STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING _____ B. WING _____	C 11/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

(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 An unannounced on site complaint investigation was conducted 11/12/19 through 11/15/19 and five of the sixteen allegations were substantiated and cited. Event ID# VDB311.	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 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	F 580		12/13/19

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

Electronically Signed | 12/11/2019

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F 580	Continued From page 1 (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 and physician interviews, the facility failed to notify the physician that a cognitively impaired resident had exited the building on two separate occasions (Resident #10) and failed to notify the physician of an elevated blood glucose reading for a resident (Resident #11), for 2 of 2 residents reviewed for notification of change. The findings included: 1. Resident #10 was admitted to the facility on 09/06/19 with diagnoses which included vascular dementia with behavioral disturbance, generalized muscle weakness and cognitive communication deficit. A review of Resident #10's most recent admission Minimum Data Set (MDS) dated 09/13/19 revealed he was severely cognitively impaired for	F 580	This plan of correction is submitted in accordance regulatory requirements only. 1. Secured units at neighboring facilities have accepted Resident #10 for admission. Resident #10 has an estimated discharge date of 1-9-2020 from the facility. Resident #10 remains at his baseline. The attending physician has been notified of the events 9-10-19 and 11 -14-19. Nurse #1 is an agency nurse and no longer works with the facility. Nurse #2 will be educated to both the Elopement and Physician Notification policies by the Director of Nursing (DON) by 12-13-19. Resident #11 remains at baseline. Resident #11's blood glucose level checks and responsive sliding scale administration continue as ordered; inclusive of MD notification per	

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F 580	Continued From page 2 daily decision making and required supervision with set up for walking with his rollator walker. A review of Resident #10's care plan dated 09/10/19 revealed he had a care plan for being at risk for elopement, injury as evidenced by: wandering, confusion, asks location of his room frequently. Wanders into other's rooms. Family states he will throw things in the trash. Pushes on exit doors. The goal was for the resident to wander safely within specified boundaries and will not have any successful elopements. The interventions included: may use stop signs with alarms, may apply stop signs to doors Resident #10 frequents, observe resident near exit doors and redirect away from exits, observe trash cans for items Resident #10 may throw away (clothes, wallet, shoes, toiletries), assure resident has proper fitting and appropriate foot attire, elopement assessments to be completed quarterly and as needed, label resident's belongings and environment to promote recognition, maintain a calm environment and approach to Resident #10, picture in elopement books, remove resident from other resident's rooms and unsafe situations and when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). A review of Resident #10's chart revealed on 09/10/19 at approximately 1:00 PM, he was observed by an Electrician (doing contract work for the facility), exiting the facility through the exit door closest to room 111. The Electrician immediately notified Nurse #1 that he had seen Resident #10 exit the facility door and stated to Nurse #1 that he was not sure if the resident was supposed to go out the exit door. Nurse #1 and	F 580	established parameters. The attending physician was notified of the physician notification variance on 11/15/19. Nurse #4 will be reeducated to the facility's policies and standards by the DON on Physician Notification by 12-13-19. 2. All residents have the potential to be impacted. A facility wide audit of all current residents who in the past thirty (30) days were identified as having an incident and/or accident, change of condition and abnormal clinical parameters have been reviewed to ensure physician and responsible party notification has occurred; confirming the presence of physician notification parameters and compliance with the same. Findings will be addressed promptly by the Director of Nursing (DON) and/or Unit Manager (UM) and forwarded to QAA for processing. 3. The facility has reviewed its expectations and policy on Physician Notification ensuring clarity. No revisions are needed. The facility has reviewed its previous practice of ensuring timely physician notification of resident events (e.g. elopements and physician notification variances per order/parameter) through Resident at Risk ("RAR") meetings. The system has been revised in the following way: Nursing Administration which consists of the DON, UM's, Shift Supervisors and the Minimum Data Set ("MDS") nurse will review 24 hour report, incident reports, and Medication Administration Records	

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F 580	Continued From page 3	F 580		

the Maintenance Director found the resident on the sidewalk walking back towards the facility from the Smoking Shed. Resident #10 was assisted back inside the facility and stated to Nurse #1 that he "got turned around" when he left the dining room.

An incident report completed on 09/10/19 by Nurse #1 was reviewed and stated the resident was moved away from the exit door on the 100 hall and closer to the nurse's station on the 300 hall. The Responsible Party was notified of the exit and the room change.

A phone interview on 11/14/19 at 4:17 PM with Nurse #1 who was caring for Resident #10 on 09/10/19 when he exited the building, was conducted. Nurse #1 stated there was an Electrician working in the facility that was not an employee and observed Resident #10 walk out the 100-hall door closest to room 111. She stated the Electrician notified she and the Maintenance Director the resident had exited the door out of the facility. Nurse #1 stated she and the Maintenance Director found Resident #10 walking back towards the facility from the Smoking Shed and stated the resident told her he had gotten turned around coming out of the dining room following lunch. She stated the resident was dressed in a shirt, pants, socks and shoes appropriate for the warm weather that day. Nurse #1 stated she remembered notifying the resident's Family Member but did not recall notifying the Physician of the resident getting out of the facility. She stated if she did not document she probably did not notify the Physician but stated she should have notified the Physician or Nurse Practitioner (NP).

("MAR's") Monday through Friday; ensuring physician notification of elopements as well as fingerstick glucose level outliers (per order) occurred in a timely fashion. These reviews are reflected in a weekly audit (see bullet 4 for details). Findings will be promptly addressed with the physician as well as the nurses through re-education. Additionally, the facility has revamped its Resident at Risk Meeting which has been augmented to include physician notification of events (e.g. elopements, physician order variances, etc.) RAR meetings have been re-scheduled to occur weekly with meeting minutes maintained. The facility has also reviewed its general orientation process for newly hired licensed nurses ensuring the policy Physician Notification is reviewed with the new orientees during orientation by the DON in a concise and comprehensive manner. All licensed nurses, which includes full time (FT), part time (PT), and per diem (PD) nurses will be re in serviced by the DON, UMs or Regional Clinical Nurse on the above policy by 12-13-19.

4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The Quality Assessment and Assurance (QAA) Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process through 1) An ongoing monitoring audit will be performed weekly x 4 then bi weekly x 2 then monthly x 2 as

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F 580	Continued From page 4 A review of Resident #10's chart revealed on 11/04/19 at approximately 4:00 PM, he was observed by a staff member walking down a gravel road beside the building that is utilized by Maintenance and the Fire Department for their connections in case of a fire. The resident stated he "just went outside." He was brought back into the facility by the Human Resources Coordinator, Business Office Manager and Activities Assistant. According to the note, he was brought to his room and was then brought out to the 300-hall nurse's station where staff could keep an eye on him. Resident #10 was educated about staying inside the facility and not going out by himself but did not understand due to his dementia. He was alert and oriented to person only and required continuous reminding about wandering into other resident rooms and staying near the nurse's station. The note went on to say the resident did not understand the instructions due to his vascular dementia and attempts made to redirect him were not always successful. An interview on 11/14/19 with Nurse #2 on 11/14/19 at 12:20 PM revealed she was the nurse caring for Resident #10 on 11/04/19. She stated she was not aware he had exited the building until several staff members brought him back into the building around 4:30 PM. According to Nurse #2, the resident was looking for his car. She stated they had not determined which door he got out of because no one had seen him exit the building. Nurse #2 stated some days he tried to sneak away from staff, and it was like it was a game to him and she stated other days he would sit for hours at the nurse's station in the recliner and read the newspaper. On days he was confused, Nurse #2 stated he would go to the 100-hall and 200-hall looking for the bathroom because he	F 580	determined by the QAA committee, Monday through Friday by Nursing Administration the DON, UMs, Shift Supervisors and the Minimum Data Set (MDS) nurse which will reflects a review of the 24 hour report, incident reports, and blood glucose values warranting physician notification; ensuring timely physician notification.. The Director of Nursing is responsible for this audit and the forwarding of it to the QAA team. Findings will be immediately addressed with the physician as well as the nurses through re-education; 2) A weekly Resident at Risk review (complete with minutes) of all residents identified as having an incident and/or accident, change of condition and abnormal clinical parameters will be reviewed to ensure timely physician and responsible party notification has occurred. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance: 12-13-2019	

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thought that's where he had to go to use the bathroom. She stated she notified his Family Member of his exit but stated she did not recall that she notified the physician.

An interview was conducted on 11/15/19 at 1:12 PM with the Medical Director (MD). The MD stated Resident #10 had improved since coming to the facility. She stated she was not aware that he had exited the building but was aware of his exit seeking behaviors. She stated she would have expected the nurses to have notified her of his actual exits, so she could have assessed him and his medication for any adjustments. The MD stated Resident #10 was probably able to exit due to lack of staff to monitor him.

An interview was conducted on 11/15/19 at 5:11 PM with the Director of Nursing (DON) and the Corporate Nurse Consultant. The DON stated she was aware the resident had gotten out of the building and stated everyone was watching Resident #10 now and if he went near the exit doors he was being redirected away from the doors. She stated she was not aware the Medical Director had not been informed of the elopement incidents. According to the DON, their procedure was to assess the resident after an elopement, document the elopement in the chart, complete an incident report with all the details and notify the Family Member and Physician. The DON stated it was possible the nurses had notified the Physician on call but stated they should have also notified the Medical Director or Nurse Practitioner, so they too could have evaluated Resident #10.

An interview was conducted on 11/15/19 at 6:47 PM with the Administrator. He stated he was

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aware of the two occasions the resident exited the building but was not aware the Physician had not been notified. He stated his expectation was the Physician be notified and the resident's elopement risk be updated after each occurrence. According to the Administrator, staff education needed to be done and would be completed with all staff.

2. Resident #11 was admitted to the facility on 08/01/15 with diagnoses which included diabetes mellitus, congestive heart failure and dementia without behavioral disturbance.

A review of Resident #11's most recent comprehensive annual Minimum Data Set (MDS) dated 06/11/19 revealed she was cognitively impaired for daily decision making. The MDS also indicated she was on a therapeutic diet for diabetes and received insulin injections. Resident #11 has had no refusals of medications.

A review of Resident #11's physician orders revealed the following:
1. Humalog U-100 Insulin (Insulin lispro) solution; 100 units/milliliter (ml)
Amount to administer: per sliding scale:
If blood sugar is less than 60, call Medical Doctor (MD)
If blood sugar is 151-200, give 6 units
If blood sugar is 201-250, give 8 units
If blood sugar is 251-300, give 10 units
If blood sugar is 301-350, give 12 units
If blood sugar is 351-400, give 14 units
If blood sugar is greater than 400, call MD
2. Lantus U-100 Insulin (insulin glargine) solution; 100 units/ml;
Amount to administer: 10 units subcutaneously (SQ) twice daily (bid);

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subcutaneous (SQ) -
Scheduled at 9:00 AM and 9:00 PM.

A review of Resident #11's blood sugar readings for the month of November 2019 revealed two readings over 400 as follows:

1. On 11/01/19 at 10:47 PM Resident #11 had a blood sugar reading of 429 and at 10:47 PM 16
Units of Humalog U-100 insulin was administered in her abdomen by Nurse #4. There was no
Indication in the chart the MD had been notified of the elevated blood sugar as per the orders.

2. On 11/13/19 at approximately 9:40 PM, Resident #11 had a blood sugar reading of 462
recorded on a piece of paper and left on the cart by Medication Aide #1. Nurse #4 who was
responsible for the insulin administration on half of the 100 hall had not been advised of the
elevated blood sugar reading for Resident #11 and stated she had not noticed the elevated
blood sugar until it was pointed out to her by the surveyor.

An interview with on 11/13/19 at 11:39 PM with Nurse #4 revealed she had worked by herself on the 300 and 400 halls and had half of 100 hall. She stated there were just too many residents and too many medications to give and it was impossible to give all medications on time. According to Nurse #4, they seldom had a nurse on each hall and usually worked with a Medication Aide (MA) on one of the halls and made it difficult because MAs could not give injections. Nurse #4 stated MA #1 had not communicated Resident #11's elevated blood

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F 580	Continued From page 8 sugar before she had left at 10:00 PM and stated she had not recorded the time she had taken the blood sugar and since it was now at least 3 ½ hours later she would re-check the blood sugars and give the insulin. According to Nurse #4, MA #1 should have notified her of the elevated blood sugar and the Physician should have been notified for any additional orders. An interview on 11/14/19 at 12:44 AM with the Director of Nursing (DON) revealed she was not aware the Physician had not been notified of the elevated blood sugars for Resident #11 on 11/01/19 and 11/13/19. The DON stated it was the standard of care to follow the doctor's orders and was not sure why the Nurse had not notified the Physician of the resident's elevated blood sugars. According to the DON, there were several residents on sliding scale insulin with instructions to call the Physician with elevated levels and stated she would be following up with the staff and providing in-service education to the Nurses and Medication Aides on following orders. An interview on 11/15/19 at 6:47 PM with the Administrator revealed he was not aware that resident's insulin was being given late and the Physician was not being notified of elevated blood sugars as ordered. He stated his expectation was medications be given on time and the Physician notified as ordered. According to the Administrator he thought the facility was adequately staffed but stated they have to reevaluate their staffing and provide additional education based on these concerns.	F 580		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		12/13/19

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F 689	Continued From page 9 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility failed to supervise a cognitively impaired resident who wandered from exiting the facility unsupervised on two separate occasions for 1 of 3 sampled residents (Resident #10). The findings included: Resident #10 was admitted to the facility on 09/06/19 with diagnoses which included vascular dementia with behavioral disturbance, generalized muscle weakness and cognitive communication deficit. A review of Resident #10's chart revealed on 09/10/19 at approximately 1:00 PM, he was observed by an Electrician (doing contract work for the facility), exiting the facility through the exit door closest to room 111. The Electrician immediately notified Nurse #1 that he had seen Resident #10 exit the facility door and stated to Nurse #1 that he was not sure if the resident was supposed to go out the exit door. Nurse #1 and the Maintenance Director found the resident on the sidewalk walking back towards the facility from the Smoking Shed. Resident #10 was assisted back inside the facility and stated to Nurse #1 that he "got turned around" when he left	F 689	1. Secured units at neighboring facilities have accepted Resident #10 for admission. Resident #10 has an estimated discharge date of 1-9-2020 from the facility. Resident #10 remains at his baseline. The attending physician has been notified of the events 9-10-19 and 11 -4-19. The facility has implemented measures to ensure Resident #10's safety and security through: a) a thorough review of Resident #10's medical records to evaluate his medication therapy and documented behaviors; b) hourly observations for the Resident until his discharge; c) the assignment of facility staff as one-on one six (6) to eight (8) hours daily until his discharge ; d) a further enhanced independent activities program specific to resident #10's preferences daily for one (1) hour; e) the installation of (5) new door alarms to the exit doors on all hallways ensuring immediate emergency response when the doors are opened without a code. Nurses #1 is an agency nurse and no longer works with the facility. Nurse #2 will be educated to both the "Elopement" and "Physician Notification" policies by the Director of Nursing ("DON") by 12-13-19.	

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F 689	Continued From page 10 the dining room. An incident report completed on 09/10/19 by Nurse #1 was reviewed and stated the resident was moved away from the exit door on the 100 hall and closer to the nurse's station on the 300 hall. The Responsible Party was notified of the exit and the room change. A phone interview on 11/14/19 at 4:17 PM with Nurse #1 who was caring for Resident #10 on 09/10/19 when he exited the building, was conducted. Nurse #1 stated there was an Electrician working in the facility that was not an employee of the facility and observed Resident #10 walk out the 100-hall door closest to room 111. She stated the Electrician notified she and the Maintenance Director the resident had exited the door out of the facility. Nurse #1 stated she and the Maintenance Director found Resident #10 walking back towards the facility from the Smoking Shed and stated the resident told her he had gotten turned around coming out of the dining room following lunch. The resident was approximately 80 feet from the door he exited when they found him. She stated the resident was dressed in a shirt, pants, socks and shoes appropriate for the warm weather that day. According to Nurse #1, there was not enough staff at the facility to "watch the resident closely" and stated they did the best they could with the staff they had at the facility. A review of Resident #10's care plan dated 09/10/19 revealed he had a care plan for being at risk for elopement, injury as evidenced by: wandering, confusion, asks location of his room frequently. Wanders into other's rooms. Family states he will throw things in the trash. Pushes on exit doors. The goal was for the resident to wander safely within specified boundaries and will	F 689	2. All residents identified to be at risk for elopement have the potential to be impacted. A facility wide audit of all current residents identified to be at risk for elopement will be conducted by12-6-2019; confirming a) elopement risk interventions are implemented and confirmed to be in place; b) resident specific elopement risk care plans reflect the elopement risk interventions; and c) Physician notification has occurred should the resident(s). Findings will be addressed promptly by the Director of Nursing (“DON”) and/or Unit Manager (“UM”) and forwarded to QAA for processing. 3. The facility has reviewed its’ policies on “Elopements”, and “Physician Notification” ensuring clarity. No revisions are needed. The facility has reviewed its’ general orientation process for newly hired licensed nurses ensuring the policies on “Elopements” and “Physician Notification” are presented during orientation in a concise and comprehensive manner. All licensed nurses, which includes full time (“FT”), part time (“PT’), and per diem (“PD”) nurses will be re in serviced by the DON, UM’s or Regional Clinical Nurse on the above policies before 12-13-2019. 4. The Licensed Nursing Home Administrator (“LNHA”) is responsible for the Plan of Correction (“POC”) implementation. The Quality Assessment and Assurance (“QAA”) Coordinator and its members as noted below will be	

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F 689	Continued From page 11 not have any successful elopements. The interventions included: may use stop signs with alarms, may apply stop signs to doors Resident #10 frequents, observe resident near exit doors and redirect away from exits, observe trash cans for items Resident #10 may throw away (clothes, wallet, shoes, toiletries), assure resident has proper fitting and appropriate foot attire, elopement assessments to be completed quarterly and as needed, label resident's belongings and environment to promote recognition, maintain a calm environment and approach to Resident #10, picture in elopement books, remove resident from other resident's rooms and unsafe situations and when resident begins to wander, provide comfort measures for basic needs (e.g., pain, hunger, toileting, too hot/cold, etc.). A review of Resident #10's most recent admission Minimum Data Set (MDS) dated 09/13/19 revealed he was severely cognitively impaired for daily decision making and required supervision with set up for walking with his rollator walker. A review of Resident #10's chart revealed on 11/04/19 at approximately 4:00 PM, he was observed by a staff member walking down a gravel road beside the building that is utilized by Maintenance and the Fire Department for their connections in case of a fire. The resident stated he "just went outside." He was brought back into the facility by the Human Resources Coordinator, Business Office Manager and Activities Assistant. According to the note, he was brought to his room and was then brought out to the 300-hall nurse's station where staff could keep an eye on him. Resident #10 was educated about staying inside the facility and not going out by himself but did	F 689	responsible for the ongoing monitoring of this process through 1) Monday through Friday resident care unit rounds by the Director of Nursing and/or Unit Managers confirming elopement interventions for identified “at risk”. 2) A “Resident at Risk” review of all residents at risk for elopement will be conducted weekly for four (4) weeks by the Director of Nursing and/or Unit Managers; ensuring elopement interventions for all residents at risk for elopement have been implemented (inclusive of physician notification with elopement type behaviors);. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance is 12-13-2019	

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not understand due to his dementia. He was alert and oriented to person only and required continuous reminding about wandering into other resident rooms and staying near the nurse's station. The note went on to say the resident did not understand the instructions due to his vascular dementia and attempts made to redirect him were not always successful.

There was no incident report completed for Resident #10's exit of the building on 11/04/19.

An interview was conducted on 11/14/19 at 10:32 AM with the Human Resources Coordinator (HRC). The HRC stated on 11/04/19 at approximately 4:00 PM she was sitting out in the parking lot on the left side of the building smoking when she saw a gentleman walking down the gravel road to the left of the building. She stated she was not sure if he was a resident or visitor, so she went to the side door of the building and yelled for administrative staff to come outside. The Business Office Manager (BOM) and Activities Assistant (AA) came out and the AA recognized the gentleman as Resident #10. The HRC stated the three of them escorted the resident back up the gravel road to the Activities Room where a staff member let them back into the facility. According to the HRC, she and the BOM and AA escorted him back to his room and informed Nurse #2 that he had left the building but had been returned to his room. She stated the AA had seen him on the 200 hall around 2:00 PM prior to him getting out of the building.

An interview was conducted on 11/14/19 at 11:00 AM with the Activities Assistant. She stated she had seen Resident #10 on the 200 hall around 2:00 PM prior to him getting out of the building on

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11/04/19. She stated it was not uncommon to see him on the 100 and 200 halls. According to the AA, Resident #10 could read the directions on how to open the doors and knew if he held the door for 15 seconds he could get out the door. She said he had told her after the first incident on 09/10/19 that he "could read and knew how to open the doors." She stated she did not recall hearing the alarms that day but stated if she was in an activity it would be hard to hear the alarm because it was faint.

An interview on 11/14/19 with Nurse #2 on 11/14/19 at 12:20 PM revealed she was the nurse caring for Resident #10 on 11/04/19. She stated she was not aware he had exited the building until several staff members brought him back into the building around 4:30 PM. According to Nurse #2, the resident was looking for his car. She stated they had not determined which door he got out of because no one had seen him exit the building. Nurse #2 stated some days he tried to sneak away from staff, and it was like it was a game to him and she stated other days he would sit for hours at the nurse's station in the recliner and read the newspaper. On days he was confused, Nurse #2 stated he would go to the 100-hall and 200-hall looking for the bathroom because he thought that's where he had to go to use the bathroom. She stated she could not recall when she had last seen him on 11/04/19 prior to him exiting the facility. According to Nurse #2, staffing was minimal at the facility and stated most of the time there was only one Nurse on the 300 and 400 halls and it was impossible to monitor the resident and know where he was at all times.

An interview on 11/14/19 at 1:30 PM with the

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Maintenance Director revealed he was aware Resident #10 had exited the building on two occasions. He stated the Administrator had purchased new alarms that had been placed on the exit doors on the 100 hall and the 200 hall exit doors on 11/12/19. According to the Maintenance Director the alarms are much louder now and everyone in the building can hear them alarm now. He stated the alarms had been tested and he provided testing of the alarms on 12/14/19 and several staff from several halls responded.

An interview was conducted on 11/15/19 at 9:57 AM with Nurse Aide (NA) #1 who was caring for Resident #10 on 09/10/19 and 11/04/19. She stated she remembered he was all over the place both days and stated he wandered to the 100 hall, 200 hall, 400 hall and the dining room frequently. On 09/10/19 and 11/04/19, NA #1 stated she could not recall what the resident was doing prior to him getting out either of those days, but stated he frequently tried getting out the exit doors on the 100 and 200 halls. She stated he could read the instructions over the door that stated to hold the door handle for 15 seconds and the door would open. NA #1 said the door did alarm but the alarm was faint and if you were in the dining room or in a resident room providing care you would not be able to hear the alarm. She stated he had told staff that he could read and knew how to get the doors to open but could not recall him setting off the alarm but one other time on 09/10/19. NA #1 stated even though they knew he could get out there was not enough staff at the facility to monitor him and his whereabouts at all times. She stated they were often short staffed and if they were tied up in rooms providing care they would not know where every resident was at any given time. She went on to say, they

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were so busy trying to get care done they could not monitor Resident #10.

An interview was conducted on 11/15/19 at 10:23 AM with NA #2 who was on the unit when Resident #10 got out of the facility on 09/10/19. NA #2 stated she did not recall the alarm sounding that day but stated if she was in the dining room assisting with lunch or in a resident room with the door closed she would not have heard the alarm. She stated she recalled Resident #10 telling her one day that he could read the instructions over the door and get out. According to NA #2, Resident #10 thought he was in a hotel and told her he had never been in a hotel that told him when to take a shower, eat and go to bed. She stated they would have done rounds that day around 11:15 AM to 12:15 PM but stated if he were in the dining room they would not have seen him. NA #2 stated she just could not remember the last time she saw him or what he was doing that day prior to him getting out of the facility. She went on to say due to short staffing at the facility they were not able to monitor his whereabouts at all times since he was mobile. NA #2 went on to say they did the best they could with the staff they had at the facility.

An interview was conducted on 11/15/19 at 10:53 AM with NA #3 who was working the day Resident #10 got out of the facility on 09/10/19. He stated he usually floats to all units but predominantly works the 200 hall. NA #3 stated he assisted in the dining room most days that he works and stated he was probably in the dining room when Resident #10 got out of the facility. He stated he did not recall hearing the alarm sound that day but stated if he was in the dining room he would not have heard the alarm.

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According to NA #3, Resident #10 stated every day that he was "trying to find the exit" and he was "going to get out." NA #3 stated he was not aware that Resident #10 had gotten out on 09/10/19 until after the fact he heard some of the staff talking about him getting out. He went on to explain that staffing at the facility did not allow them to monitor any of the residents closely to prevent them from exiting the building.

An interview was conducted on 11/15/19 at 1:12 PM with the Medical Director (MD). The MD stated Resident #10 had improved since coming to the facility. She stated she was not aware that he had exited the building but was aware of his exit seeking behaviors. She stated she would have expected the nurses to have notified her of his actual exits, so she could have assessed him and his medication for any adjustments. According to the MD, staffing had been an issue at the facility for some time and she stated she had discussed talking with corporate about staffing with the Administrator. She stated he had told her the facility had a "robust staffing budget" and assured her she did not need to talk with corporate, but she stated things had not changed. The MD stated based on her knowledge of the staffing issues, it was not possible for Resident #10 to be monitored closely to prevent his exiting the facility and especially since he now knew how to get out the exit doors.

An interview was conducted on 11/15/19 at 5:11 PM with the Director of Nursing (DON) and the Corporate Nurse Consultant. The DON stated she was aware the resident had gotten out of the building on 09/10/19 and 11/04/19 and stated everyone was watching Resident #10 now and if he went near the exit doors he was being

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redirected away from the doors. Upon redirecting him, the DON stated they brought him to the 300 hall nurse's station and offered him a snack, the newspaper or offered him activities. According to the DON, new alarms had been placed on the 100 and 200 hall exit doors and these alarms were much louder and alerted all the staff now if someone went out the exit doors. The DON also stated Resident #10's picture was in the elopement books at each of the nursing stations and the front desk and stated they had started closing the doors at night between the 300 hall and the 100 and 200 halls so the resident was confined to the 300 and 400 hallways at night. She went on to say, the facility was in such a staffing crisis, it was impossible to monitor Resident #10 as closely as needed.

An interview was conducted on 11/15/19 at 6:47 PM with the Administrator. The Administrator stated he was aware of Resident #10 exiting the building on 09/10/19 and 11/04/19. He stated they had put measures of increased observations in place and had started closing the double doors between 300 hall and the 100 and 200 halls at night, placed Resident #10's picture in the elopement books at the nurses' stations and front desk and ensured his room location was close to the nurse's desk. According to the Administrator, they had also added new alarms to the 100 hall and 200 hall exit doors on 11/12/19 that were exponentially louder than the old alarms. The Administrator also stated they were doing audits of the alarms and staff response to the alarms but stated they had not been documented; however, he had one in his office he was working on that would be documented. The Administrator stated it was his expectation that Resident #10's elopement risk assessment be updated after

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F 689	Continued From page 18 each attempt and as needed as well as his care plan with new interventions. He stated the resident had been moved to the 400 hall on 11/15/19 with permission of the Family Member as this was the most secure hall in the facility. According to the Administrator, they had also started education about elopement with all the staff and the need to notify the physician any time a resident leaves the building unattended.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge	F 725		12/13/19

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F 725	Continued From page 19 nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident, staff and Physician interviews, the facility failed to provide sufficient nursing staff to provide care and services for 6 of 14 sampled residents. The facility failed to have sufficient nursing staff to prevent a cognitively impaired resident with wandering behaviors from exiting the facility on two occasions (Resident #10), failed to have sufficient nursing staff to administer oral medications as ordered by the Physician for four residents (Resident #1, Resident #2, Resident #3 and Resident #4) and failed to provide sufficient nursing staff to administer insulin injections to a resident (Resident #5) as ordered by the Physician. The findings included: 1. This tag is cross referred to F 689: Based on observation, record review, resident, staff and physician interviews, the facility failed to supervise a cognitively impaired resident who wandered from exiting the facility unsupervised on two separate occasions for 1 of 3 sampled residents (Resident #10). A phone interview on 11/14/19 at 4:17 PM with Nurse #1 who was caring for Resident #10 on 09/10/19 when he exited the building was conducted. She stated she and the Nurse Aide were in rooms assisting other residents and would not have known the resident had exited the building if the Electrician had not seen him. According to Nurse #1 they were not able to keep a close watch of the resident because there was not enough staff working to watch him closely and	F 725	1. Resident #1 was discharged from the facility on 10-13-2019. Secured units at neighboring facilities have accepted Resident #10 for admission. Resident #10 has an estimated discharge date of 1-9-2020 from the facility and at his baseline. The attending physician has been notified of the events 9-10-19 and 11-4-19. The facility has implemented extensive measures to ensure Resident #10's safety and security to include: a) increased observations and monitoring; and b) the installation of five (5) new door alarms to the exit doors on all hallways ensuring immediate emergency response when the doors are opened without a code. Residents #2, #3, #4 and #5 remain at baseline. The resident's attending physician was notified of the medication administration variances. A fourteen (14) day review of the Medication Administration Records (MAR) for Residents #2, #3 and #4 was conducted on 12-6-2019 confirming timely medication administration. Blood glucose level checks and responsive insulin coverage (and physician notification per established parameters) continue as ordered for Resident #5. All licensed nurses will be reeducated to the expectations of physician notification, following physician's orders as well as how to immediately access the DON or UM with concerns regarding staffing. The facility continues its' recruiting efforts with	

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F 725	Continued From page 20 keep him from exiting the building. An interview was conducted on 11/14/19 at 12:20 PM with Nurse #2 who was caring for Resident #10 on 11/04/19. According to Nurse #2, she was the only nurse on the 300 and 400 hall that day and it was impossible to watch Resident #10 closely. She stated most of the day she was busy with medication pass (which she could not get done on time) and she and the NAs stayed so busy they could not watch for the resident and make sure he was on the hall at all times. Nurse #2 stated they needed at least 2 Nurses for the 300 and 400 hall due to medications and treatments and the demands of the rehab residents but stated it was usually just one nurse on the halls and it was difficult to even get medications passed on time and stated they were often late. She went on to say that residents had to wait for pain medication if she was tied up in a room and stated they were often upset about having to wait for their medication. Nurse #2 stated it would be helpful if they could have Agency staff again but had been told that was not a possibility. An interview was conducted on 11/15/19 at 9:57 AM with Nurse Aide (NA) #1 who was caring for Resident #10 on 09/10/19 and 11/04/19 when he exited the facility. According to NA #1 they are frequently working short staffed and stated sometimes she had worked both the 100 hall and the 300 and 400 halls by herself. She stated on those days it was impossible to keep a close eye on residents and know where they are at all times and especially Resident #10 since he was so mobile. An interview was conducted on 11/15/19 at 5:11	F 725	success. The facility has temporarily augmented its' licensed nurse needs with the implementation of shift bonuses while they continue their recruitment efforts. 2. All residents have the potential to be impacted. The DON has reviewed the nursing staffing from the past two (2) weeks ensuring the presence of licensed staff to meet the needs of the residents. The facility confirms ongoing, active recruitment efforts for open facility positions including in the nursing department; netting positive results. Nursing management "on call" system remains in effect to support and augment staffing as needed. 3. The facility has reviewed its policies on Staffing, Medication Administration, Elopement, Physician Notification and the Vero NC Employee Handbook to address attendance for scheduled employees. No revisions are needed. The facility has reviewed its general orientation process for newly hired licensed nurses ensuring the policies on Staffing, Medication Administration, Elopement, Physician Notification and the Vero NC Employee Handbook are presented during orientation in a comprehensive and clear manner. All current licensed nurses, medications aide and CNAs which includes full time (FT), part time (PT), and per diem (PD) will be re-educated by the DON, UMs or Regional Clinical Nurse to the policy and handbook by 12-13-19. In addition, the licensed nurses and CNA's will be reminded to reach out to the "on	

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F 725	Continued From page 21 PM with the Director of Nursing (DON) and the Corporate Nurse Consultant. According to the DON, the resident probably needed to be in a locked unit for his safety and protection because of their lack of staffing. She stated she had asked numerous times about getting agency staff into the building and had been told by the Administrator he would have to talk with corporate about getting agency staff. The DON went on to say she had not heard back from the Administrator. An interview was conducted on 11/15/19 at 6:47 PM with the Administrator. He stated he felt like there was adequate staff in the facility to care for the residents. When asked why a resident was able to exit the building on two occasions, why medications were being given late or not at all, he responded that he was not aware of these issues. The Administrator went on to say they may have to look at finding an acceptable setting for Resident #10 and look at staffing to alleviate some of the other issues. 2. This tag is cross referred to F 760: Based on observations, resident, staff and the Medical Director interviews, and record review, the facility failed to administer oral medications as ordered by the physician for 4 of 4 residents observed for medication administration (Resident #5, Resident #12, Resident #13 and Resident #14). The facility also failed to administer insulin (hormone used to treat diabetes) injections as ordered by the physician for 1 of 1 resident (Resident #3) reviewed for diabetes management.	F 725	call" nursing management staff should they need assistance or staffing support. The DON, Scheduler and LNHA will review the nursing master schedule daily; ensuring the presence of licensed staff to meet the needs of the residents. Nursing management (DON, Unit Managers and shift supervisors) rotate on call to ensure sufficient licensed nurse availability to meet the needs of the residents including nurse call outs and/or emergencies. Aggressive recruitment efforts for nursing personnel remains ongoing with success. Medicine aides will be scheduled to assist in timely medication administration and support; as needed. Daily assignment sheets are reviewed by Administration; ensuring sufficient staffing. Supplemental (Agency) staff will be scheduled as needed. The DON and NHA will submit a report monthly to the QAA team reflective of the following: a) review of daily nursing schedule and assignment sheet-confirming adequate licensed nurse coverage, b) utilization of "on call" or supplemental staff to augment call outs or emergencies, c) ongoing licensed nurse recruitment efforts and d) new licensed nurse hires. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1) Daily reviews of the staffing schedule by the Licensed Nursing Home Administrator (LNHA),	

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F 725	Continued From page 22	F 725	Director of Nursing (DON) and the Staffing Coordinator; ensuring the presence of licensed staff to meet the needs of the residents. 2) Monday through Friday resident care unit rounds by the DON or Unit Managers ensuring the presence of licensed staff as scheduled. The DON and NHA will submit a report monthly to the QAA team reflective of the following: a) review of daily nursing schedule and assignment sheet-confirming adequate licensed nurse coverage, b) utilization of “on call” or supplemental staff to augment call outs or emergencies, c) ongoing licensed nurse recruitment efforts and d) new licensed nurse hires. The DON will be responsible for all of the documentation of the monitoring listed above as well as presenting all findings to the QAA committee. Findings will be addressed promptly. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance is 12-13-2019.	
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 755		12/13/19

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F 755	Continued From page 23 §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and Pharmacist interviews the facility failed to reorder an as needed pain medication from the pharmacy for 1 of 3 residents reviewed for pharmacy services (Resident #5). The findings included: Resident #5 was admitted to the facility on 05/22/19 with diagnoses which included acute deep vein thrombosis (blood clot) in right leg, polyneuropathy (nerve damage on both sides of the body) and chronic pain.	F 755	1. Resident #5 remains at baseline. Resident #5's attending physician was notified of the medication variance. A review of Resident #5's Medication Administration Record (MAR) confirms the administration of PRN Tramadol for moderate pain is occurring in accordance with the physician's order. Nurses #2 and #4, and MA#3 will be re-educated to the facility's policies and expectations of re ordering medications in a timely fashion, administering pain medications in accordance with physician's orders as well as notifying the physician should a	

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F 755	Continued From page 24 The most recent quarterly Minimum Data Set (MDS) assessment dated 08/21/19 indicated, Resident #5 was cognitively intact and received pain medication as need for frequently experienced pain. The MDS also indicated, Resident #5 had received opioids (a narcotic pain medication) 7 days in the 7 day look back period. Resident #5's care plan (CP) for pain dated 09/26/19 revealed, a goal that Resident #5 would achieve an acceptable level of comfort and/or not exhibit non verbal signs of pain. The interventions included, to administer pain medications as ordered and record the effectiveness, to allow resident to discuss feelings about pain, and to encourage resident to request pain medication before the pain becomes unbearable. Review of Resident #5's Physician Orders indicated, effective 11/08/19 Tramadol (an opioid) 50 mg (milligrams) tablets give 2 tablets by mouth three times a day as needed for moderate pain. Resident #5's Medication Administration Record (MAR) for 11/08/19 indicated, Resident #5 received Tramadol 50 mg 2 tablets by mouth at: 11/13/19 at 11:22 AM administered by Medication Aide (MA) #3. An interview was conducted with Resident #5 on 11/13/19 at 2:30 PM. During the interview Resident #5 explained, when MA #3 took her afternoon medication to her, she requested her Tramadol for pain in her legs and back. Resident #5 stated, the MA told Resident #5 she was out of her Tramadol and offered her some Tylenol instead, but Resident #5 explained the Tylenol was not strong enough to relieve her pain. The Resident stated, MA #3 told her the Tramadol	F 755	prescribed medication not be available requesting a one time order of a medication available through the emergency/interim box by the DON and UM by 12-13-19. 2. All residents with medication orders for pain management have the potential to be impacted. On 12-5-19 the facility identified all residents with medication orders for pain management. The facility is currently conducting a review of the December 2019 Medication Administration Records (MARs); ensuring compliance with physician orders as evidenced by a nurse's initials signaling administration. Findings will be addressed promptly and forwarded to QAA for processing. 3. The facility has reviewed its' policies on "Reordering Medications" "Medication and Treatment Orders" and "Physician Notification", ensuring clarity. No revisions are needed. The facility has reviewed its' general orientation process for newly hired licensed nurses ensuring the policies on" Re ordering Medications", "Medication and Treatment Orders" and "Physician Notification" are presented during orientation in a comprehensive and clear manner. All licensed nurses and medication aides, which includes full time ("FT"), part time ("PT'), and per diem ("PD") nurses will be re in-serviced by the DON, UM's or Regional Clinical Nurse on the above policies before 12-13-19. 4. The Licensed Nursing Home	

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F 755	Continued From page 25 would be delivered from the Pharmacy later that night. On 11/13/19 at 11:10 PM during an interview with Resident #5 she reported, she had not received her Tramadol for her pain since she had it earlier that morning when MA #3 gave her the morning medications. Resident #5 stated, her Tramadol would not be delivered from the Pharmacy until late that night. An interview was conducted with Nurse #4 on 11/13/19 at 11:34 PM. Nurse #4 acknowledged, she was responsible for Resident #5 and stated she was aware Resident #5 was out of her pain medication, Tramadol. The Nurse explained, Resident #5 requested her Tramadol for pain during the medication pass this evening, but Nurse #4 had to report to Resident #5 that her Tramadol had not been delivered from the Pharmacy yet that night. Nurse #4 explained, the facility's system to reorder medications was 1) to directly request a refill on line electronically to the Pharmacy 2) pull the bar code sticker from the medication card and fax it to the pharmacy or 3) to obtain a prescription from the Provider. Nurse #4 stated, she thought the reason Resident #5 was out of Tramadol was because there needed to be a new prescription obtained from the Provider. The Nurse also explained, the facility kept a reserve of medications in the Omni Cell which was a "back-up" supply of medications supplied by the Pharmacy. Nurse #4 stated the Tramadol could be pulled from the Omni Cell, but she knew there was no Tramadol currently in the Omni Cell. An interview was conducted with the Director of Nursing (DON) at 12:44 AM on 11/14/19. The	F 755	Administrator (“LNHA”) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: a)The DON and UM will conduct a review of all pain medication orders weekly x 4 then monthly x 3 as well as a “cart” check; confirming the presence of pain medications as ordered. b) The DON or UM will randomly check pain medication availability monthly x 3 then quarterly x 2; confirming prescribed pain medications are present. Findings will be addressed promptly and forwarded to the QAA team for processing. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance is 12-13-2019.	

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DON explained, the Nurse on the hall was responsible for reordering the medications from the Pharmacy and if the medications were reordered by 3:00 PM, they would be delivered that same night. The DON continued to explain, if a new prescription needed to be obtained from the Providers, they were in the facility several times a week and it was the Nurses responsibility to obtain a new prescription for that medication before the Resident was completely out of the medication. The DON added, the facility kept a "back-up" supply of medications in the Omni Cell, but the Omni Cell was currently out of narcotics because she could not reorder narcotics until the Drug Enforcement Agency (DEA) issued her an identification number which allowed her to order narcotic medications to refill the Omni Cell. The DON stated, she was not aware that Resident #5 was out of Tramadol but regardless, the nurses' should have followed through with obtaining the Tramadol for Resident #5 and she should not have run out of her pain medication.

An interview was conducted with MA #3 on 11/14/19 at 11:51 AM who confirmed, he was responsible for medicating Resident #5. The MA explained, Resident #5 was alert and oriented and voiced her needs. MA #3 continued to explain, when Resident #5 complained of pain she would specifically request the Tramadol and added, she could receive the Tramadol up to three times a day. The MA stated, Resident #5 asked for the Tramadol yesterday (11/13/19) but he had to tell her she was out of the Tramadol and offered her some Tylenol instead. The MA stated, Resident #5 refused the Tylenol and added, the Tylenol would not relieve her pain. The MA explained, he reported to Nurse #2 that Resident #5 had run out of Tramadol but could

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not remember what Nurse #2 said about it. MA #3 reported, when he saw that Resident #5 was running low on her Tramadol, he noticed the barcode reorder sticker had been pulled from the card and thought that someone had already ordered the Tramadol from the Pharmacy. The MA added, he did not believe the reason the Tramadol had run out was that there needed to be a new prescription because he stated, the last card of Resident #5's Tramadol that he pulled from had several refills available on it.

During an interview with Nurse #2 on 11/14/19 at 12:10 PM the Nurse explained, she was made aware that Resident #5 had run out of Tramadol yesterday (11/13/19) by MA #3 and checked the Omni Cell to find there was no Tramadol available in the "back-up" supply. Nurse #2 stated, when she spoke with Resident #5, she offered her some Tylenol until the Tramadol was delivered from the Pharmacy but Resident #5 declined the Tylenol and stated it was not effective for her pain. Nurse #2 stated, she reported Resident #5's Tramadol was out to the Unit Manager (UM) that morning and the UM was going to follow up on the Tramadol.

During an interview with Resident #5 on 11/14/19 at 12:24 PM she reported, she had just finished walking with therapy and it made her legs hurt. She stated, she had asked a female staff member (she did not know her name) to let the Nurse know she was hurting and wanted her Tramadol pain medication. Resident #5 stated, the female staff member told her that her medication had not come from the Pharmacy yet.

An interview was conducted with the UM on 11/14/19 at 2:41 PM. During the interview the UM

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explained, she had been employed by the facility for about 2 months and was still getting use to her responsibilities. The UM continued to explain, she asked the Nurses/MAs to request a refill for medications from the Pharmacy when they were about a week from being out of the medication. She stated, if the medication happened to be a narcotic then she would call the Pharmacy herself and find out if the narcotic was able to be refilled or if the Pharmacy needed a new prescription. If a new prescription was needed, she would request the prescription from the Providers. The UM explained, she was off yesterday (11/13/19) and no one followed up with the narcotics and could not be responsible for what did not get done when she was not working. The UM explained, she was made aware that the facility was out of Resident #5's Tramadol that morning by Nurse #2 and MA #3 and had already called the Pharmacy to find out what needed to be done. The UM stated, the Pharmacy informed her that there were refills available on the current prescription for Resident #5's Tramadol, and all they needed was to be notified to refill the Tramadol. The UM stated, the Pharmacy was going to make a 12:00 PM delivery to the facility and she expected the arrival time would take about 2 hours. The UM was also unable to explain why Resident #5 had to go over 24 hours without her pain medication.

On 11/14/19 at 3:49 PM the DON provided the last 2 undated medication refill sheets for 300/400 halls. There were no medication barcodes for Resident #5 on the refill sheets.

On 11/14/19 at 3:59 PM during an interview with the Pharmacist she explained, the facility has requested a refill for Resident #5's Tramadol on 10/21/19 which was too early to refill then

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F 755	Continued From page 29 requested it again that morning of 11/14/19 at 8:40 AM. The Pharmacist stated, the Tramadol was sent out on the 12:00 noon delivery and should arrive in about 2 hours. At 4:43 PM on 11/14/19 Nurse #2 reported, Resident #5's Tramadol had arrived from the Pharmacy and she had already given Resident #5 the Tramadol for pain. During an interview with the Administrator on 11/15/19 at 6:47 PM the Administrator revealed, he was not aware that the Omni Cell was out of Tramadol and indicated, the staff should not have neglected to reorder Resident #5's pain medication before she totally ran out of her pain medication.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, resident, staff and the Medical Director interviews, and record review, the facility failed to administer oral medications as ordered by the physician for 4 of 4 residents observed for medication administration (Resident #5, Resident #12, Resident #13 and Resident #14). The facility also failed to administer insulin (hormone used to treat diabetes) injections as ordered by the physician for 1 of 1 resident (Resident #3) reviewed for diabetes management. The findings included:	F 760	1. Residents #3, #5, #13 and #14 remain at baseline. The attending physician was notified of the medication administration variances. Nurse #4 and MA#2 were reeducated to the facility's policies and expectations of timely and compliant medication administration and administering insulin in accordance with physicians' orders by the DON and UM by 12-13-19 2. All residents the potential to be impacted. The facility will conduct a	12/13/19

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F 760	Continued From page 30 1.a. An observation of medication administration with Medication Aide (MA) #2 was made on 11/12/19 at 10:41 AM. MA #2 was observed giving Resident #12 her 8:00 AM scheduled medication doses for Carbamazepine (anticonvulsant), Gabapentin (nerve pain medication) and Furosemide (diuretic). b. Continuation of this medication administration observation on 11/12/19 at 10:54 AM revealed MA #2 giving Resident #13 an 8:00 AM scheduled medication dose for Buspirone (anti-anxiety). An interview with MA #2 on 11/12/19 at 10:56 AM revealed she was late giving the 8:00 AM medications this morning because one of the nurse aides was late and she had to help with patient care before she started the medication pass. MA #2 stated she did start her medication pass at 8:00 AM this morning and she wasn't always late with her medication pass. 2.a. An observation of medication administration with Nurse #4 was made on 11/13/19 at 10:41 PM. Nurse #4 was observed giving Resident #5 her 8:00 PM scheduled medication doses for Pregabalin (nerve pain medication) and Quetiapine (antipsychotic). b. Continuation of this medication administration observation on 11/13/19 at 11:04 PM revealed Nurse #4 giving Resident #14 an 8:00 PM scheduled medication dose for Hydrocodone (opioid pain medication) and Lorazepam (benzodiazepine sedative). On 11/13/19 at 11:39 PM, an interview with Nurse #4 revealed she was late giving the 8:00 PM	F 760	review of the December 2019 Medication Administration Records (MARs); ensuring compliance with medication orders as evidenced by a nurse's initials signaling administration. On 11-15-19 the facility conducted a review of all current diabetic residents who have experienced elevated blood sugar levels with responsive insulin coverage in the past thirty (30) days; confirming physician notification as ordered. Findings will be addressed promptly and forwarded to the QAA committee. 3. The facility has reviewed its policies on Medication and Treatment Orders, Physician Notification and Insulin administration; ensuring clarity. No revisions are required. The facility with the assistance of the pharmacy, has initiated staggered the medication pass times for each unit. Prescribers, nurses and medicine aides have been educated to the above modification. Nurses and Medicine aides will be reminded that should they need assistance with the completion of tasks, inclusive of timely medication administration, that they should notify their immediate supervisor who will coordinate assistance. Nursing management will monitor timely medication administration with the staggered medication pass up to three (3) times weekly; ensuring timely medication administration per physician's orders. The facility has reviewed its general orientation process for newly hired licensed nurses ensuring the policies on Medication and Treatment Orders, Physician Notification	

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F 760	Continued From page 31 medications because they did not have enough staff. Nurse #4 stated she oversaw the whole facility at night as well as being responsible for medication pass for 300, 400 and half of 100 hall. She said there were just too many residents and too many medications to give, and that it was impossible to give all medications on time. On 11/15/19 at 3:29 PM, an interview with Unit Manager revealed she was aware that medication passes have been running late especially on 100 and 200 halls which have a very heavy medication load. The Unit Manager said the facility was in the process of staggering the medication times for each section of the hall to accommodate the scheduled medication times. She further stated it was not acceptable to give medications over an hour before or after the scheduled time. She said that if there was a nurse for each hall, late medication pass would not be an issue. On 11/13/19 at 12:44 AM, an interview with the Director of Nursing (DON) revealed she was aware that the medication pass was "horrendous" especially on 100 and 200 halls. In order to improve the late medication pass situation, the facility was currently working on switching to another computer system which would lessen the documentation time during medication pass. In addition, she had asked the pharmacist to review the medications and to recommend discontinuing unnecessary medications. The facility was also in the process of staggering the medication times for each end of the halls. Despite all the above interventions, the DON stated she realized she needed at least one nurse for each hall in order to get all the medications administered within the scheduled time range of an hour before or after.	F 760	and Insulin Administration are presented during orientation in a comprehensive and clear manner. All licensed nurses and medication aides, which includes full time (FT), part time (PT), and per diem (PD) nurses will be re in serviced by the DON, UMs or Regional Clinical Nurse on the above policies before 12-13-19. 4. The Licensed Nursing Home Administrator (LNHA) is responsible for the Plan of Correction (POC) implementation. The QAA Coordinator and its members as noted below will be responsible for the ongoing monitoring of this process as follows: 1)The DON and UM will conduct random reviews of-medication orders and corresponding MARs weekly x 4 then monthly x 3 confirming medication administration is occurring in a timely fashion as ordered as evidenced by a nurses initials signaling administration. 2) The DON or UM will randomly check medication availability monthly x 3 then quarterly x 2; confirming prescribed medications are present. 3) A Resident at Risk review all diabetic residents will be conducted weekly for four (4) weeks by the Director of Nursing and/or Unit Manager; ensuring physician orders were followed in response to blood glucose levels, responsive insulin administration and physician notification. Findings will be promptly addressed. 4) Random Chart Audits will be conducted for up to 20% of insulin dependent residents with a focus on compliance with physician's orders for blood glucose levels, insulin administration, and	

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	345302	A. BUILDING _____ B. WING _____	C 11/15/2019

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F 760	Continued From page 32 On 11/15/19 at 1:11 PM, an interview with the Medical Director revealed she has been aware of an ongoing problem with late medication passes at the facility. The Medical Director stated this was due to the facility not having enough nurses to pass the medications. She further stated she wasn't as concerned about some of the medications being given over 2 hours late, but she expected insulins, benzodiazepines and opioids to be given on the times she had ordered them to be given. On 11/15/19 at 6:47 PM, an interview with the Administrator revealed it was not acceptable for medications to be given over 2 hours late. He stated the facility was actively making some changes which included staggering the medication times, switching to a new computer system and hiring more nurses to pass the medications. 2. Resident #3 was admitted to the facility on 9/9/19 with a diagnosis of type 1 diabetes mellitus. A review of the admission minimum data set (MDS) assessment dated 9/16/19 revealed Resident #3 was moderately cognitively impaired and received insulin injections. A review of Resident #3's Physician Orders revealed an order for (Lantus) Insulin glargine (long-acting insulin) to be given at 8:00 PM. A review of Resident #3's Medication Administration Record (MAR) for October 2019 revealed Resident #5's 8:00 PM Lantus was administered late on 10/14/19 (11:32 PM) and	F 760	physician notification quarterly x one (1) year. The DON will be responsible for all of the documentation of the monitoring listed above as well as presenting all findings to the QAA committee. Findings will be promptly addressed. After the conclusion of the ongoing monitoring as described above, the QAA team will determine the frequency of ongoing monitoring. Date of Compliance is 12-13-2019.	

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10/16/19 (11:17 PM) by Nurse #4. Nurse #4 indicated in Resident #3's MAR that for both 10/14/19 and 10/16/19, his Lantus was administered late "due to busy with medication pass." The MAR further indicated that Resident #3's 8:00 PM Lantus was again administered late on 10/21/19 (11:17 PM), 10/22/19 (11:56 PM), 10/25/19 (11:37 PM) & 10/26/19 (11:47 PM) by Nurse #5. Nurse #5 indicated in Resident #3's MAR that for 10/21/19, 10/22/19, 10/25/19 & 10/26/19, his Lantus was administered late "due to acuity."

On 11/12/19 at 3:55 PM, an interview with Resident #3 revealed he sometimes receives his Lantus insulin over 2 hours late at night.

On 11/13/19 at 11:39 PM, an interview with Nurse #4 revealed she administered Resident #3's Lantus late on 10/14/19 and 10/16/19 because they did not have enough staff on those dates. She said they seldom worked with a nurse on each hall. They usually worked with a medication aide for one of the halls and that made it difficult because medication aides were not allowed to give injections.

On 11/13/19 at 11:54 PM, an interview with Nurse #5 revealed she administered Resident #3's Lantus late on 10/21/19, 10/22/19, 10/25/19 & 10/26/19 because they did not have enough nurses to work on the halls on those dates. Nurse #5 stated there must be a nurse for each hall in order to give the medications within the time period of an hour before and an hour after the scheduled time. She further stated it was hard to give all medications on time even with a medication aide on one hall because the nurses were still responsible for giving all the insulins on

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F 760	Continued From page 34	F 760		

that hall.

On 11/15/19 at 3:29 PM, an interview with the Unit Manager she was aware that medication passes have been running late especially on 100 and 200 halls which have a very heavy medication load. The Unit Manager said the facility was in the process of staggering the medication times for each section of the hall to accommodate the scheduled medication times. She further stated it was not acceptable to give medications over an hour before or after the scheduled time. She said that if there was a nurse for each hall, late medication pass would not be an issue.

On 11/13/19 at 12:44 AM, an interview with the Director of Nursing (DON) revealed she was aware that the medication pass was "horrendous" especially on 100 and 200 halls. In order to improve the late medication pass situation, the facility was currently working on switching to another computer system which would lessen the documentation time during medication pass. In addition, she had asked the pharmacist to review the medications and to recommend discontinuing unnecessary medications. The facility was also in the process of staggering the medication times for each end of the halls. Despite all the above interventions, the DON stated she realized she needed at least one nurse for each hall in order to get all the medications administered within the scheduled time range of an hour before or after. She further stated that the late administration of insulins was unacceptable and that she would have to hire more nurses in order to fix this concern.

On 11/15/19 at 1:11 PM, an interview with the

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F 760	Continued From page 35 Medical Director revealed she has been aware of an ongoing problem with late medication passes at the facility. The Medical Director stated this was due to the facility not having enough nurses to pass the medications. She further stated she wasn't as concerned about some of the medications being given over 2 hours late, but she expected insulins, benzodiazepines and opioids to be given on the times she had ordered them to be given. She did not consider this insulin being given late as a significant medication error but she did expect it to be given at the same time each day. On 11/15/19 at 6:47 PM, an interview with the Administrator revealed it was not acceptable for medications to be given over 2 hours late. He stated the facility was actively making some changes which included staggering the medication times, switching to a new computer system and hiring more nurses to pass the medications.	F 760		