expired “12/23.” -The breadcrumbs were documented with multiple dates. There was a received date of 6/3/21 and an expired date of 5/5/23, received 6/28/21 and an expired date of 6/2/23, a received date of 10/10/21 and an expired date of 8/21/21, received 12/2/21 and an expired date of 9/20/22, and received 3/14/22 and an expired date of 1/28/24. -The cornstarch had no date documentation of received or expired dates. An observation on 7/13/22 at 10:15 a.m. revealed that an opened and undated container of hydrolyte thickened water that was approximately 2/3 full was observed in the freestanding refrigerator with an expiration of 3/3/23. The container stated to discard opened bottles10 days after opening. Dietary Staff B

	stated that they did not usually receive thickened drinks and were not aware of the discarding instructions on the containers. Dietary Staff B was interviewed on 7/15/22 at 9:55 a.m. They stated that they were not aware of how long the cornstarch had been in the bin but used the dry storage items with the "first in and first out" method. They were not sure how long they could keep each of these stored dry food items but said that they thought it was as long as the items were not contaminated. They further stated that they would look up the information. An interview was conducted on 7/15/22 at 10:42 a.m. with Dietary Staff B. They said that they looked on the internet to find out the timeline of how long to keep their dry storage items. They said that they were able to keep the sugar for two (2) years, the rice for two (2) years, the breadcrumbs for six (6) months, the flour for six (6) to eight (8) months, and the cornstarch for as long as it was kept dry. Dietary Staff B stated that the flour was expired. On 7/15/22 at 2:25 p.m. the dry storage bins were again observed for proper storage and labeling. The expired flour was still found in the container, and the dry storage labels were not corrected.
§ 51.180 (c) Drug regimen review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the primary physician and the director of nursing, and these reports must be acted upon. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observation, record review, and interview, the facility failed to act upon Consultant Staff A recommendations that were reviewed and signed by the provider. Resident #1's medication regimen review dated [DATE] had a recommendation to discontinue quetiapine. The provider agreed with the discontinuance on [DATE]. Staff failed to discontinue the quetiapine (antipsychotic) for one (1) of one (1) resident reviewed for pharmacy services. The findings include: Review of the facility policy titled, "Medication Regimen Review," dated 10/6/2017, revealed that "**I. STANDARD** The consultant pharmacist must review each resident's medication regimen at least once a month in order to identify irregularities and to identify clinically significant risks and or actual or potential adverse consequences, which may result from, or be associated with medications. The frequency of these reviews depends upon the resident's condition but at minimum must occur monthly. This includes short-term stay residents. The findings of the review are to be reported to the attending physician, the facility's medical director and the director of nursing. **II. PROCEDURES** C. The Consultant Pharmacist is to report in writing any irregularities to the attending physician, the facility's medical director and the director of nursing. These findings are to be acted upon in a reasonable time frame in

	accordance with the severity/acuity of the finding. Urgent action needed to protect the resident will occur immediately upon discovery of the irregularity by the consultant pharmacist. D. Acknowledgement of receipt of the medication regimen review findings will be logged monthly by the facilities director of nursing and medical director." Resident #1 was admitted to the facility in 2019 with a diagnosis including but not limited to anxiety and psychotic disorder with delusions due to known physiological condition. A review of Resident #1's Physician Order revealed an order dated [DATE] for quetiapine tablet; 25mg [milligrams]; amt [amount]: 25mg; gastric tube every eight (8) hours. A review of Resident #1's medical record revealed "Consultant [Staff A's] Recommendations" dated [DATE], which stated, "Assessment/Drug related problems: the Resident is a [Resident #1] with current order for quetiapine 25 mg every 8 [eight] hours for psychotic disorder. This medication was restarted upon return from the hospital on [DATE]. Previously on [DATE] Psychiatric services had recommended the quetiapine 25 mg three [3] times daily be discontinued due to no evidence of psychosis and Resident was too sedated. Discussion: within the first year of SNF [skilled nursing facility] admission, GDR [gradual dose reduction] attempt is recommended in 2 [two] separate quarters (at least 1 [one] month between the attempts) unless clinically contraindicated. After the first year, GDR must be attempted annually unless clinically contraindicated. The GDR may be considered clinically contraindicated if the target symptoms worsened after the most recent GDR attempted within SNF. Plan/Pharmacy Recommendations: Review for clinical appropriateness of GDR of Seroquel (quetiapine)." The provider responded with "D/C [discontinue] quetiapine" on [DATE]. A review of Resident #1's Medication Administration Record (MAR) revealed the Resident had received quetiapine 25 mg at 6:00 a.m., 2:00 p.m., and 10:00 p.m. on [DATE], [DATE], [DATE] and at 6:00 a.m. and 2:00 p.m. on [DATE]. During an observation on 7/13/22 at 1:00 p.m., Licensed Nurse B was observed administering quetiapine tablet 25mg via gastric tube to Resident #1. During an interview on 7/14/22 at 3:22 p.m., Administrative Nurse B stated that the pharmacy medication regimen reviews were put in a folder for the provider to review. After the provider reviewed them, the nursing supervisor made the changes or assigned a nurse to make the changes. The medication regimen reviews were then scanned into the electronic chart, and the

	paper copy was placed in the paper medical record. Administrative Nurse B stated it was their assumption that for Resident #1, their medication regimen review was put in the paper chart and not given to the nursing supervisor to carry out the recommendation signed by the provider. They stated that the turnaround time for recommendations on the medication regimen reviews that had been signed by the provider was 24 hours. During an interview on 7/14/22 at 3:27 p.m., Administrative Nurse C stated that they received the pharmacy recommendations. They were placed in a folder for the provider to review. When the provider signed off on the reviews, they made the changes and wrote the orders. They signed the reviews and gave them to administrative staff to scan and place in the resident's chart. They stated that they do not recall getting Resident #1's medication regimen review. Medication regimen reviews that were signed by the provider were reviewed by Administrative Nurse C that day. When they were signed off in the evening, Administrative Nurse C reviewed them in the morning. They are reviewed and acted upon within 24 hours after the provider had signed them.
§ 51.180 (e) (1) Storage of drugs and biologicals. (1) In accordance with State and Federal laws, the facility management must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Based on observations, interviews, and record reviews, the facility failed to ensure medications were stored appropriately by failing to lock medication and treatment carts. The findings include: 1) The facility's policy titled, "Medication Administration" was reviewed. The policy was dated 12/31/21. Section seven (7) of the policy read, "The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time, and right method (route of administration) prior to giving the medication." Section 15 of the policy read, "During administration of medications, the medication cart will be kept closed and locked when out of sight of the personnel administering medication." On 7/14/22 at 8:58 a.m. an observation of medication administration was conducted for Resident #14 with Licensed Nurse A. At the beginning of the encounter, Licensed Nurse A stated, "I have to write down the medications from this computer and take them around the corner to the other computer. I think that computer is encrypting, and it doesn't have a mouse." They accessed the resident's Medication Administrator Record (MAR), wrote the name and dose of medications on a yellow sticky note, and proceeded around the corner and down the hall to a second medication cart near the resident's room. They

	began pouring the medications while referencing the yellow sticky note. Licensed Nurse A prepared and administered six (6) medications for Resident #14 without comparing each medication's label with the Physician Order. On 7/14/22 at 9:05 a.m. Licensed Nurse A left the medication cart unlocked and unattended while they went down the hall and around the corner to a second medication cart to prepare and administer medications to Resident #14. On 7/14/22 at 9:10 a.m., Licensed Nurse A left the medication cart unlocked and unattended while they walked to Resident #14's room and administered their medications. On 7/14/22 at 4:25 p.m., an interview was conducted with Administrative Nurse B. They stated, "the nurse should have had another computer with [them]. [They] should not be writing down medication orders and preparing them from a sticky note." 2) A treatment cart was observed unlocked and unsupervised on 7/12/22 at 10:36 a.m. outside the whirlpool bathroom [LOCATION]), across from resident room [LOCATION]. On the top of the cart was a loosely folded section of aluminum foil. Inside the foil was a small section of Telfa Non-adherent dressing package. The four (4) treatment cart drawers were observed to be easily opened with no staff around. Inside the drawers of the treatment cart were prescription ointments, treatment sprays, gauze, and treatment tools. One (1) registered nurse, Licensed Nurse C, was observed entering the centrally located nurse station but did not observe the treatment cart drawers being easily opened during this observation. On 7/12/2022 at 10:41 a.m. a resident was observed entering the [LOCATION] hallway in their electric wheelchair and passing the unlocked treatment cart. On 7/12/2022 at 10:42 a.m., Licensed Nurse C returned to the [LOCATION] hallway and locked the treatment cart and continued down the facility hallway. On 7/15/2022 at 1:30 p.m. Administrative Nurse D was interviewed about secured treatment and medication carts. They said that they would expect all the carts to be locked and secured for safety.
§ 51.210 (m) (2) Administration	Based on record review and staff interviews, the facility failed to ensure laboratory services were obtained according to

(2) The facility management must— (i) Provide or obtain laboratory services only when ordered by the primary physician; (ii) Promptly notify the primary physician of the findings; (iii) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance; and (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. Level of Harm – No Actual Harm, with potential for more than minimal harm Residents Affected – Few	Physician Order. The facility failed to ensure physician laboratory orders were completed for one (1) of six (6) residents reviewed for medications (Resident #8) out of 58 sample residents. The findings include: Resident #8 was originally admitted in 2008, and most recently admitted in 2020, with diagnoses including diabetes type two (2), congestive heart failure, degenerative disc disease, coronary artery disease, chronic blindness, history of stage 3A kidney disease, and bradycardia. The resident was noted to be alert and oriented x two (2), according to the [DATE] history and physical. A Care Plan, initiated [DATE] and last revised [DATE], revealed the resident was at risk for potential complications related to diagnosis of diabetes. The approaches, in pertinent part, included monitoring labs and accuchecks per orders, and to notify the physician of abnormal results in a timely manner. A [DATE] Physician Order revealed a laboratory order for CBC (complete blood count), CMP (comprehensive metabolic panel), lipid profile, other test A1C (glycated hemoglobin) once a day on the second Tuesday of January, April, July, and October. This was an ongoing Physician Order. An additional [DATE] Physician Order was noted to request an additional one (1)-time lab for the CBC, CMP, lipid profile, TSH (thyroid-stimulating hormone), and other test for A1C. Review of the resident's medical record revealed the last documented A1C laboratory results from [DATE]. The resident's A1C was documented as 7.0 (high), normal 4.0-6.0. The [DATE] lab results were not completed. The [DATE] labs were found in the laboratory website system but had not been identified or placed in the resident's record. The A1C had not been completed. The [DATE] labs were completed, except for the A1C. The [DATE] labs were completed, except for the A1C. An interview was conducted on 7/15/22 at 10:15 a.m. with Licensed Nurse D. They said that all resident lab results would be in the resident's current medical record. They said that the Physician Order was written for the resident's CBC, CMP, lipid profile, and A1C in a manner to indicate the full laboratory order should be done each quarter. They reviewed the resident's

	record and could not find the [DATE] laboratory results. Licensed Nurse D accessed the laboratory website to see if they could find the lab results for the resident since [DATE]. They were not able to find quarterly A1C labs in the resident's records. They said that the resident was having the A1C drawn due to the resident's history of unstable blood sugars. They said that the night nurse was responsible for reviewing all the Physician Orders each night on their shift to make sure that they were all in the electronic system. An interview was conducted on 7/15/22 at 1:30 p.m. with Administrative Nurse D. They said that the facility nurses usually take telephone orders from the doctors and then place the orders into the electronic system. They said that if the order was faxed, the administrative staff would give the nurse the orders and the nurse would again put the Physician Order into the system. They said that the night nurse should do a daily audit of all Physician Orders. An additional interview was conducted on 7/15/22 at 2:00 p.m. with Administrative Nurse D. They said that they reviewed the resident's records, and lab services for the quarterly A1C results. They said that it appeared that the Physician Order for lab services was put in the system, but the complete lab order was not identified in the request and the A1C was "dropped," and not completed by the laboratory. They said that they would run a new lab for the resident now, to address the issue. An interview was conducted on 7/15/22 at 2:34 p.m. with Administrative Nurse E. They said that there was no laboratory policy that could be found. They said that the nurse should transcribe Physician Orders so that they could then be placed into the resident's electronic medication administration record or electronic treatment administration record. The night shift would print out the order for the phlebotomist and the order should go on the 24-hour report. As the laboratory results were received, the unit nurse would sign off on those labs that they were waiting on, so the facility did not lose anything through the cracks.