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	345216	A. BUILDING _____ B. WING _____	07/01/2021

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WESTFIELD REHABILITATION AND HEALTH CENTER	3100 TRAMWAY ROAD SANFORD, NC 27330

(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
E 000	Initial Comments An unannounced recertification survey was conducted 6/28/21 through 7/1/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # GNWK11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 6/28/21 - 7/1/21. Event ID # GNWK11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of accidents (Residents #32 & #11), nutrition (Residents #32 & #11) and diagnoses (Resident #5) for 3 of 19 sampled residents reviewed. Findings included: 1a. Resident #32 was admitted to the facility on 4/1/21 with multiple diagnoses including dementia. The significant change in status MDS assessment dated 5/11/21 indicated that Resident #32 had no falls since admission/entry, reentry or prior assessment. Review of the facility's incident/accident log revealed that Resident #32 had falls on 4/10/21, 4/12/21, 4/13/21, 4/16/21 and 4/19/21.	F 641		

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

Electronically Signed

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The Treatment Nurse was interviewed on 6/30/21 at 3:45 PM. She stated that currently, the facility did not have an MDS Nurse. She used to be the MDS Nurse but had changed role to a Treatment Nurse. She indicated that a corporate MDS Nurse was helping the facility in completing the MDS assessments. The Treatment Nurse verified that Resident #32 had falls on 4/10/21, 4/12/21, 4/13/21, 4/16/21 and 4/19/21 and the MDS assessment dated 5/11/21 should have been coded for falls but it was not.

The Corporate MDS Nurse was interviewed on 7/1/21 at 8:58 AM. She stated that she had been helping the facility in completing the MDS assessments remotely starting December 2020 since the facility did not have an MDS Nurse. She verified that Resident #32 had falls during the assessment period and the MDS assessment dated 5/11/21 should have been coded for falls but it was not. She reported that it was an oversight on her part.

The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON indicated that she expected the MDS assessments to be coded accurately.

1b. Review of Resident #32's weights revealed that he had a significant weight loss of 12% in one month. The resident weighed 175 pounds (lbs.) on 4/1/21 and 154 lbs. on 5/11/21.

The dietary note dated 4/22/21 revealed that Resident #32's current weight was 154 lbs., a significant weight loss of 11.8 % since admission.

The significant change in status MDS

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assessment dated 5/11/21 indicated that Resident #32 did have a weight loss during the assessment period.

The Corporate MDS Nurse was interviewed on 7/1/21 at 8:58 AM. She stated that she had been helping the facility in completing the MDS assessments remotely starting December 2020 since the facility did not have an MDS Nurse. She reported that the Dietary Manager (DM) was responsible for completing section K (nutrition) of the MDS assessment.

The DM was interviewed on 7/1/21 at 9:15 AM. The DM stated that she was responsible for completing section K of the MDS assessments. She verified that Resident #32 had a significant weight loss during the assessment period and the MDS assessment dated 5/11/21 should have been coded for a significant weight loss but it was not. She reported that it was an oversight and she would correct it.

The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON indicated that she expected the MDS assessments to be coded accurately.

2. Resident #5 was admitted to the facility on 11/3/20 with multiple diagnoses including depression and hyperlipidemia. The quarterly Minimum Data Set (MDS) assessment dated 4/9/21 indicated that Resident #5 did not have diagnoses of depression and hyperlipidemia.

Resident #5's doctor's orders were reviewed. Resident #5 had orders for Mirtazapine and Trazodone for depression and Atorvastatin for

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F 641	Continued From page 3 hyperlipidemia. The Medication Administration Records (MARs) for April 2021 revealed that Resident #5 had received Mirtazapine, Trazodone and Atorvastatin during the assessment period. The Corporate MDS Nurse was interviewed on 7/1/21 at 8:58 AM. She stated that she had been helping the facility in completing the MDS assessments remotely starting December 2020 since the facility did not have an MDS Nurse. She verified that Resident #5 had received Trazodone, Mirtazapine and Atorvastatin during the assessment period and the 4/9/21 MDS assessment should have been coded for depression and hyperlipidemia under the diagnoses but it was not. She reported that it was an oversight on her part. The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON indicated that she expected the MDS assessments to be coded accurately. 3a) Resident #11 was originally admitted to the facility on 7/17/19 with diagnoses that included congestive heart failure (CHF), adult failure to thrive and dementia. Resident #11's weight data revealed the following weights during the Minimum Data Set (MDS) assessment look back period of November 2020 to April 2021, which showed a weight loss: 11/7/20 119.4 pounds (lbs.) 1/7/21 108.2 lbs. 2/7/21 100 lbs. 4/9/21 103.8 lbs. The quarterly MDS assessment dated 4/15/21	F 641		

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indicated Resident #11 had severe cognitive impairment. She was not coded for weight loss of 5% of more in the last month or a loss of 10% of more in the last 6 months.

On 7/1/21 at 8:59 AM, a telephone interview was conducted with the Corporate MDS Nurse who stated the Dietary Manager coded the nutritional section of the MDS assessment.

The Dietary Manager was interviewed on 7/1/21 at 9:11 AM who reviewed the MDS assessment dated 4/15/21 and Resident #11's weight data. She indicated the weight loss section should have been coded and felt it was an oversight.

During an interview on 7/1/121 at 10:21 AM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately.

3b) Resident #11 was originally admitted to the facility on 7/17/19 with diagnoses that included dementia, congestive heart failure (CHF), and chronic obstructive pulmonary disease (COPD).

A review of Resident #11's medical record revealed she had falls without injury on 3/3/21, 3/10/21, 3/14/21, 3/16/21, 3/19/21, 3/20/21 and 4/1/21.

The quarterly Minimum Data Set (MDS) assessment dated 4/15/21 indicated Resident #11 had severe cognitive impairment. She was not coded with any falls since admission/reentry or prior assessment.

On 7/1/21 at 8:59 AM, a telephone interview occurred with the Corporate MDS Nurse. She

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F 641	Continued From page 5 reviewed the MDS dated 4/15/21 and confirmed she had coded this section of the MDS. The Corporate MDS Nurse added it was an oversight not to code the MDS with the falls noted in Resident #11's medical record. During an interview on 7/1/121 at 10:21 AM, the Director of Nursing indicated it was her expectation for the MDS to be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to follow physician's orders to administer a medication on an empty stomach for 3 of 7 residents reviewed for medications (Residents #14, #32 and #257). The findings included: 1) Resident #14 was admitted to the facility on 4/9/21 with diagnoses that included chronic kidney disease and anemia. A review of Resident #14's cumulative physician orders revealed an order dated 4/9/21 for Ferrous Sulfate 325 milligrams (mg) 1 tablet by mouth two times a day for iron supplementation. Take on an empty stomach with a full glass of water. A review of Resident #14's admission Minimum	F 658		

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Data Set (MDS) assessment dated 4/16/21 indicated she had moderately impaired cognition.

The April, May, and June 2021 Medication Administration Records (MARs) revealed Resident #14 was scheduled to receive 325mg of Ferrous Sulfate at 9:00 AM and 5:30 PM.

A review of the facility's meal delivery times indicated the breakfast trays were delivered to the 200 hall at 7:40 AM and dinner trays were delivered at 5:40 PM.

On 6/30/21 at 8:20 AM, Resident #14 was observed with her breakfast tray in front of her and had completed the meal.

Nurse #3 was interviewed on 6/30/21 at 10:00 AM and indicated she was assigned to Resident #14. She reported the breakfast cart arrived on the 200 hall around 7:45 AM to 8:00 AM and the dinner cart arrived around 5:30 PM. Nurse #3 indicated Resident #14's Ferrous Sulfate was scheduled to be administered at 9:00 AM and 5:30 PM and normally administered the medication at those times. Nurse #3 reported she was not aware the resident's Ferrous Sulfate was ordered to be given on an empty stomach and would change the time of administration to be given before breakfast and dinner and notify the physician.

On 7/1/21 at 9:54 AM an interview occurred with Nurse #5 who reported he was not aware that Resident #14's Ferrous Sulfate was ordered to be given on an empty stomach. He verified the medication was ordered to be administered at 9:00 AM and 5:30 PM and had one hour before and after to administer her medications. Nurse #5

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further stated medications ordered to be given on an empty stomach should be given before breakfast and dinner.

The Director of Nursing was interviewed on 7/1/21 at 10:25 AM and indicated she expected the nursing staff to follow physician orders and to administer medications ordered on an empty stomach before breakfast and dinner.

2) Resident #257 was admitted to the facility on 6/15/21 with diagnoses that included iron deficiency anemia.

A review of Resident #257's cumulative physician orders revealed an order dated 6/15/21 for Ferrous Sulfate 325 milligrams (mg) 1 tablet by mouth once a day. Take on an empty stomach with a full glass of water.

A review of Resident #257's admission Minimum Data Set (MDS) assessment dated 6/22/21 indicated she had severe cognitive impairment.

The June 2021 Medication Administration Record (MAR) revealed Resident #257 was scheduled to receive 325mg of Ferrous Sulfate at 9:00 AM.

On 6/30/21 at 8:15 AM, Resident #257 was observed with her breakfast tray in front of her. She had finished her meal.

Nurse #2 was interviewed on 6/30/21 at 9:00 AM and indicated she was assigned to Resident #257. She reported the breakfast cart arrived on the 100 hall around 7:30 AM to 7:45 AM . Nurse #2 indicated Resident #257's Ferrous Sulfate was

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scheduled to be administered at 9:00 AM and normally administered the medication at that time. Nurse #2 reported she was not aware the resident's Ferrous Sulfate was ordered to be given on an empty stomach and would change the time of administration to be given before breakfast and notify the physician.

On 7/1/21 at 9:54 AM an interview occurred with Nurse #5 who reported he was not aware that Resident #257's Ferrous Sulfate was ordered to be given on an empty stomach. He verified the medication was ordered to be administered at 9:00 AM and had one hour before and after to administer her medications. Nurse #5 further stated medications ordered to be given on an empty stomach should be given before breakfast.

The Director of Nursing was interviewed on 7/1/21 at 10:25 AM and indicated she expected the nursing staff to follow physician orders and to administer medications ordered on an empty stomach before breakfast.

3. Resident #32 was admitted to the facility on 4/1/21 with multiple diagnoses including hypothyroidism. The significant change in status MDS assessment dated 5/11/21 indicated that Resident #32 had severe cognitive impairment.

Resident #32's doctor's orders were reviewed. Resident #32 had doctor's orders dated 4/1/21 for Synthroid (used to treat hypothyroidism) 137 micrograms (mcg) - 1 tablet by mouth daily on empty stomach at least 30-60 minutes before breakfast and on 4/7/21 for Ferrous Sulfate (for iron supplementation) 325 milligrams (mgs) - 1 tablet by mouth daily on an empty stomach.

Review of the April, May and June 2021

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Medication Administration Records (MARs) revealed Resident #32 was scheduled to receive Synthroid and Ferrous Sulfate at 9 AM.

On 6/30/21 at 9:05 AM, Resident #32 was observed with his breakfast tray in front of him. He was finished eating his breakfast.

On 6/30/21 at 9:35 AM, Nurse # 4 was interviewed. She indicated that she was assigned to Resident #32. She reported the breakfast cart arrived on the 300 hall at 8 AM. Nurse #4 indicated that resident's medications were scheduled to be administered at 9 AM and she normally administered his medications around 8 AM. Nurse #4 reported that she was not aware that resident's Synthroid and Ferrous Sulfate were ordered to be given on an empty stomach. She indicated that she would change the time of administration on the MAR for the Synthroid and Ferrous Sulfate to be given before breakfast instead of 9 AM and she would notify the physician of the resident.

On 7/1/21 at 10:02 AM, Nurse #5 was interviewed. Nurse #5 reported that he was not aware that Resident #32's Synthroid and Ferrous Sulfate were ordered before breakfast. He verified that his medications were ordered to be administrated at 9 AM and he has one hour before and 1 hour after to administer his medications. He commented that medications ordered to be given on empty stomach should be given before breakfast.

The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON indicated that she expected the nurses to follow doctor's orders and to administer medications ordered on empty

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F 658	Continued From page 10 stomach before breakfast.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record review, the facility failed to provide nail care for a resident dependent on staff for assistance with her activities of daily living (ADLs). This was for 1 (Resident #54) of 1 resident reviewed for nail care. The findings included. Resident #54 was admitted on 4/23/16 with cumulative diagnoses of chronic venous ulcers, malnutrition and Peripheral Vascular Disease. Resident #54's significant change Minimum Data Set (MDS) dated 6/21/21 indicated she was cognitively intact and she exhibited no behaviors. She was coded for extensive assistance with her personal hygiene. Resident #54's ADL care plan last revised on 4/15/21 read she required ADL assistance due to her limited mobility. Interventions included staff assistance with grooming and personal hygiene. Review of Resident #54's undated electronic care guide read as follows: Keep fingernails short. In an observation and interview on 6/28/21 at 8:55 AM, Resident #54 was sitting up in her bed.	F 677		

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She stated she finished breakfast and was waiting on the aide to come and get her ready for the day. She confirmed she required staff assistance with her ADLs. Her fingernails appeared unkept. They were clean but long and jagged with partial nail polish to several nails. Resident #54 stated her fingernails had not been done since she attended an activity and they painted her nails. She stated her nails were not cut during the activity but shaped and painted. She stated she really needed her fingernails to be cut and she did not want the polish on my fingernails.

In an interview on 6/28/21 at 10:10 AM, Nursing Assistant (NA) #1 confirmed she was assigned Resident #54. She stated the nurses cut fingernails of diabetic residents and the aides or activities department provided routine nail care. NA #1 stated Resident #54 was very cooperative and never refuses care.

In another observation on 6/30/21 at 11:18 AM, Resident #54 was sitting up in bed dressed for the day. She stated none of the staff noticed her fingernails and none of the staff had yet provided any nail care. Resident #54's fingernails were clean but their appearance was unchanged.
In an interview on 6/30/21 at 11:24 AM, NA #2 stated she was assigned Resident #54 and assisted her with her morning ADLs. She stated the aides provided routine nail care as needed. NA #2 stated Resident #54 was very cooperative and never refuses care.

In an observation on 6/30/21 at 1:30 PM, the Director of Nursing (DON) was taken to see Resident #54's fingernails. Resident #54's fingernails were clean but long and jagged with

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F 677	Continued From page 12 partial nail polish to several nails. The DON stated her fingernails were likely last done a few weeks ago in activities but they only file and paint nails. Resident #54 stated to the DON that she liked her fingernails short and without polish. She further stated it had been a long time since her fingernails were cut and filed. The DON stated she was not aware of Resident #54's preferences for short fingernails. On 6/30/21 at 2:15 PM, the DON stated she completed nail care on Resident #54 and it was the expectation that routine nail care be provided by the aides unless the resident was a diabetic. The DON stated the floor staff should not rely on nail care being completed in activities. In an interview on 6/30/21 at 2:54 PM, the Activity Director (AD) stated she was not allowed to cut fingernails. She could only file and paint. The AD stated Resident #54 seldom attended any out of the room activities. In an interview on 7/1/21 at 9:15 AM, the Administrator stated she expected the aides to complete routine nail care. She stated she audited all the residents on the 200 hall and found other residents in need of nail care which she completed nail care yesterday. In an interview on 7/1/21 at 10:35 AM, the Administrator and DON stated it was their expectation that the aides provide routine nail care and the nurses provide nail care on diabetic residents.	F 677		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		

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(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 686	Continued From page 13 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 2 of 4 residents reviewed for pressure ulcer (Residents #27 and #45). The findings included: 1) Resident #45 was admitted to the facility on 6/3/21 with multiple diagnoses that included osteomyelitis (an infection in the bone) of the vertebra and stage 4 pressure ulcer of the sacral region. A review of Resident #45's June 2021 physician orders revealed an order dated 6/8/21 for a low air loss mattress to the bed. An admission Minimum Data Set (MDS) assessment dated 6/10/21 indicated Resident #45 had severe cognitive impairment and displayed no behaviors or refusal of care during	F 686		

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	345216	A. BUILDING _____ B. WING _____	07/01/2021

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the 7 day look back period. She required limited assistance with personal hygiene and extensive assistance with all other Activities of Daily Living (ADL's), was coded with 1 stage 4 pressure ulcer that was present on admission and had a pressure reducing device to the bed.

Resident #45's weight on 6/11/21 was 114.2 pounds (lbs.).

Resident #45's active care plan included the following focus areas:
- I currently have a pressure ulcer to my sacrum with a wound vac in place and am at risk for development of additional pressure ulcers due to decreased ability to reposition, incontinence and immobility. The interventions included an air mattress.
- I am at risk for pressure ulcer development due to incontinence, wheelchair bound, history of pressure ulcers and other comorbidities. The interventions included pressure reducing mattress to the bed.

Resident #45's weight on 6/17/21 was 111.8 lbs.

Resident #45's alternating pressure reducing mattress machine was observed on 6/28/21 at 9:49 AM and was set at 200 lbs. The machine had settings from 80 to 400 lbs. and indicated to set according to resident's weight per lbs.

On 6/30/21 at 10:00 AM, Resident #45 was observed lying in bed on her right side. The alternating pressure reducing mattress machine was set at 200 lbs.

On 6/30/21 at 11:00 AM the alternating pressure mattress machine was observed by the

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Treatment Nurse who confirmed it was set at 200 lbs. She corrected the weight to read 120 lbs. and locked the panel after the mattress was reset to the correct weight. She was unable to state why the weight was set at 200 lbs. and indicated nursing staff are to check each shift for proper functioning.

Nurse #4 was interviewed on 6/30/21 at 1:35 PM and verified nursing staff check the air mattresses twice a day for correct functioning then sign as completed on the Medication Administration Record (MAR). Nurse #4 further stated when she checked Resident #45's alternating air mattress she ensured it was inflated properly and whether the machine was operational. She stated she had not noticed the weight being set at 200 lbs. and agreed it should have been at 120 lbs.

The Maintenance Director was interviewed on 6/30/21 at 3:28 PM and stated he set up the alternating air mattresses when ordered by the physician and set the weight according to what he was told by the nursing staff. He added after the initial set-up he was not involved with monitoring the settings.

An interview was conducted with the Director of Nursing (DON) on 7/1/21 at 10:21 AM and indicated the nursing staff monitored the functionality of the air alternating pressure mattresses but was unsure if the weight settings were checked as well. She further indicated she expected the alternating air mattresses to be set according to the resident's weight for residents with pressure ulcers to promote healing.

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2. Resident #27 was admitted to the facility on 11/16/2015 with diagnoses that included rheumatoid arthritis and atherosclerosis (disease that causes narrowing of the arteries).

A review of Resident #27's active physician orders for June 2021 revealed an order for a low air loss mattress to the bed.

Resident #27's quarterly Minimum Data Set (MDS) assessment dated 5/17/2021 indicated Resident #27 was cognitively intact and displayed no behaviors or refusal of care during the 7 day look back period. She required extensive assistance with bed mobility and transfers. She also required extensive assistance for dressing, eating, toileting, and personal hygiene. Resident #27 was coded with no existing pressure ulcers and 1 arterial/venous ulcer that was present on admission. The MDS indicated she had a pressure reducing device to the bed and was coded for unplanned weight loss.

Resident #27's medical record revealed her most recent documented weight was 80.0 pounds (lbs) on 6/5/2021.

The resident's active comprehensive care plan dated 5/27/2021 included a focus area for skin impairment (arterial ulcers) to both feet and heels. Interventions included air mattress on bed.

Resident #27's alternating pressure reducing mattress machine was observed on 6/30/2021 at 3:00 PM and was set at 400 lbs. The machine had settings from 80 to 400 lbs. and indicated the

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F 686	Continued From page 17 mattress should be set according to resident's weight in lbs. On 6/30/21 at 3:25 PM and interview was conducted with nurse assistant (NA) #3 who was assigned to Resident #27, she stated she made sure the mattress was on and functioning. She did not adjust the settings. She further stated she did not know where or how to determine what the resident's mattress setting should be. On 6/30/21 at 1:35 PM Nurse #4, who was assigned to Resident #27 that day, stated nursing staff check the air mattresses twice a day for correct functioning then sign as completed on the Medication Administration Record (MAR). The Maintenance Director was interviewed on 6/30/21 at 3:28 PM and stated he set up the alternating air mattresses when ordered by the physician and set the weight according to what he was told by the nursing staff. He added after the initial set-up he was not involved with monitoring the settings. An interview was conducted with the Director of Nursing (DON) on 7/1/21 at 10:21 AM and indicated the nursing staff monitored the functionality of the air alternating pressure mattresses but was unsure if the weight settings were checked as well. She further indicated she expected the alternating air mattresses to be set according to the resident's weight for residents with pressure ulcers to promote healing.	F 686		
F 694 SS=D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids.	F 694		

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F 694	Continued From page 18 Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to measure the length of exposed catheter for a peripherally inserted central catheter (PICC) per physician's orders for 1 of 1 sampled resident (Resident #256) reviewed for intravenous medications. Findings include: Resident # 256 was admitted to the facility 6/10/2021 with diagnoses including acute cystitis. Resident #256's admission Minimum Data Set (MDS) was not available. The resident's care plan dated 6/11/2021 had a focus for risk of complications such as infection and infiltration of PICC line while receiving intravenous (IV) antibiotics. Resident #256's active orders included a physician's order dated 6/11/2021 that read; change PICC line dressing with sterile procedure weekly and as needed. Measure length of exposed catheter to check for migration every night shift, every Wednesday. A review of Resident #256's June 2021 Medication Administration Record (MAR) revealed no measurements documented on Wednesday 6/16/2021 or Wednesday 6/23/2021. A telephone interview was conducted on	F 694		

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F 694	Continued From page 19 6/30/2021 at 3:16 PM with Nurse # 1 who was assigned to Resident #256 Wednesday evening 6/16/2021. She stated she changed the PICC line dressing on Wednesday evening but did not complete any measurements. She further stated she did not measure the line because there was no redness or swelling to the site. Attempts to contact the nurse who was assigned to Resident #256 on Wednesday 6/23/2021 were unsuccessful. However, there were no PICC line measurements documented on the MAR or in the resident's progress notes. The Director of Nursing was interviewed at 7/1/2021 at 10:21 AM and stated she expected nurses to follow the physician's orders for assessing and maintaining the PICC line.	F 694		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be	F 757		

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F 757	Continued From page 20 reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to hold the blood pressure medications as ordered (Resident #32) and failed to check the blood pressure prior to administering the blood pressure medications (Resident #5) for 2 of 5 sampled residents reviewed for unnecessary medications. Findings included: 1. Resident #32 was admitted to the facility on 4/1/21 with multiple diagnoses including hypertension. The significant change in status Minimum Data Set (MDS) assessment dated 5/11/21 indicated that Resident #32 had severe cognitive impairment. Resident #32 had doctor's orders dated 5/20/21 for Amlodipine (used to treat hypertension) 10 milligrams (mgs) - 1 tablet by mouth daily - hold for systolic blood pressure of less than 120 and on 5/22/21 for Metoprolol (used to treat hypertension) 25 mgs - 1/ 2 tablet by mouth in the morning - hold for systolic blood pressure of less than 120 and hold for heart rate less than 60. Resident #32's May and June 2021 Medication Administration Records (MARs) were reviewed. The MARs revealed that Resident #32 had received the Amlodipine and the Metoprolol despite the systolic blood pressure (SBP) was below 120 and the heart rate (HR) was below 60	F 757		

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F 757	Continued From page 21 on the following dates: 5/26/21 - HR - 59 5/27/21 - HR - 44 5/28/21 - BP - 108/58 5/30/21 - BP - 119/71 & HR - 54 6/3/21 - BP - 107/62 6/12/21 - HR - 56 6/14/21 - HR - 59 6/15/21 - BP 107/49 6/17/21 - HR -59 6/18/21 - HR -48 6/19/21 - HR 51 6/21/21 - BP - 117/56 & HR -52 6/24/21 - BP 115/62 6/25/21 - HR - 59 6/30/21 - HR - 59 Nurse #4 was interviewed on 6/30/21 at 9:35 AM. She stated that she was assigned to Resident #32 on 6/14/21, 6/18/21, 6/25/21 and 6/30/21. Nurse #4 indicated that she was aware the resident had parameters to hold the Amlodipine and the Metoprolol. She reported that the vital signs including the BP and the HR were taken by the nursing assistants (NAs) in the morning and were recorded on the MARs. When pointed out that the Metoprolol was administered despite the HRs were below 60 on the days she was assigned to the resident, she responded that it was an error on her part. She reviewed the MARs and verified that she should have withheld the Metoprolol when the HRs were below 60 but she did not. Nurse #2 was interviewed on 6/30/21 at 12:31 PM. She stated that she was assigned to Resident #32 on 5/27/21, 6/3/21 and 6/15/21. Nurse #2 indicated that she was aware the	F 757		

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resident had parameters to hold the Amlodipine and the Metoprolol. She reported that the vital signs including the BP and the HR were taken by the NAs anytime in the morning prior to the medication administration and were recorded on the MARs. When pointed out that the Amlodipine and the Metoprolol were administered despite the SBPs were below 120 and the HRs were below 60 on the days she was assigned to the resident, she responded that she might have missed to hold them on the days she was assigned to the resident. She reviewed the MARs and verified that she should have withheld the Amlodipine on 6/3/21 and 6/15/21 and the Metoprolol on 5/27/21 but she did not.

Nurse #5 was interviewed on 7/1/21 at 10:21 AM, He stated that he was assigned to Resident #32 on 6/17/21 & 6/21/21. He was aware that the resident had parameters to hold his blood pressure medications. He verified that on 6/17/21, the resident's HR was 59 and on 6/21/21 his BP was 117/56 and his HR was 52, he should have withheld his Amlodipine and Metoprolol, but he did not. Nurse #5 confirmed that it was an error on his part.

The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON stated that she expected the nurses to follow doctor's orders including blood pressure medications with parameters to hold. The DON further stated that she expected the nurses to check the BP and the HR right before medication administration.

2. Resident #5 was admitted to the facility on 11/3/20 with multiple diagnoses including hypertension.

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Resident #5 had a doctor's order dated 11/11/20 for Amlodipine 2.5 milligrams (mgs) - 1 tablet by mouth daily - check manual blood pressure (BP) before administration - hold if systolic BP (SBP) is less than 120.

Resident #5 had a doctor's order dated 12/5/21 for Carvedilol 25 mgs - 1 tablet by mouth 2 times a day - hold for SBP of less than 110.

Review of Resident #5's Medication Administration Records (MARs) from December 2020 through June 2021 revealed that the blood pressure was not checked manually prior to the administration of the Amlodipine and the Carvedilol. There were no daily BP readings recorded on the MARs from December 2020 through June 2021.

Nurse #4 was interviewed on 6/30/21 at 9:37 AM. She stated that she was assigned to Resident #5. She indicated that Resident #5 was a long- term resident, and her vital signs including blood pressure were taken weekly and recorded on the MARs. Nurse #4 reported that the resident did not have ordered medication with a parameter to hold. When she checked the doctor's order and the MARs, she verified that Resident #5 had a doctor's order to check the BP and to hold the Amlodipine and the Carvedilol if the SBP was below 110 and 120. She also verified that there were no BP readings recorded on the MARs daily. Nurse #4 commented that the nurse who transcribed the order for the Amlodipine and the Carvedilol to the MARs did not indicate to check the BP prior to the administration.

Nurse #2 was interviewed on 6/30/21 at 12:31

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F 757	Continued From page 24 PM. She stated that she had known Resident #5. Nurse #2 indicated that she was not aware the resident had parameters to hold the Amlodipine and the Carvedilol when the SBP was below 110. Nurse #5 was interviewed on 7/1/21 at 10:21 AM, He stated that he had known Resident #5. He was not aware that the resident had parameters to hold his blood pressure medications when the SBP was below 110.. The Director of Nursing (DON) was interviewed on 7/1/21 at 10:21 AM. The DON stated that she expected the nurses to check the blood pressure prior to administering the ordered medications with parameters to hold and to document the BP on the MARs daily.	F 757		