STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 A complaint investigation survey was conducted from 10/01/19 through 10/04/19. There were two allegations investigated and they were both substantiated and cited. Immediate Jeopardy was identified at: CFR 483.12 at tag F-600 at a scope and severity of (J). The tag F 600 constituted Substandard Quality of Care. Immediate Jeopardy began on 09/15/19 and was removed on 10/03/19. An extended survey was completed.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the	F 580		10/23/19

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

Electronically Signed | 10/23/2019

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F 580	Continued From page 1 resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Medical Director interview the facility failed to notify the medical provider of a delay in administering an antibiotic and steroid for 1 of 4 sampled residents (Resident #3). The findings included:	F 580	F580 1. Resident # 3 received his antibiotic on 10/03/19, physician was notified of delay in treatment on 10/03/19. Resident # 3 infection has resolved. 2. All residents have potential to be	

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F 580	Continued From page 2 Resident #3 was admitted to the facility on 11/12/18 with diagnoses that included chronic lymphocytic leukemia (cancer of the blood), chronic obstructive pulmonary disease, and others. Review of the quarterly Minimum Data Set (MDS) dated 08/19/19 revealed that Resident #3 was cognitively intact and was independent with activities of daily living. The MDS further revealed that Resident #3 received intravenous (IV) medication while in the facility during the assessment reference period and required the use of oxygen. Review of hand written physician order dated 10/01/19 read in part, Cefepime (antibiotic) 1 gram (gm) IV every 12 hours x 7 days for pneumonia and Solu-Medrol (steroid) 40 milligrams (mg) IV every 12 hours x 7 days. The order was written signed by the Medical Director (MD) and signed off by Nurse #1 on 10/01/19 with no time noted. Review of Resident #3's Medication Administration Record (MAR) dated 10/01/19 revealed that Resident #3 had not received any of the Cefepime or Solu-Medrol since being ordered by the MD on 10/01/19. The Cefepime and Solu-Medrol were present on the MAR but were not initialed indicating that they were not administered on 10/01/19, 10/02/19, or 10/03/19. An interview was conducted with Nurse #1 on 10/03/19 at 5:15 PM. Nurse #1 stated that on 10/01/19 after her night time medication pass, she had signed off the orders the MD had written for Resident #3, entered them into the electronic record and faxed the order to the pharmacy to be	F 580	effected. 100% audit of current residents was completed by the Director of Nursing to ensure that all residents with order for antibiotics have received as ordered, and physician notified of any delays. 3. Education was completed by the Director of Nursing for 100% of all licensed nursing staff. Education included FT, PT, PRN and agency staff on how to order medications. Any new hires or agency staff will be required to have this training during their orientation. Orientation education will include the process for following up with medication that has not delivered from the pharmacy timely and prompt notification of physician when a medication is not readily available as ordered. 4. The RN supervisor or Nursing Designee will conduct an audit 5 x week for the medication cart to confirm that medications correspond to the MAR, to ensure medication availability and ensure physician notified of any delay in medication availability. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/23/19	

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F 580	Continued From page 3	F 580		

delivered to the facility. Nurse #1 stated that she returned to work on 10/02/19 at 7:00 PM and attempted to reach the pharmacy but was unsuccessful. She added that before she left on 10/03/19 at 7:00 AM, she had called the pharmacy and spoke to someone who stated that the pharmacy never received the order for Resident #3's IV medication. Nurse #1 indicated she faxed the order again but stated she did not contact the MD or NP to notify them that the IV medication for Resident #3 had not arrived from the pharmacy or that it had not been administered yet.

An interview was conducted with Nurse #5 on 10/03/19 at 4:10 PM. Nurse #5 confirmed that she was caring for Resident #3 and was familiar with him. She stated that she arrived at work this morning and had a note from Nurse #1 that stated she had faxed the pharmacy in reference to Resident #3's Cefepime and Solu-Medrol. Nurse #5 stated that she had been working all morning trying to get the medication to the facility and had again faxed the order to the pharmacy. Nurse #5 stated that she had not contacted the MD or the NP to notify them that the IV medication ordered on 10/01/19 for Resident #3 had not yet arrived from the pharmacy. She added, "I think we should have called the doctor and see if there was something else to give."

An interview was conducted with the Director of Nursing (DON) on 10/03/19 at 4:31 PM. The DON stated she was informed earlier that the staff had not yet received Resident #3's IV antibiotic or steroid and when asked why was told the order was faxed but the pharmacy indicated they had not received the faxed order. The DON stated she instructed Nurse #5 to fax the order again

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F 580	Continued From page 4	F 580		

and to call the pharmacy and let them know that the medication was needed immediately. The DON stated that she expected Nurse #1 to contact the MD or NP when the medication did not arrive on the 10/02/19 when medications were delivered to the facility and let them know that IV medication and steroid ordered on 10/01/19 had not arrived and to update them on Resident #3's condition and obtain any additional orders that may be needed.

An interview was conducted with the Nurse Practitioner (NP) on 10/03/19 at 3:56 PM. The NP stated she had not been made aware that Resident #3 had not received the antibiotic or steroid that the MD had prescribed on 10/01/19. The NP stated she would expect the staff to communicate that to her or the MD immediately so additional orders could have been given to treat Resident #3 until the Cefepime and Solu-Medrol came in from the pharmacy.

A telephone interview was conducted with the MD on 10/03/19 at 3:30 PM. MD stated that for the last week Resident #3 has been much shorter of breath, had some hypoxia (absence of enough oxygen in the tissues to sustain bodily function), and was congested. She indicated that Resident #3 had been aggressively treated with IV antibiotic and steroids without much improvement. The MD stated that she ordered Cefepime which was a new antibiotic for him and some Solu-Medrol on 10/01/19 in hopes of seeing some improvement. The MD indicated she was not aware that Resident #3 had not yet received the Cefepime or Solu-Medrol that she ordered on 10/01/19 and stated maybe the staff notified the Nurse Practitioner (NP). She added that she certainly would have wanted to be notified of any

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F 580	Continued From page 5 delay in obtaining the antibiotic and steroid. The facility had an emergency supply of antibiotics and she could have covered Resident #3 with something else until the Cefepime arrived from the pharmacy.	F 580		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, Physician and staff interviews the facility neglected to protect a cognitively impaired and dependent resident who was left unattended in the facility's outside courtyard for at least 3 hours in the sun with an outside temperature of 86 degrees Fahrenheit for 1 of 4 residents reviewed for neglect. Resident #1 was found outside in the courtyard lethargic and sluggish and received second degree burns with blisters on both of his thighs. Resident #1 was sent to the hospital for evaluation and treatment and returned to the facility.	F 600	F600 1. Resident # 1 remains in the center and continues with treatment to burns on thighs. Resident is supervised when he wishes to sit outside. 2. All residents have the potential to be affected. No other residents have been affected by this deficient practice as evidenced by no burns identified on Skin Assessments completed since 9/15/19, and no residents with signs and	10/23/19

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F 600	Continued From page 6 Immediate jeopardy began on 09/15/19 when Resident #1, who was moderately impaired in cognition, was left outside in a courtyard smoking area in the sun for at least 3 hours and had second degree burns on both of his thighs. Immediate jeopardy was removed on 10/03/19 when the facility provided and implemented a Credible Allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Findings included: Resident #1 was admitted to the facility on 08/25/16 with diagnoses which included diabetes, history of a stroke, Alzheimer's disease, dementia, anxiety and depression. A current care plan most recently reviewed by staff on 05/22/19 revealed Resident #1 could smoke with supervision and the goal indicated Resident #1 would smoke safely every shift. The interventions were listed in part to supervise Resident #1 with smoking in accordance with his assessed needs. A Quarterly Minimum Data Set (MDS) dated 07/02/19 indicated Resident #1 was moderately impaired in cognition for daily decision making and was totally dependent on staff for bed mobility, transfers and locomotion on and off the unit in a wheelchair. A Smoking Evaluation dated 07/02/19 indicated in part Resident #1 required supervised smoking	F 600	symptoms of exposure. As evidenced by skin assessments completed on 100% current residents week of 9/16-9/21/19. 3. On 10/02/19 Education was initiated to include review of Center Neglect Policy and re-education on not leaving dependent residents unattended in the Courtyard area. Education also addressed ensuring residents are free from Sun Exposure/ heat to include ensuring that residents that wish to be outside on days of extreme heat have access to shade and sufficient fluids, and monitoring residents that choose to sit outside. Education included Full time/Part time/PRN and Agency staff members, as well as contract staff members for Therapy, Dietary, Laundry and Housekeeping. Education is ongoing with new hires and oncoming agency. All existing staff have been in-serviced at 100% as of 10/23/2019. Any hired staff and new agency staff received this training prior to working their position. 4. Center Leadership (Administrator, Director of Nursing, Social Worker, Maintenance, RN Supervisor, Nurse Educator, and weekend manager on duty) will conduct 5 random audits per week on residents in the Courtyard area for safety. These audits will be on all three shifts and on weekends. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance.	

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F 600	Continued From page 7 because he could not hold a cigarette safely. During a telephone interview on 10/04/19 at 10:18 AM, Nurse Aide (NA) #4 explained on 09/15/19 she was told to take residents out to smoke at 1:00 PM to a courtyard smoking area. She stated she left her assigned unit and went to the courtyard but Resident #1 was already there with other residents. She further stated she did not know who had transported Resident #1 outside. She explained she recalled Resident #1 smoked 1 cigarette and when residents had finished smoking, she asked Resident #1 if he wanted help to get back inside the facility, but he said no. She stated she told a Nurse, but could not recall who it was, the alarm needed to be turned off and she assisted all the residents except Resident #1 inside the facility. She confirmed she did not tell the Nurse she had left Resident #1 outside in the courtyard. She explained she did not realize Resident #1 could not get back inside the facility by himself. She stated she put the resident's smoking materials away and went back to her assignment because it was a busy day and she was behind on getting work done. She further stated she should have gone back to check on Resident #1 but she did not. She explained she recalled Resident #1 was dressed in a shirt with sleeves down to his elbows, he had on long pants and was wearing a toboggan on his head and was sitting in his wheelchair half way under the canopy and half way in the sun. During an interview on 10/01/19 at 4:07 PM, the Social Worker explained she was the manager on duty on Sunday 09/15/19 from 8:00 AM until 12:00 PM. She stated there were no concerns reported to her regarding Resident #1 while she was at the facility and after she left the facility she	F 600	5. Date of Compliance 10/23/19	

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did not receive any calls about Resident #1.

A review of a Nurse's note dated 09/15/19 at 4:31 PM documented by Nurse #1 revealed NA #1 called for Nurse #1 to come to the smoking area. The note indicated Resident #1 was found sitting in a wheelchair outside in the smoking area and Nurse #1 found Resident #1 was lethargic (sluggish) and would not respond verbally to Nurse #1. The note further indicated Resident #1 was immediately brought inside, and his vital signs were obtained and his blood pressure was 146/77, pulse 129, oxygen saturation percentage 94, respirations 18 and his temperature was 101.2 degrees Fahrenheit (F). The note revealed Resident #1 was transported to the emergency room (ER) for evaluation and treatment.

During an interview on 10/03/19 at 9:03 AM, Nurse #1 explained she was assigned to Resident #1 on 09/15/19 during the 6:30 AM to 6:30 PM shift and remembered it was a very busy day. She stated she recalled Resident #1 ate lunch in his room and she gave him medications around 12:30 PM. She further stated she saw Resident #1 after lunch in the hallway in his wheelchair but she did not recall what time that was. She explained Nurse Aides (NAs) assigned to the 400 hall were responsible to take resident's out for the 1:00 PM smoke break and they were supposed to stay with residents until they finished smoking. She stated if a resident stayed outside after the smoke break the NAs were supposed to let the Nurse or the NA assigned to the resident know that the resident so they could check on them frequently. She explained later that afternoon, NA #1 came to her around 4:00 PM and told her she needed to go to the smoking area right away. Nurse #1 stated she went

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outside to the courtyard and Resident #1 was sitting in a wheelchair in the sun on the concrete patio and he was slumped to one side and did not speak her. She further stated she took Resident #1 inside to the nurse's station to check his vital signs and she asked Resident #1 if he could speak and he said yes but Resident #1 said nothing else. She confirmed Resident #1 had on a toboggan and sweatshirt and long pants. She stated and it was a hot day and her first concern was Resident #1 had gotten too hot. She explained she remembered Resident #1's temperature was over a 100 degrees F and they took him to his room and put him on his bed because she was trying to hurry to get him ready to send to the hospital. She stated when she saw Resident #1's legs her first instinct was he had been sunburned. She confirmed she had not seen Resident #1 in the courtyard smoking area until NA #1 called her to go out there around 4:00 PM. She confirmed it was a hot day and there was no water station or fluids for residents to drink in the smoking area. She explained she notified the Administrator about the incident after Resident #1 had been sent to the hospital.

During a telephone interview on 10/01/19 at 2:25 PM, NA #1 stated she was assigned to Resident #1 on 09/15/19 during the 6:30 AM to 6:30 PM shift and confirmed he ate lunch in his room. She explained after Resident #1 ate lunch he got his wheelchair stuck between the overbed table and the door of his room and she assisted him to propel into the hallway. She further explained Resident #1 was unable to propel himself through both doors at the courtyard and needed staff assistance to go outside. She confirmed NA #4 was assigned to go outside with residents in the smoking area at 1:00 PM but NA #4 did not report

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off to her that Resident #1 stayed outside after the smoke break was finished. NA #1 stated it was their usual routine to make rounds every 2 hours to check and change residents but Resident #1 usually stayed out of his room and she did not realize he was still outside in the courtyard. NA #1 further stated she was assigned to take residents outside for the 4:00 PM smoke break and when she went to the courtyard she found Resident #1 was sitting in a wheelchair in the sun and he was unresponsive. She explained she called for Nurse #1 and they brought Resident #1 inside the facility and transferred him to bed. She explained when they took his pants off she saw blisters on the upper part of his thighs and one leg had more blisters than the other. She stated she recalled Resident #1 had on long pants that were a light and dark color.

During an interview on 10/01/19 at 11:06 AM, Nurse #2 explained the facility had designated smoking times at 9:00 AM, 11:00 AM, 1:00 PM, 4:00 PM and 8:00 PM and NAs from each hall rotated to take residents out to smoke on weekends. She explained she recalled on 09/15/19 Resident #1 was sitting across from the nurses station before the 1:00 PM smoke break and when it was time to go out to smoke he propelled himself to the first door of the courtyard. She stated Resident #1 could not get himself through the door but she did not recall who took Resident #1 out to the courtyard. She explained it usually took residents about 30 minutes to finish smoking and she was told all of the residents came back in after the smoke break except Resident #1 did not come back insided. She further explained NA #4 who was in the courtyard during the 1:00 PM smoke break did not report

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that Resident #1 had been left outside. She stated it was a hot and sunny day and around 4:00 PM she heard NA #1 call for Nurse #1 to come to the courtyard. Nurse #2 stated she ran out to the courtyard and Resident #1 was sitting in a wheelchair in the sun approximately half way between a covered canopy and the courtyard door and he was slumped to his right side with saliva running from his mouth and down onto his shirt. She explained Resident #1 was unresponsvide and they took him inside to his room and transferred him to his bed. She stated when NAs removed Resident #1's pants there were multiple areas with bilsters on the top of both of his thighs approximately 1-2 inches in length and they were raised approximately one-half inch and it looked like his legs had been sunburned. She further stated she recalled Resident #1 had on long pants but did not recall any specifics about them or his other clothing.

During a telephone interview on 10/01/19 at 2:40 PM, NA #3 stated on 09/15/19 she fed Resident #1's roommate lunch while Resident #1 ate lunch in his room. She explained Resident #1 could propel himself in his wheelchair but only for short distances of about 5 feet. She stated she was not sure who took Resident #1 out to the courtyard at 1:00 PM but at approximately 4:00 PM the 300 hall NAs were taking residents out to smoke and found Resident #1 outside. She explained when she got to the courtyard Resident #1 was slumped over and had saliva running out of his mouth. She stated she recalled his shirt was wet from sweat and he had on long pants that had a light and dark print. She explained when NAs removed Resident #1's pants, she saw his thighs were red and blistered.

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During a telephone interview on 10/01/19 at 3:30 PM, NA #2 explained on 09/15/19 she went to Resident #1's room to help out after staff had brought him inside. She stated she recalled he had on long black pants that were thin but she was not sure what the fabric was made of. She also stated he had on a long sleeve shirt that was wet with sweat. She explained when they removed his pants the skin on his thighs were bright red with blisters. She also confirmed Resident #1 could not propel himself without staff assistance through the doors at the courtyard.

An Emergency Department note dated 09/15/19 at 4:34 PM revealed in part Resident #1 was taken outside to smoke and he was left alone and was found to have blisters on his legs. The note also indicated a large water type blister was on his inner thigh of his left leg and both legs were red. The note further indicated Resident #1 was nonverbal on arrival to the ER, his temperature was 99.9 degrees F and his vital signs were monitored.

A section of the Emergency Department note titled physical exam dated 09/15/19 at 5:59 PM indicated Resident #1 was awake but lethargic and his burns were debrided and his condition had improved.

An attempt on 10/03/19 at 10:39 AM to interview the ER Physician who had treated Resident #1 was unsuccessful.

A Nurse's progress note dated 09/16/19 at 3:29 AM indicated a call was received from the hospital that the ER Physician had debrided Resident #1's left upper leg and the dressing on the area was to be changed twice a day and

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Silvadene applied with an abdominal pad (thick dressing) and wrapped loosely with kling (gauze wrap). The note also revealed Resident #1 was to follow up with a Physician and start Keflex (antibiotic) 500 milligrams by mouth 3 times a day for 7 days. The note further revealed Resident #1 returned to facility on 09/16/19 at 3:29 AM by Emergency Medical Services with a dressing to his left upper leg and redness with multiple blisters was observed above the top of the dressing on his left leg and redness was throughout the top of his right leg.

A skin integrity report dated 09/18/19 documented by Nurse #4 revealed in part Resident #1's right upper thigh burn measured 9.7 centimeters (cm) x 2.3 cm and a right lower thigh burn measured 18.3 cm x 5.6 cm. The note also indicated a left lower thigh burn measured 27.9 cm x 18.6 cm.

A Physician's progress note dated 09/24/19 revealed Resident #1 was placed on rounds today for burns which were acquired earlier this week and he was seen in the ER and was given topical (on the skin) Silvadene. The note further revealed Resident #1 stated he was outside and it was caused by the "sun." The note also revealed Resident #1's burns were along the proximal (close to the center) thigh but no where else. The note indicated Resident #1 was slow to self-propel a wheelchair and moved slowly along the hand rail. A section labeled plan indicated to continue topical Silvadene as ordered with dressings and monitor for secondary infection. The note also revealed there was no infection present and Resident #1's pain was controlled with Norco (narcotic pain medication) and continue to monitor closely.

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During an interview on 10/01/19 at 1:30 PM, Resident #1's Physician who was also the facility Medical Director explained she was notified Resident #1 had been sent to the hospital with burns. She stated she was asked to see Resident #1 last week on rounds and when she asked him what happened, he told her "in the sun." She explained the burns were distributed on both thighs and down in his medial (middle) thighs and thought it could have been caused by the sun. She confirmed Resident #1 had second degree burns on both thighs and they were extensive. She stated Resident #1 had not had any secondary infections from the burns and the burns should heal but she expected there would be scarring. She explained due to Resident #1's medical conditions he could not defend himself or get himself out of that type of situation and she felt the incident was avoidable.

During a follow up telephone interview on 10/03/19 at 3:32 PM with Resident #1's Physician she stated in her professional opinion Resident #1's rise in temperature to 101.2 degrees F. could have been related to him sitting in the heat for approximately 3 hours. She further stated she did not know what the temperature was that day but recently they had heat indexes in the 90's. She also stated Resident #1's unresponsiveness could have been due to the heat from sitting in the sun and she was concerned because he was also an insulin dependent diabetic.

During an observation and interview on 10/01/19 at 10:10 AM, Resident #1 was seated in a broda chair in the hallway dressed in sweat pants, a long sleeve shirt and he had a toboggan on his head. When asked what had caused the burns on his legs, he stated "the sun" but did not offer

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any other explanation.

During an interview and observation on 10/01/19 at 10:48 AM, Nurse #4 confirmed she had already provided treatments to Resident #1's burns earlier that morning but the dressings could be observed. Resident #1 was observed in bed and when his pants were removed the gauze wrap had rolled down at the top of the dressings on both thighs and both thighs had areas of open skin with Silvadene ointment in place.

During a follow up interview on 10/03/19 at 1:07 PM, Resident #1 stated when asked what had happened to his legs "I burnt them up" but they are getting better. When asked how he did that he said in the hot sun and he verified he had on a long sleeve shirt and long pants and his toboggan because that was what he liked to wear everyday.

A review of local weather data revealed a high temperature of 86 degrees on 09/15/19.

Observations of the courtyard smoking area revealed a large concrete pad with no covering or shade at the front. Near the back of the courtyard there was a large canopy with a table and chairs underneath.

During an interview with the Administrator on 10/02/19 at 11:26 AM she confirmed Nurse #1 called her around 5:45 PM on 09/15/19 and told her an event had taken place with Resident #1. She explained Nurse #1 told her Resident #1 was left outside unattended and she thought he had sustained sunburns. She stated Nurse #1 also said Resident #1 was unresponsive to verbal stimuli and he was brought inside and was sent to the hospital. She confirmed NA #4 was in the

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courtyard for the 1:00 PM smoke break but did not do a clear all to ensure all residents had been brought back inside after the smoke break. She explained NA #4 did not go back outside later to check to see if any residents were still outside.

The Administrator was informed of immediate jeopardy on 10/02/19 at 3:43 PM.

The facility provided an Acceptable Allegation of Immediate Jeopardy removal on 10/03/19 at 12:32 PM as follows:
" Identify those residents who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance:

Resident #1 was admitted to the facility on 08/25/16. His diagnoses included diabetes, history of a stroke, Alzheimer's disease, dementia, anxiety and depression.

On 9/15/2019 at approximately 4:00 pm the resident was found outside in courtyard/smoking area unresponsive. Resident # 1 was noted to be in the sun without shade or fluids available. He was taken into the center and assessed by the nurse on duty. Temperature was 101.2, BP 146/77 and Pulse 129. Difficult to arouse. Upon assessment resident was noted to have burns/blisters to both thighs. Resident was sent to the emergency room for evaluation where he had 2nd degree burns debrided and returned to the center with treatment orders and an antibiotic.

On Monday September 16, 2019 a full investigation was initiated and a self-report was sent to DHHS. Through the investigation it was determined that resident had been outside in the courtyard/smoking area since approximately 1:00

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F 600	Continued From page 17 pm for the scheduled smoking time. Resident estimated to have been outside in high temperatures (between 85 and 90 degrees) for approximately 3 hours unattended. Staff failed to check on residents that had been out on the 1:00 p.m. smoke break. No other residents have been affected by this deficient practice as evidenced by no burns identified on Skin Assessments completed since 9/15/19, and no residents with signs and symptoms of exposure. As evidenced by skin assessments completed on 100% current residents week of 9/16-9/21/19. " Specify action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when action will be complete: Center Executive Director notified the Regional Nurse of this event on 9/16/19 and a plan of correction was drafted to address and prevent future occurrences. Part of this plan included education for the staff and ongoing monitoring. Education was conducted, however did not include 100% of current staff. This education included importance of checking on residents frequently and not leaving dependent residents unattended in courtyard and rounding on residents more frequently. An ADHOC QAPI was held with IDT however it did not include the Medical Director. Ongoing audits were conducted according to the plan, however did not include off shifts and weekends. On 10/02/19 Education was initiated to include review of Center Neglect Policy and re-education	F 600		

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on not leaving dependent residents unattended in the Courtyard/Smoking area. Education also addressed ensuring residents are free from Sun Exposure/ heat to include ensuring that residents that wish to be outside on days of extreme heat have access to shade and sufficient fluids, and monitoring residents that choose to sit outside. Residents who are dependent and /or cognitively impaired that wish to sit outside will either have staff member present with them or be checked every 15 minutes. Education included Full time/Part time/PRN and Agency staff members, as well as contract staff members for Dietary, Laundry and Housekeeping. Education is at 80 % for all Nursing Employees, any staff that have not received this training will not work until they have completed the education. This education will be added to the orientation/onboarding process for all new hires and new agency staff.

Center Executive Director will draft a memo to family members, which will be sent out today, addressing concerns with heat exposure and what steps have been taken by the center to ensure residents have shade, fluids, sun screen and monitoring while they enjoy the outdoors. The Center Executive Director and/or the Social Service Director will personally discuss these actions with each alert and oriented resident today and provide a copy of the memo. Any visitors today will receive this education in person by the Center Executive Director or the Director of Social Services. Social Services Director will be responsible tracking what family members have received in person education or mailed the information.

On 10/03/19 at approximately 9:00 a.m. an electronic, self-serve water cooler and disposable

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F 600	Continued From page 19 cups were placed outside in the courtyard/smoking area for residents to have access to fluids while outside. The water cooler will be maintained by the Maintenance Director. Residents requiring assistance with fluids and/or on thickened liquids will be offered hydration by staff through the monitoring process established in this plan. Alleged date Immediate Jeopardy was removed, 10/03/19. Administrator is responsible for the implementation of this plan. The facility's Credible Allegation of Immediate Jeopardy removal was verified on 10/03/19 at 6:08 PM. Administrative, nursing, housekeeping, dietary, social work and therapy staff all verified they had received training regarding neglect and the importance of checking on residents frequently when they were outside. They also verified they had been educated about not leaving dependent residents unattended in the courtyard and they were expected to round on residents more frequently when residents were outside. Verification also revealed letters had been mailed to family members regarding heat exposure and the facility had a canopy in the courtyard and encouraged residents to sit in shady areas. There was also verification of sunscreen and a water station was in the courtyard for residents. Interviews with residents who smoked revealed they were aware of the water station, shade and sunscreen. Reviews of the training and education materials revealed they had been provided to all departments.	F 600		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F 760		10/23/19

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F 760	Continued From page 20 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 observations, record reviews, and resident, staff, Pharmacy Representative, Nurse Practitioner, and Medical Director interviews the facility failed to administer an antibiotic and steroid per the Physician's orders for 1 of 4 sampled residents (Resident #3) . The findings included: Resident #3 was admitted to the facility on 11/12/18 with diagnoses that included chronic lymphocytic leukemia (cancer of the blood), chronic obstructive pulmonary disease, and others. Review of the quarterly Minimum Data Set (MDS) dated 08/19/19 revealed that Resident #3 was cognitively intact and was independent with activities of daily living. The MDS further revealed that Resident #3 received intravenous (IV) medication while in the facility during the assessment reference period and required the use of oxygen. Review of hand written physician order dated 10/01/19 read in part, Cefepime (antibiotic) 1 gram (gm) IV every 12 hours x 7 days for pneumonia and Solu-Medrol (steroid) 40 milligrams (mg) IV every 12 hours x 7 days. The order was written signed by the Medical Director (MD) and signed off by Nurse #1. Review of Resident #3's Medication Administration Record (MAR) dated 10/01/19	F 760	F760 1. Resident # 3 received his antibiotic on 10/03/19, physician was notified of delay in treatment on 10/03/19. Resident # 3 infection has resolved. 2. All residents have potential to be effected. 100% audit of current residents was completed by the Director of Nursing to ensure that all residents with order for antibiotics have received as ordered, and physician notified of any delays. 3. Education was completed by the Director of Nursing for 100% of all licensed nursing staff. Education included FT, PT, PRN and agency staff on how to order medications. Any new hires or agency staff will be required to have this training during their orientation. Orientation education will include the process for following up with medication that has not delivered from the pharmacy timely and prompt notification of physician when a medication is not readily available as ordered. 4. The RN supervisor or Nursing Designee will conduct an audit 5 x week for the medication cart to confirm that medications correspond to the MAR, to ensure medication availability and ensure	

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F 760	Continued From page 21 revealed that Resident #3 had not received any of the Cefepime or Solu-Medrol since being ordered by the MD on 10/01/19. The Cefepime and Solu-Medrol were present on the MAR but were not initialed indicating that they were not administered on 10/01/19, 10/02/19, or 10/03/19. Review of a nurses note dated 10/03/19 at 6:35 AM read, this nurse called the pharmacy regarding order for Resident #3's IV medications. The pharmacy stated that they never received the order. This nurse did in fact fax the orders over to them on 10/01/19. The orders were faxed again this morning to the pharmacy and indicated the IV medications would be sent out STAT (immediately or as soon as possible) to the facility. Signed by Nurse #1. An observation and interview were conducted with Resident #3 on 10/03/19 at 12:31 PM. Resident # 3 was resting in bed with his eyes open. He was alert and verbal but audibly congested. When he would speak gargling of secretions could be heard. Resident #3 had oxygen in place and stated to me "I can't quit coughing." Resident #3 indicated he had seen the MD and she had ordered some medication to be given through an IV, but it had not come in yet. He stated he had been sick for the last 3 weeks or so. Resident #3 explained that he continued to go out and smoke at his predetermined smokes times and when he was smoking was the only time he was not coughing. An observation and interview were conducted with Resident #3 on 10/03/19 at 3:02 PM. Resident #3 remained in bed with his eyes open and alert and verbal. Resident #3 remained audibly congested and when he spoke the	F 760	physician notified of any delay in medication availability. Results of these audits will be brought before the Quality Assurance and Performance Improvement Committee monthly with the QAPI Committee responsible for ongoing compliance. 5. Date of compliance: 10/23/19	

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gargling of secretions could still be heard. He had an IV site in his right arm and stated, "there is not a damn thing in it."

An interview was conducted with Nurse #1 on 10/03/19 at 5:15 PM. Nurse #1 stated that on 10/01/19 after her night time medication pass, she had signed off the orders that the MD had written, entered them into the electronic record and faxed them to the pharmacy to be delivered to the facility. Nurse #1 stated that she went ahead and put the IV access in Resident #3 in anticipation of the IV medication but when she returned to work on 10/02/19 at 7:00 PM she learned the medication had not yet arrived. She indicated she had tried to call the IV department and the pharmacy and got no answer. Nurse #1 stated that she did not notify the Nurse Supervisor (NS), Director of Nursing (DON), Nurse Practitioner (NP) or MD but had reported to Nurse #5 that the medication had not yet arrived. Nurse #1 stated that on 10/03/19 before she left at 7:00 AM, she had called the pharmacy and spoke to someone who stated that the pharmacy never received the order for Resident #3's IV medication. Nurse #1 indicated she faxed the order again and reported to Nurse #5 that the medication should be coming soon from the pharmacy. Nurse #1 stated that Resident #3 had been pretty stable the last two nights and no obvious cough like he had last week, and his oxygen saturations were between 88 and 92% which was his baseline.

An interview was conducted with Nurse #5 on 10/03/19 at 4:10 PM. Nurse #5 confirmed that she was caring for Resident #3 and was familiar with him. She stated that she arrived at work this morning and had a note from Nurse #1 that

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stated she had faxed the pharmacy in reference to Resident #3's Cefepime and Solu-Medrol order. Nurse #5 stated that she had been working all morning trying to get the medication to the facility and had faxed the order to the pharmacy again. Nurse #5 stated that earlier on her shift the pharmacy had delivered a STAT order of Solu-Medrol, but she had not given it yet but the Cefepime was not in the tote from the pharmacy. Nurse #5 stated she again called the pharmacy and they stated that the IV department had issues with their fax machine and that was why there was a delay in getting the IV Cefepime to the facility. She confirmed that Resident #3 had not yet received the Cefepime or Solu-Medrol as ordered on 10/01/19 by the MD.

An interview was conducted with the NS on 10/03/19 at 4:46 PM. The NS stated this was her first day on the floor and she and Nurse #5 had been working all day to obtain the IV medications for Resident #3 from the pharmacy. She added that the order had been faxed numerous times but was told by the pharmacy that the IV department was having issues with their fax machine and did not receive the order. The NS stated she told the pharmacy that she needed the medication STAT, but the pharmacy would not give an estimated time when the medication would be delivered. She stated that the pharmacy had delivered medication 2 times to the facility but did not contain the antibiotic.

An interview was conducted with the DON on 10/03/19 at 4:31 PM. The DON stated she was informed earlier that the staff had not yet received Resident #3's IV antibiotic or steroid that were ordered by the Physician on 10/01/19. She was told the order was faxed on 10/01/19 but the

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ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

(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 760	Continued From page 24	F 760		

pharmacy indicated they had not received the faxed order. The DON stated she instructed Nurse #5 to fax the order again and to call the pharmacy and let them know that the medication was needed immediately. She stated that the issue concerned her for several reason, first one was Resident #3's safety and we were not addressing the infection for which the antibiotic was prescribed and the potential for Resident #3's decline and possible hospitalization. The DON stated that the omission of the antibiotic and steroid were significant because "he is a sick individual." She added she expected the medication to be given as ordered and to be notified by Nurse #1 when the medication did not arrive from the pharmacy on 10/02/19.

An interview was conducted with Pharmacy Representative (PR) on 10/04/19 at 1:45 PM. The PR stated that he had received a call from the facility on 10/03/19 about Resident #3's IV medication and when he checked they had not received the order on 10/01/19 and asked that it be faxed over to the pharmacy again. The PR started that he received the order on 10/03/19 and sent it to the pharmacist who then sent the order over to the IV department to be filled and sent out to the facility. The PR stated that he did not realize that the IV department's fax machine was not working properly, and they had not received the order. Once he discovered this, he called them and verified the order with them and at that point the IV medication was filled and prepared to be delivered to the facility. The PR stated that to his knowledge the antibiotic had left the pharmacy around 2:00 PM on 10/03/19 but could not verify the time it had been delivered to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345261	A. BUILDING _____ B. WING _____	C 10/04/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY CENTER	179 COMBS STREET SPARTA, NC 28675

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F 760	Continued From page 25	F 760		

A telephone interview was conducted with the MD on 10/03/19 at 3:30 PM. The MD stated that Resident #3 was a very sick gentleman who had leukemia and did not tolerate chemotherapy and several months ago had anaphylaxis (an acute allergic reaction to an antigen) so the management of his leukemia was currently on hold. She explained that Resident #3 was seeing an Oncologist (doctor that specialized in cancer) and he decided he did not want to go back and had a Do Not Resuscitate (DNR) in place in which we have talked in great lengths about. The MD stated that for the last week Resident #3 has been much shorter of breath, had some hypoxia (absence of enough oxygen in the tissues to sustain bodily function), and was congested. She indicated that Resident #3 had been aggressively treated with IV antibiotic and steroids without much improvement. She stated that on 10/01/19 she visited with Resident #3 and offered him emergency room (ER) and/or hospitalization to treat him and he declined stating he wanted to remain in the facility for treatment. The MD stated that she ordered Cefepime which was a new antibiotic for him and some Solu-Medrol on 10/01/19 in hopes of seeing some improvement. She added that Resident #3 was critically ill and any delay in his treatment was a concern to her. The delay in his medication management could have led to adverse outcome and the fact he has not yet received the medication she ordered on 10/01/19 was a significant medication error and 48 hours could make a difference in whether or not he became septic (infected with harmful bacteria).