STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345336	A. BUILDING _____ B. WING _____	C 06/18/2021

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SIGNATURE HEALTHCARE OF ROANOKE RAPIDS	305 FOURTEENTH STREET ROANOKE RAPIDS, NC 27870

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E 000	Initial Comments An unannounced recertification survey was conducted on 6/14/21 through 6/18/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #3KG11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 6/14/21 through 6/18/21. Event ID# 3KGI11. 5 of the 19 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.	F 561		8/2/21

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

Electronically Signed | 07/19/2021

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F 561	Continued From page 1 §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews the facility failed to provide food preferences and offer an alternate meal for 1 of 1 resident reviewed for choices (Resident #12). The findings included: Review of the clinical record revealed Resident #12 was admitted to the facility on 4/30/19. The most recent Minimum Data Set (MDS) Assessment dated 3/26/21 revealed the resident was cognitively intact and required extensive to total assistance with activities of daily living with the exception the resident was independent with eating with tray set-up. The resident's care plan last reviewed on 3/30/21 for nutritional status noted the resident was at risk for weight loss with a low body mass index, and variable by mouth intake. Received regular diet. The approaches were to assess for dehydration, assess resident's food preferences, encourage oral intake of food and fluids. Monitor and record weights and provide nutritional interventions as ordered. On 6/14/21 at 12:57 PM a meal tray was observed to be delivered to Resident #12. The meal served was roast beef and gravy, carrots, rice, biscuit, marble cake and tea. The resident	F 561	I. Resident #12 had her food preferences updated by the Nutritional Services Manager on 6/23/21. 2. Residents residing in the facility had their food preferences reviewed and updated by the Nutritional Services Manager on or before July 15, 2021. 3. On 6/24/21 the Regional Nutritional Services Director educated the Nutritional Services Manager that residents are to have their food preferences reviewed and updated by the Nutritional Services Manager, or manager in charge, within 72 hours of admission, re-admission, quarterly, and with identification of significant weight loss per Resident Assessment Instrument Manual. 4. Weekly for twelve weeks, The Nutritional Services Manager, NHA, or Regional Nutritional SErvices Director will audit one resident's food preference on each unit to validate that food preferences are honored. The Nutritional Services Manager will present the results of the audit to the Quality Assurance and Performance IMprovement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audits, making recommendations as needed, to assure	

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F 561	Continued From page 2	F 561		

commented, "Doesn't look very appetizing does it?" At 1:05 PM the resident had pushed aside the meal tray and had consumed a few bites of carrots, rice and had eaten the marble cake and half of the iced tea. The Resident stated she was not much of a beef eater. The Resident further stated she was never a big eater but she would eat if she had something good.

On 6/15/21 at 8:55 AM the resident received her breakfast tray that had scrambled eggs, grits, toast, juice and milk. The resident ate a few bites of eggs, grits and a bite of the toast and drank the juice. The milk carton remained on the meal tray unopened. The resident stated she did not like scrambled eggs and did not get any meat but she liked bacon. The Resident stated she did not like milk. The Resident further stated she got fish for supper last night and did not like fish but ate the potato tots, coleslaw and a piece of cake. Review of the resident's meal card revealed no likes or dislikes on the card. The Resident stated no one from the kitchen had talked with her about her likes or dislikes. At 9:14 AM Nursing Assistant (NA) #1 was observed to enter the room and asked the resident if she was finished and picked up the meal tray and removed the tray from the room. The NA did not offer the resident a meal alternate or comment on the amount of food left on the meal tray.

On 6/15/21 at 9:18 AM NA#1 was asked if she offered the resident an alternate meal since she did not eat her breakfast and the NA responded, "She has all kinds of snacks in her room that people brought to her."

On 6/16/21 at 8:40 AM Resident #12 was observed sitting up in bed with her meal tray in

compliance is sustained ongoing. The Nursing Home Administrator(NHA) is responsible for the execution of the plan of correction.

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F 561	Continued From page 3	F 561		

front of her. The meal tray contained scrambled eggs, bacon, grits, pancakes, juice and milk. The Resident stated she did not like the eggs or the milk.

On 6/17/21 at 8:30 AM Resident #12 was observed sitting up in bed with her breakfast tray in front of her. The tray contained scrambled eggs, grits, biscuit, juice and milk. The Resident stated she did not like scrambled eggs and did not like milk. The Resident stated she did not like shrimp either but they kept bringing it. The resident was observed to eat a few bites of grits, a bite of the biscuit and the juice. The Resident stated she did not get any meat. The milk carton on the tray remained unopened. Review of the meal card revealed no likes or dislikes listed on the card.

On 6/17/21 at 8:48 AM an interview was conducted with the Dietary Manager. The Dietary Manager (DM) stated she had been the Dietary Manager since October 2020 and did not do this resident's likes and dislikes when she took over because her likes and dislikes were on the tray card and the DM left to get a tray card. When the DM returned, she stated they started a new system in the past week and the likes and dislikes were not printed on the tray card. The DM did not provide a list of the resident's likes and dislikes. The DM stated the resident was on weekly weights and was put on a fortified diet for breakfast that included added nutrition to the eggs and whole milk. The DM continued and stated when the staff communicated to her the resident did not like what was on the meal tray she would see that the resident would get something else. The DM then stated, yes, she had talked with the resident about her likes and

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F 561	Continued From page 4 dislikes and one week she liked one thing and the next week she did not like it. On 6/18/21 at 12:17 PM the Director of Nursing stated in an interview that she expected the staff to offer the resident an alternative meal if the resident did not eat.	F 561		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to provide a surety bond for 37 of 71 residents reviewed, which named the residents of the facility as the obligee. The findings included: The facility surety bond, dated 4/1/21, titled "General Surety Rider" revealed the principal was listed as LP Roanoke Rapids, LLC doing business as Signature HealthCARE of Roanoke Rapids and the obligee was listed as Residents Personal Funds Trust Fund State of North Carolina During an interview with the Administrator on 6/18/21 at 12:25PM, he revealed corporate would update the surety bond.	F 570	F570 Surety Bond C 1. No specific residents were identified as having been affected. 2. The facility reviewed and updated the surety bond for the affected residents. 3. On 6/23/21 the Regional Business Office Director educated the Business Office Director and NHA on Surety Bond Obligee. The Surety Bond was updated to reflect the Obligee as the Resident Personal Fund Trust Fund State of North Carolina. 4. The NHA will audit the Surety Bond Monthly to validate the Obligee is correctly stated. The NHA will present the result of the monthly audit to the facility□s Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the	8/2/21

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F 570	Continued From page 5	F 570	results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA is responsible for the execution of the plan of correction.	
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 observations, record review, and staff interviews the facility failed to accurately code the admission Minimum Data Set (MDS) assessment and the annual Minimum Data Set assessment in the areas of Preadmission Screening and Resident Review (PASARR) for 1 of 1 resident reviewed (Resident #37). Findings included: Resident #37 was admitted to the facility on 3/31/20 with diagnoses that included bipolar disorder. A review of Resident #37's admission PASARR Level II determination notification dated 2/29/20 revealed Resident #37 had been approved for a 30 day nursing home stay and then would require a re-screening. A review of Resident #37's PASARR Level II determination notification dated 11/20/20 indicated there was no expiration for this determination.	F 641	F641 Accuracy of Assessments D 1. Resident #37□s Admission Minimum Data Set (MDS) dated 3/30/20 and annual MDS dated 3/31/21 were modified on 6/16/21 to reflect Resident #37□s level II PASARR. 2. Residents with Level II PASARRs had their respective MDSs reviewed by the Regional MDS Director to validate the Level II PASARR was correctly coded, with modifications completed as needed on three Minimum Data Set Assessments. 3. On 7/13/21 the Clinical Reimbursement Specialist educated the MDS Coordinators to validate the PASARR level when coding the MDS and to code section A A1500 of the MDS per the Resident Assessment Instrument Manual. 4. Clinical Reimbursement Specialist or Director of Clinical Consulting will audit two comprehensive MDS assessments per week for 12 weeks to validate the PASARR is correctly coded. The Clinical Reimbursement Specialist or NHA will	8/2/21

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F 641	Continued From page 6 During an interview with the MDS Nurse on 6/16/21 at 1:25PM, she stated Resident #37's admission MDS dated 3/30/20 and the annual MDS dated 3/31/21 were coded incorrectly as PASARR Level I. She further stated Resident #37 had a PASARR Level II determination upon admission. The MDS Nurse revealed she had copied information from the admission MDS to the annual MDS dated 3/31/21 without verifying the PASARR information. She further stated she should have verified this information prior to coding the MDS assessments. Interview with the Administrator on 6/18/21 at 12:25PM revealed the MDS should be coded correctly.	F 641	present the result of the weekly audits to the facility□s Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA is responsible for the execution of the plan of correction	
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 observations, record review, and staff interviews the facility failed to check gtube placement and residual for 1 of 1 residents during medication pass. (Resident #17) The findings included: Resident #17 was admitted to the facility on 8/23/19 and had a diagnosis of dementia, pressure ulcers, disorder of the skin and subcutaneous tissues, nutritional deficiency and gastrostomy (feeding) tube.	F 658	F658 Professional Standards D 1. Resident #17 is currently getting her gastric tube placement and residual feeding checked with medication administration. On 6/22/21 Licensed Nurse #1 received a one to one educational in-service from the Director of Clinical Consulting on checking gastric tube placement and residual feeding checked with medication administration. 2. Residents with gastric tubes have been identified as having the potential to	8/2/21

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F 658	Continued From page 7 A physician's order dated 1/30/21 read: "Check tube placement and residual by injecting small amount of air and aspirating stomach contents. If > (greater) than 100ccs (cubic centimeters), place feeding on hold for one hour then recheck. If no change, notify MD (Medical Doctor)." On 6/16/21 at 8:25 AM, Nurse #1 was observed to crush the medications and mix with water for Resident #17. The nurse was observed to put the feeding tube pump on hold, disconnect the tubing from the feeding tube, insert a catheter tip syringe and flushed the tube with 30ccs of water, poured in the medication mixture and flushed with 30ccs water. The nurse did not check placement of the feeding tube or check for residual prior to administering the medications. On 6/16/21 at 3:00 PM Nurse #1 stated in an interview she was supposed to check the feeding tube for placement and residual before she did anything during the medication pass. The Nurse further stated she was nervous and did not check for placement or residual. The Nurse continued and stated she did go back later and check for placement and residual and there was no residual. On 6/17/21 at 8:09 AM an interview was conducted with the staff development coordinator (SDC). The SDC stated the nurse should have checked the placement of the feeding tube and checked for residual prior to giving the medications. On 6/18/21 at 11:52 the Director of Nursing stated in an interview that it was her expectation the nurse check for placement and residual prior to	F 658	be affected. 3. On 6/22/21 Licensed Nurses were in-serviced by the Director of Clinical Consulting on checking gastric tube placement and residual feeding checked with medication administration. 4. The Director of Clinical Consulting, Pharmacy Nurse Consultant, Staff Development Coordinator, Assistant Director of Nursing, Unit Manager or Director of Nursing will perform observation audits three residents, who receive their medications via g-tube, per week for 12 weeks for checking gastric tube placement and residual feeding checked with medication administration. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.	

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F 658	Continued From page 8 administering medications via a gastric tube.	F 658		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, physician and staff interviews, the facility failed to follow physician's orders to administer scheduled pain medication every 4 hours to control a resident's pain for 1 of 1 resident reviewed for pain management (Resident #41). The findings included: Resident #41 was admitted to the facility on 9/16/19 and had a diagnosis of diabetic neuropathy and chronic pain. The most recent Minimum Data Set Assessment (Quarterly) dated 4/16/21 revealed the resident was cognitively intact, had no behaviors and required extensive assistance with bed mobility, transfers, ambulation, dressing and personal hygiene and total assistance with toileting. The MDS noted the resident had pain occasionally that did not prevent the resident from sleeping or interfere in day-to-day activities. The MDS noted the resident received an opioid (pain) medication 7 days during the 7 day assessment period. The resident's Care Plan last reviewed on 4/20/21	F 697	F697 Pain Management G 1. Resident #41 is receiving his medications as prescribed by the Medical Doctor. On 6/22/21 Licensed Nurse #4/#3 received a one to one educational in-service by the Director of Clinical Consulting on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. 2. Residents prescribed medication by the Medical Doctor have been identified as having the potential to be affected. Residents with prescribed opioids have been identified as having the potential to be affected. On 7/16/21 Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Unit Manager, or Minimum Data Set Coordinator validated the identified residents have available pain medication on hand as prescribed. On 7/19/21 Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing,	8/2/21

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F 697	Continued From page 9 noted a focus area of Pain and noted the resident reported general body/joint pain as well as diabetic neuropathy. The interventions included the following: Monitor side effects of pain. Report to the physician if the resident does not experience reduction or relief of pain after one hour or resident's prescribed interventions. Observe effectiveness of pain medication. Administer pain medication per physician's orders. Review of the physician's orders revealed an order with a start date of 11/16/20 that read as follows: "Oxycodone/Acetaminophen 10-325 mg (milligrams) every 4 hours scheduled for pain." Oxycodone is a narcotic pain medication used to treat moderate to severe pain. 1a. Review of the resident's Medication Administration Record (MAR) for June 2021 revealed that the Oxycodone/Acetaminophen was scheduled to be given at 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM. On June 1, 2021 there was a notation on the MAR for 10:00 AM, 2:00 PM and 6:00 PM that read: "Not Administered: Drug/Item Unavailable" and signed by Nurse #4. The only other pain medication ordered for the resident was Acetaminophen 650mg with an order date of 10/12/20 to be given every 4 hours as needed for pain. On 6/1/21 the MAR revealed Acetaminophen 650mg was given at 3:25 PM and initialed by Nurse #4. On 6/17/21 at 8:32 AM an interview was conducted with Nurse #4 who stated on June 1, 2021 the Oxycodone had been ordered from the pharmacy and the pharmacy told her they were waiting on a prescription from the doctor and the medication was delivered to the facility on the	F 697	Unit Manager, or Minimum Data Set Coordinator validated the residents with prescribed opioids have a pain scale on their Medication Administration Record. On 7/16/21 a Medication Administration Record to Medication Cart audit was performed by the Nurse Supervisor on each Medication Cart to validate prescribed medication was readily available. There were no concerns noted as a result of this audit. 3. On 6/22/21 the Director of Clinical Consulting educated the Licensed Nurses on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. On 7/16/21 the Pharmacist provided education materials for the Licensed Nurses on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. 4. Five times weekly for a minimum of 12 weeks in Clinical Morning Meeting the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will perform an audit reviewing the Medication Availability / Unavailability. If medication is indicated as unavailable, the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will validate the Medical Doctor was notified and appropriate follow up action was initiated. If the Director of Nursing, Staff	

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F 697	Continued From page 10 night of 6/1/21. The Nurse further stated she gave the resident his PRN (as needed) Acetaminophen. The Nurse stated they had Oxycodone 5/325mg in the emergency medication kit but did not have Oxycodone 10/325mg. The Nurse continued and stated the resident did not say he was in pain and she did not call the doctor to let him know the medication was not available. Review of the nursing progress notes for Resident #41 revealed no information that the physician was notified of the Oxycodone not being available. On 6/17/21 at 10:17 AM an interview was conducted with Resident #41. When asked if he received his pain medications regularly the resident stated: "Sometimes they are out of it." The resident was asked what he said to the nurse when told they were out of his pain medications and he stated he said "Okay." When asked how much pain he had when he did not get his pain medications, Resident #4 stated: "Oh, intolerable" and stated his pain level went up to a "9-10." On a pain scale, 0 is no pain and 10 is unbearable pain. The resident was observed to be very stoic and did not complain about the facility not having his medication. On 6/17/21 at 10:50 AM, Resident #41 was interviewed in the presence of the Director of Nursing (DON). The DON asked the resident what his pain level was when he did not get his pain medication and the resident stated 8-9 and when he did get his pain medication his pain was 8-9. The Resident stated he had degenerative osteoarthritis and was very stiff and when he got the pain medication the pain was tolerable but	F 697	Development Coordinator, Assistant Director of Nursing, or Unit Manager determine that the Licensed Nurse did not take the appropriate follow up steps of notifying the Medical Doctor for further orders, the Licensed Nurse will be removed from the schedule by the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager until education provided by the Director of Nursing, Staff Development Coordinator or Assistant Director of Nursing to the Licensed Nurse as well as appropriate follow up including disciplinary action can be provided. Weekly during At Risk Meetings for a minimum of 12 weeks, the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will perform an audit reviewing the residents who are prescribed opioids for pain management to validate that pain management is provided to the residents who require such services, consistent with professional standards of practice, and the goals and resident preferences. The Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will contact the attending physician for any recommendations or follow up actions needed. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the	

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when he did not get the pain medication the pain was intolerable.

On 6/17/21 at 11:58 AM an interview was conducted with the resident's Physician who stated no one had called him about the resident's pain medication this month. The Physician further stated the resident was very stoic and did not complain about anything. The Physician continued and stated he had tried to educate the facility on not running out of medications and when he was in the facility, he tried to be proactive and ask the nurses if they need written prescriptions for any controlled medications. The Physician further stated they have a back-up pharmacy in town and if the nurse had called him, he could have called the prescription in to the pharmacy and the staff could have gone to pick it up. The Physician continued and stated the facility had an emergency medication kit and they could add any medication they wanted to the emergency kit.

On 6/18/21 at 10:29 AM the Physician stated in an interview that all prescriptions (including narcotics) could be done electronically in the state of North Carolina and he wrote prescriptions seven days a week.

On 6/18/21 at 12:11 PM the Director of Nursing stated in an interview that it was her expectation that the nurse notified the physician of any medication that was not available. The DON stated in this case, in order to obtain a narcotic medication for the resident from the emergency kit or from the back-up pharmacy, the physician would need to be called. The DON stated the Oxycodone 10/325mg was not a medication that was currently stocked in the emergency

results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.

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medication kit.

1b. Review of the June 2021 Medication Administration Record (MAR) for Resident #41 revealed the Oxycodone/Acetaminophen 10/325mg was scheduled to be given at 2:00 AM, 6:00 AM, 10:00 AM, 2:00 PM, 6:00 PM and 10:00 PM.
On June 7, 2021 there was a notation on the MAR for 10:00 AM, 2:00 PM and 6:00 PM that read: "Not Administered: Drug/Item Unavailable" and signed by Nurse #3. The only other pain medication on the MAR had a start date of 10/12/21 and was Acetaminophen 650mg every 4 hours as needed for pain.

On 6/17/21 at 7:58 AM an interview was conducted with Nurse #3 who stated when she started her shift Resident #41 had no Oxycodone on the cart and the pharmacy was supposed to deliver the medication the night before. The Nurse stated she called the pharmacy and was told they would bring the medication at lunch time and the medication was not delivered so she called the pharmacy back and the medication was delivered that night. The Nurse stated they have Oxycodone 5/325mg in their emergency medication kit but they did not have Oxycodone 10/325mg in the kit. The Nurse further stated the resident did not say he was in pain and she did not call the physician to let him know they were out of the resident's pain medication.

Review of the progress notes for Resident #41 revealed no documentation the physician was notified that the resident was out of the pain medication.

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On 6/17/21 at 10:17 AM an interview was conducted with Resident #41. When asked if he received his pain medications regularly the resident stated: "Sometimes they are out of it." The resident was asked what he said to the nurse when told they were out of his pain medications and he stated he said "Okay." When asked how much pain he had when he did not get his pain medications, Resident #4 stated: "Oh, intolerable" and stated his pain level went up to a "9-10." On a pain scale, 0 is no pain and 10 is unbearable pain. The resident was observed to be very stoic and did not complain about the facility not having his medication.

On 6/17/21 at 10:50 AM, Resident #4 was interviewed in the presence of the Director of Nursing (DON). The DON asked the resident what his pain level was when he did not get his pain medication and the resident stated 8-9 and when he did get his pain medication his pain was 8-9. The Resident stated he had degenerative osteoarthritis and was very stiff and when he got the pain medication the pain was tolerable but when he did not get the pain medication the pain was intolerable.

On 6/17/21 at 11:58 AM an interview was conducted with the resident's Physician who stated no one had called him about the resident's pain medication this month. The Physician stated the resident was very stoic and did not complain about anything. The Physician stated he had tried to educate the facility on not running out of medications and when he was in the facility, he tried to be proactive and ask the nurses if they need written prescriptions for any controlled medications. The Physician further stated they have a back-up pharmacy in town and if the

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F 697	Continued From page 14 nurse had called him, he could have called the prescription into the pharmacy and the staff could have gone to pick it up. The Physician continued and stated the facility had an emergency medication kit and they could add any medication they wanted to the emergency kit. On 6/18/21 at 10:29 AM the Physician stated in an interview that all prescriptions (including narcotics) could be done electronically in the state of North Carolina and he wrote prescriptions seven days a week. On 6/18/21 at 12:11 PM the Director of Nursing stated in an interview that it was her expectation that the nurse notified the physician of any medication that was not available. The DON stated in order to obtain a narcotic medication for the resident from the emergency medication kit or from the back-up pharmacy, the physician would need to be called. The DON stated the Oxycodone 10/325mg was not a medication that was currently stocked in the emergency medication kit.	F 697		
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. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755		8/2/21

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F 755	Continued From page 15 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 record review, resident, staff, Pharmacist and Medical Doctor (MD) interviews, the facility failed to follow the facility's system for obtaining medications resulting in missed doses for 1 of 3 residents reviewed for unnecessary medications (Resident #43). Findings included: Resident #43 was admitted to the facility on 1/5/2021 with diagnoses that included hypertension and anxiety disorder. A review of Resident #43's medical record revealed a physician's order dated 1/29/2021 for Clonazepam 0.5 milligrams(mg) three times a day/every eight hours by mouth for anxiety.	F 755	F755 Pharmacy Services E 1. Resident #43 is currently receiving medication as prescribed. On 6/22/21 Licensed Nurse #1 received a one to one educational in-service by the Director of Clinical Consulting on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. 2. Residents prescribed medication by the Medical Doctor have been identified as having the potential to be affected. On 7/16/21 a Medication Administration Record to Medication Cart audit was performed by the Nurse Supervisor on	

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A review of the Admission Minimum Data Set (MDS) Assessment dated 4/13/2021 revealed Resident #43 was cognitively intact. The MDS revealed Resident #61 received an antianxiety medication for 7 days during the assessment look back period.

The resident's Care Plan last reviewed on 4/13/21 revealed a focus area of psychotropic drug use for treatment of anxiety. The interventions included the following: Administer medication as ordered, monitor resident's mood and response to medication, Monitor for drug use effectiveness and adverse consequences.

On 6/14/21 at 3:49 PM an interview was conducted with Resident #43. The resident stated she took Clonazepam and did not receive the medication for 4 days in May and June. Resident #43 stated she was told the medication did not come in or that staff forgot to order it. Resident #43 stated she had a history of anxiety and panic attacks but did not experience any increased anxiety the days she did not receive the Clonazepam.

1a. Review of the resident's Medication Administration Record (MAR) for April 2021 revealed that the Clonazepam 0.5 mg was scheduled to be given at 6:00 AM to 8:00 AM, 2:15 PM to 4:00 PM, 10:00 PM to 11:00 PM. On April 26, 2021 there was notation on the MAR for 5:28 PM and 11:23 PM that read: "Not Administered: Drug/Item Unavailable." On April 27, 2021 there was notation on the MAR for 9:58 AM and 2:51 PM the read: "Not Administered: Drug/Item Unavailable. A total of 4 doses were documented as not administered in April 2021. Nurse #1 signed the MAR on 4/26/21 and noted

each Medication Cart to validate prescribed medication was readily available. There were no concerns noted as a result of this audit.
3. On 6/22/21 the Director of Clinical Consulting educated the Licensed Nurses on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. On 7/16/21 the Pharmacist educated the Licensed Nurses on medication re-ordering in a timely manner, administering medications as prescribed, notifying the Medical Doctor if medications are not readily available and use of the back-up pharmacy, if indicated. Beginning 7/17/21 no Licensed Nurse will be permitted to work without first having received the preceding education.
4. Five times weekly for 12 weeks in Clinical Morning Meeting the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will perform an audit reviewing the Medication Availability / Unavailability. If medication is indicated as unavailable, the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager will validate the Medical Doctor was notified and appropriate follow up action was initiated. If the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager determine that the Licensed Nurse did not take the appropriate follow up steps of notifying the Medical Doctor for further

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F 755	Continued From page 17 the medication was not available. The nurse that signed the MAR on 4/27/21 was not available for interview. Review of the nursing progress notes for Resident #43 revealed no information that the physician was notified of the Clonazepam not being available. On 6/16/21 at 5:31 PM an interview was conducted with Nurse #1. The nurse stated that sometimes Resident #43's Clonazepam "gave out" and she called the physician to make him aware. The nurse stated the process was to notify the physician, then call pharmacy to see if the resident had any refills on the prescription. The nurse further stated the physician was made aware that a prescription needed a refill if there were none. Nurse #1 stated that she called the physician and pharmacy to reorder the medication and expected it to arrive with the next medication delivery. 1b. Review of the resident's Medication Administration Record (MAR) for May 2021 revealed that the Clonazepam 0.5 mg was scheduled to be given at 6:00 AM to 8:00 AM, 2:15 PM to 4:00 PM, 10:00 PM to 11:00 PM. On May 30, 2021 there was notation on the MAR for 12:03 AM, 6:29 AM, and 4:50 PM that read: "Not Administered: Drug/Item Unavailable. On May 31, 2021, there was notation on the MAR for 12:20 AM, 6:20 AM, 4:39 PM that read: "Not Administered: Drug/Item Unavailable." A total of 6 doses were documented as not administered in May 2021. The nurse that signed the MAR on 5/30/21 was not available for interview. Nurse #1 signed the MAR on 5/31/21 and noted the medication was not available for two doses.	F 755	orders, the Licensed Nurse will be removed from the schedule by the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Unit Manager until education provided by the Director of Nursing, Staff Development Coordinator or Assistant Director of Nursing to the Licensed Nurse as well as appropriate follow up including disciplinary action can be provided. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.	

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Review of the nursing progress notes for Resident #43 revealed no information that the physician was notified of the Clonazepam not being available.

On 6/16/21 at 5:31 PM and interview was conducted with Nurse #1. The nurse stated that sometimes resident #43's Clonazepam "gave out "and she called the physician to make him aware. The nurse stated the process was to notify the physician, then call pharmacy to see if the resident has any refills on the prescription. The nurse further stated the physician was made aware that a prescription needs a refill if there are none. The nurse stated she followed up with the pharmacy to have the medication refilled expected it to arrive with the next medication delivery.

1c. Review of the resident's Medication Administration Record (MAR) for June 2021 revealed that the Clonazepam 0.5 mg was scheduled to be given at 6:00 AM to 8:00 AM, 2:15 PM to 4:00 PM, 10:00 PM to 11:00 PM. On June 1, 2021 there was notation on the MAR for 5:25 AM, 6:50 AM, and 4:42 PM that read: "Not Administered: Drug/Item Unavailable." On June 2, 2021 there was notation on the MAR for 9:58 AM and 2:51 PM the read: "Not Administered: Drug/Item Unavailable. A total of 5 doses were noted as not available in June. Nurse #1 signed the MAR on 6/1/21 and noted the medication was not available for two doses. The nurse that signed the MAR on 6/2/21 was not available for interview.

Review of the nursing progress notes for Resident #43 revealed no information that the

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physician was notified of the Clonazepam not being available.

On 6/16/21 at 5:31 PM and interview was conducted with Nurse #1. The nurse stated that sometimes resident #43's Clonazepam "gave out" and she called the physician to make him aware. The nurse stated the process was to notify the physician, then call pharmacy to see if the resident has any refills on the prescription. The nurse further stated the physician was made aware that a prescription needs a refill if there are none. The nurse stated she followed up with the pharmacy to have the medication refilled and expected it to arrive with the next medication delivery.

On 6/17/21 at 10:44 AM an interview was conducted with the Pharmacist. The Pharmacist stated that medications are to be reordered 2 days prior to them running out. The Pharmacist stated medication refills can be called in or sent electronically and scheduled narcotic medications require a call from the prescribing physician. The Pharmacist further stated medication refills must be in by 5:30 PM for the medications to be received the next day. The Pharmacist added that the facility did have a backup pharmacy to ensure medications were available.

On 6/18/21 at 12:58 PM an interview was conducted with the Director of Nursing (DON). The DON stated she expected that the nurse notified the physician of any medication that was not available. The DON stated Clonazepam 0.5 mg was not currently stocked in the emergency kit. The DON started at the facility on 6/18/21 and was unfamiliar with the missed doses for Resident #43

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F 755	Continued From page 20 . On 6/18/21 at 10:29 AM an interview was conducted with the resident's physician. The Physician stated he had been notified after the medication was out. The Physician stated that the missed doses had not negatively affected Resident #43 and the facility had attempted to do a gradual dose reduction of the medication which the resident refused. The Physician further stated all prescriptions (including narcotics) could be done electronically in the state of North Carolina and he wrote prescriptions seven days a week and the facility should have contacted him to write a prescription for the Clonazepam before she ran out. He would have expected the medication to be given as ordered.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to have a medication error rate of less than 5 percent as evidenced by 2 medication errors out of 26 opportunities for error resulting in a medication error rate of 7.69 percent for 2 of 5 residents observed during medication pass (Resident #18 and #17). The findings included: 1. Resident #18 was admitted to the facility on 11/12/17 and had a diagnosis of glaucoma.	F 759	F759 Medication Error D 1. Resident #18 is currently receiving eye drops as directed according to the manufacturer's guidelines. Resident #17 is currently receiving gastric tube medications as directed, crushed, and administered individually with flushes per physician's orders. Licensed Nurse #1 received a one to one educational in-service by the Director of Clinical Consulting on administering eye drops per manufacturer's guidelines and physician's	8/2/21

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F 759	Continued From page 21 There was a physician's order dated 6/23/20 for Brimonidine eye drops 0.2% (percent) one drop in both eyes twice a day. There was also an order dated 6/23/20 for Timolol Maleate eye drops 0.5%, one drop in each eye twice a day. Both eye drops are used to treat glaucoma. The manufacturer's specifications for the use of Brimonidine eye drops read: "If you are using in combination with other eye drop medicine, wait 5-15 minutes before applying the second eye drop." On 6/16/21 at 8:10 AM, Nurse #1 was observed to administer the eye drops to Resident #18. The Nurse was observed to instill 1 drop of Brimonidine drops 0.2% in each eye. After one minute (timed) the nurse administered one drop of Timolol Maleate 0.5% in each eye. On 6/16/21 at 8:15 AM, Nurse #1 stated in an interview that she was supposed to wait 5 minutes between eye drops and she only waited about 10 seconds. On 6/17/21 at 8:09 AM the Staff Development Coordinator (SDC) stated in an interview the nurse was supposed to wait at least 5 minutes between the eye drops. On 6/18/21 at 11:52 AM the Director of Nursing stated in an interview that the nurse did not wait long enough between the two eye drops and she expected the nurse to wait the appropriate amount of time between eye drops. 2. Resident #17 was admitted to the facility on	F 759	orders and on individually crushing and administering gastric tube medications and flushes per physician's orders. 2. Residents with prescribed medications have the potential to be affected. 3. On 6/22/2021 Certified Medication Aides and Licensed Nurses were educated by the Director of Clinical Consulting on administering eye drops per manufacturer's guidelines and physician's orders. On 6/22/2021 Licensed Nurses were educated by the Director of Clinical Consulting on individually crushing and administering gastric tube medications and flushes per physician's orders. On 7/16/2021 Certified Medication Aides and Licensed Nurses were educated by the Pharmacist on administering eye drops per manufacturer's guidelines and physician's orders. On 7/16/2021 Licensed Nurses were provided educational materials by the Pharmacist on individually crushing and administering gastric tube medications and flushes per physician's orders. 4. The Director of Clinical Consulting, Pharmacy Nurse Consultant, Staff Development Coordinator, Assistant Director of Nursing, Unit Manager or Director of Nursing will perform observation audits on medication administration of three residents who received their medication via gastric tubes weekly for 12 weeks, observing administering medications per physician's order, to include individually crushing medications and flushing medications appropriately. The Director of Clinical	

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F 759	Continued From page 22 8/23/19 and had a diagnosis of dementia, pressure ulcers and nutritional deficiency. There was a physician's order dated 1/30/21 for Vitamin C 500 milligrams (mg) per gastric tube twice a day. Vitamin C is a dietary supplement and often ordered to enhance wound healing. There was a physician order dated 1/30/21 for Memantidine 10mg per gastric tube twice a day. Memantidine is a medication used to slow the progression of moderate-to-severe Alzheimer's Disease (dementia). There was also an order dated 1/30/21 for Zinc Sulfate 220mg per gastric tube twice a day. Zinc is a dietary supplement used to treat zinc deficiency. Zinc is important for growth and development of healthy body tissues and is often used in the treatment of pressure ulcers (bed sores). On 6/16/21 at 8:25 AM, Nurse #1 was observed to prepare medications for Resident #17. The nurse was observed to prepare Vitamin C 500mg 1 tablet, Memantidine 10mg 1 tablet and Zinc Sulfate 220mg 1 tablet and place each tablet in the same medicine cup. The nurse then emptied all 3 pills into a pouch and crushed the medications. The nurse emptied the crushed medications into a cup and added 100ccs of water to the crushed medications and stirred the mixture to dissolve the medications. The nurse was observed to disconnect the tubing and insert a catheter tip syringe into the feeding tube and flushed with 30 ccs (cubic centimeters) of water and poured the medication mixture in the feeding tube and flushed the feeding tube with 30ccs water. On 6/16/21 at 3:00 PM an interview was conducted with Nurse #1 who stated she was	F 759	Consulting, Pharmacy Nurse Consultant, Staff Development Coordinator, Assistant Director of Nursing, Unit Manager or Director of Nursing will perform observation audits on three licensed nurses and one Medication Aid per week for 12 weeks to observe administration of eye drops per manufacturer's guidelines and physician's order. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.	

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F 759	Continued From page 23 trained to crush the medications and mix with water and put the mixture down the feeding tube. The Nurse stated she was never trained to give each medication individually. On 6/17/21 at 8:12 AM the Staff Development Coordinator stated in an interview, the gastric tube medications should have been crushed individually and given separately and flushed with 5ccs of water between each medication. On 6/18/21 at 11:52 AM the Director of Nursing stated in an interview it was her expectation that each medication should be given individually with 5ccs water flush between each medication.	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		8/2/21

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F 761	Continued From page 24 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to store unopened insulin in the refrigerator, failed to discard expired medications, failed to date medications when opened, failed to properly store intravenous medications and failed to store refrigerated medications at temperatures specified by the manufacturer for 2 of 3 medication carts (Station 2 and Station 1) and 2 of 3 medication refrigerators (Station 3). The facility also failed to store medications appropriately by leaving medications in resident's rooms for 2 of 2 residents observed with medications in their rooms (Resident #37 and #63). The findings included: 1. On 6/17/21 at 3:34 PM an observation of the medication cart at Station 2 was made with Nurse #5. There was one unopened bottle of Levemir Insulin stored on the medication cart. The Levemir Insulin was dispensed by the pharmacy on 6/15/21. The label on the insulin said to refrigerate until opened. There was also one bottle of Lispro Insulin stored on the medication cart that had not been opened and was dispensed by the pharmacy on 6/5/21. The label on the bottle said to store the medication in the refrigerator until opened. During the observation, Nurse #5 stated she did not know who put the insulin on the cart or how long it had been on the medication cart. The Nurse further stated that	F 761	F761 Medication Storage and Labeling E 1. Residents #37 and #63 do not have medications stored in their respective rooms. 2. Residents receiving prescribed medications have been identified as having the potential to be affected. Unopened insulin is currently being stored in the medication refrigerators. Expired medications have been discarded and re-ordered as needed. Opened medications have been dated as indicated. Intravenous medication is being stored properly. Refrigerator medications are being stored at the appropriate temperature. 3. On 6/22/2021 the Director of Clinical Consulting in-serviced the Certified Medication Aides and Licensed Nurses on medication storage, including storage of medication in resident rooms, storage of unopened insulin, storage of expired medications, storage of temperature controlled medications, storage of intravenous medications, and dating medications as appropriate. 4. Weekly for a minimum of twelve weeks the Director of Clinical Consulting, SDC, ADON, UM or DON will audit each medication cart, each medication room and seek permission to observe one random resident room on each nursing	

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F 761	Continued From page 25 unopened insulin was supposed to be stored in the refrigerator. On 6/17/21 at 12:03 PM the Director of Nursing stated in an interview it was her expectation that the staff follow the manufacturer's guidelines. 2. Review of the manufacturer's package insert for Humulog Insulin revealed that once opened the vial should be thrown away after 28 days. On 6/17/21 at 3:46 PM the medication cart at Station 1 was inspected with Nurse #3. There was a bottle of Humulog Insulin that was dated as opened on 5/17/21. Nurse #3 stated the resident whose name was on the vial had received the insulin that AM. The Nurse further stated that Humulog Insulin was good for 30 days after it was opened. An interview was conducted with the Director of Nursing (DON) on 6/18/21 at 12:03 PM. The DON stated the medication was good for 28 days after it was opened and if opened on 5/17/21, the medication expired on June 14, 21. The DON further stated the medication should have been discarded per manufacturer's guidelines. 3. On 6/16/21 at 7:40 AM 2 bags of intravenous fluids (IV), one with a vial of antibiotic attached and ready to mix when needed and another bag of IV fluids premixed with an antibiotic were observed lying on top of the medication cart. There was no staff observed in the area at the time. At 7:50 AM Nurse #1 approached the cart to pass medications. The 2 bags of IV fluids with medications remained on top of the medication cart during the medication pass for 2 residents during which the nurse was in the residents' room	F 761	unit to validate medications are stored appropriately per manufacturer's guidelines to include observation of storage of unopened insulin, storage of expired medications, storage of temperature controlled medications, storage of intravenous medications, and dating medications as appropriate. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.	

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with the door closed and was unable to monitor the medication cart.
On 6/16/21 at 8:15 AM at the completion of the medication pass observation, an interview was conducted with Nurse #1. The Nurse stated she took the bags of IV medications out of the refrigerator that morning to give to a resident later in the morning. The Nurse was observed to remove the 2 IV bags and place in the bottom drawer of the medication cart.

On 6/17/21 at 8:09 AM an interview was conducted with the Staff Development Coordinator who stated that medications should not be left on top of the medication cart and that anyone walking by the cart could pick up the medication including a resident.

On 6/18/21 at 12:01 PM the Director of Nursing stated in an interview that medications should be locked in the medication cart.

4. The facility policy dated September 2018 and titled Medication Storage under number 11 noted that medications that required "refrigeration" or temperatures between 36 degrees Fahrenheit and 46 degrees Fahrenheit were to be kept in a refrigerator with a thermometer to allow temperature monitoring. A temperature log or tracking mechanism was to be maintained to verify that the temperature has remained within accepted limits.

On 6/17/21 at 3:54 PM, observations were made of medication refrigerator #1 (black refrigerator) at Station 3 with Nurse #2. The temperature of refrigerator #1 was confirmed by Nurse #2 as being 32 degrees Fahrenheit. The refrigerator temperature log taped to the front of the

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refrigerator noted to keep the refrigerator temperature at 36-41 degrees Fahrenheit and if not to contact maintenance immediately. It was noted on the temperature log that only maintenance was authorized to adjust refrigerator settings. The Refrigerator Temperature Log noted the temperature of the refrigerator on 6/14 and 15/21 was 30 degrees Fahrenheit and on 6/16/21 was 32 degrees Fahrenheit. There were 7 boxes of Novolog 70/30 insulin mix with 5 insulin pens in 6 of the boxes and 3 insulin pens in one box. Directions on the insulin boxes said to refrigerate at 36-46 degrees Fahrenheit. Do not freeze.

On 6/17/21 at 4:10 PM an interview was conducted with the Unit Manager who stated if the refrigerator temperature was out of range they were supposed to make sure there were no vaccines in the refrigerator and to adjust the temperature and recheck and if the temperature was still not in range, notify maintenance to check the refrigerator.

On 6/17/21 at 4:17 PM an interview was conducted with the Nurse #5 that initialed the refrigerator temperature log on 6/14,15 and 16/21. The Nurse stated the refrigerator temperature was supposed to be over 32 degrees Fahrenheit. The Nurse further stated on one of those nights he noted the temperature was 30 degrees Fahrenheit when he removed medication for a resident from the refrigerator. The Nurse stated when he checked the refrigerator again the temperature was greater than 32 degrees Fahrenheit.

On 6/18/21 at 11:52 AM the Director of Nursing (DON) stated in an interview that if the refrigerator temperature was out of range, the

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medications were to be moved to a refrigerator that was the correct temperature. The DON further stated the refrigerator temperature should be adjusted and rechecked and if still not in range, maintenance was to be notified and the refrigerator replaced.

5. On 6/17/21 at 4:05 PM an observation of Refrigerator #2 (white refrigerator) at Station #3 was made with Nurse #2. The temperature was verified by Nurse #2 as being 28 degrees Fahrenheit. On 6/16/21 the temperature was recorded as 34 degrees Fahrenheit. The refrigerator contained 3 vials of Purified Protein Derivative (PPD) that is used to do a skin test for tuberculosis. The box in which the vials of PPD was stored noted the medication was to be stored at 35-46 degrees Fahrenheit. Do not freeze. Also stored in the refrigerator were 2 injectable Victoza pens, a medication used to reduce blood sugar. The package insert for Victoza gave directions to store in a refrigerator at 36-46 degrees Fahrenheit before opening. There were 2 boxes of Humulog Insulin 70/30 mix containing 5 insulin pens in each box. The box gave instructions to store the insulin at 36-46 degrees Fahrenheit. Do not freeze.

The temperature log lying on top of the refrigerator noted the refrigerator temperature must be kept between 36-41 degrees Fahrenheit and if not contact maintenance immediately. It was noted on the log that only maintenance was authorized to adjust refrigerator settings.

On 6/17/21 at 4:10 PM an interview was conducted with the Unit Manager who stated if the refrigerator temperature was out of range they

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were supposed to make sure there were no vaccines in the refrigerator and to adjust the temperature and recheck and if the temperature was still not in range, notify maintenance to check the refrigerator.

On 6/17/21 at 4:17 PM an interview was conducted with the Nurse #5 that initialed the refrigerator temperature log on 6/16/21 and was recorded as 34 degrees Fahrenheit. The Nurse stated the refrigerator temperature was supposed to be over 32 degrees Fahrenheit and the temperature was 34 degrees Fahrenheit.

On 6/18/21 at 11:52 AM the Director of Nursing (DON) stated in an interview that if the refrigerator temperature was out of range, the medications were to be moved to a refrigerator that was the correct temperature. The DON further stated the refrigerator that the temperature was out of range should be adjusted and rechecked and if still not in range, maintenance was to be notified and the refrigerator replaced.

6. The package insert for Purified Protein Derivative (PPD) noted a vial that had been entered and in use for 30 days should be discarded.

On 6/17/21 at 4:05 PM an observation of Refrigerator #2 (white refrigerator) at Station #3 was made with Nurse #2. There was one vial of Purified Protein Derivative (PPD) that was opened and not dated. The vial was approximately one half full. Nurse #2 stated she did not know who opened the vial of PPD or when it was opened.

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The Director of Nursing stated in an interview on 6/18/21 at 12:03 PM that PPD should be dated when opened and was good for 30 days once opened.

7. During an observation on 6/14/21 at 10:05AM, a tube of zinc oxide was seen on the bedside table in the room of Resident #37.

Resident #37 was admitted to the facility on 3/31/20.

A quarterly Minimum Data Set (MDS) assessment conducted 4/19/21 revealed Resident #37 was cognitively intact.

Review of the physician order dated 1/29/21 revealed an order for zinc oxide to be applied to the upper right inner thigh near brief line and sacrum to redness twice a day.

During an interview with the Corporate Compliance Nurse (CCN) on 6/14/21 at 2:40PM, she stated zinc oxide should not be at the resident's bed side but should be on the treatment cart.

A subsequent interview with the CCN on 6/15/21 revealed the nurse was responsible to administer the zinc oxide. She further stated there was no policy on self-administration of zinc oxide.

During an interview with the Director of Nursing (DON) on 6/17/21 at 2:15PM, she stated medications should not be at the resident's bedside.

8. During an observation on 6/14/21 at 10:06AM, a prescription of nystatin powder was on the bedside table in the room of Resident # 63.

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F 761	Continued From page 31 Resident #63 was admitted to the facility on 1/4/21. A quarterly MDS assessment dated 5/4/21 revealed Resident #63 was severely cognitively impaired. Review of the physician order dated 1/4/21 revealed an order for nystatin powder to by applied twice a day to skin folds. During an interview with Nurse #1 on 6/14/21 at 1:13PM, she stated the nystatin powder should not be in the resident's room. Nurse #1 removed the nystatin and returned it to the medication cart. An interview with the DON on 6/17/21 at 2:15PM revealed medications should not be at the bedside.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F 880		8/2/21

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reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the

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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 880	Continued From page 33 corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, policy review and staff interview the facility failed to disinfect a glucometer per manufacturer's specifications for 1 of 3 observations (Resident #18) and failed to follow infection control practices by handling a resident's pills during medication pass for 1 of 5 residents observed during medication pass (Resident #36). The facility staff also failed to wear PPE (Personal Protective Equipment) according to the facility policy when entering two isolation rooms and failed to sanitize their hands between the two rooms where residents were under enhanced droplet precautions. (Resident #36, Resident #56) The findings included: 1. The facility policy effective 11/4/19 titled Glucometer Cleaning and Disinfecting noted the purpose was "To minimize the risk of transmitting blood-borne pathogens, cleaning and disinfection procedure should be performed." The Policy Statements read: The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfection procedure. The disinfection procedure is needed to prevent the transmission	F 880	F880 Infection Control E 1. The glucometers are being properly disinfected after use. On 6/22/21 Licensed Nurse #1 was provided a one to one educational in-service by the Director of Clinical Consulting regarding storing and disinfecting glucometers. Medication Cups are being utilized to administer Resident #36's oral medications. On 6/16/2021 and 6/22/21 Licensed Nurse # 2 was provided a one to one educational in-service by the Director of Clinical Consulting regarding proper administration of oral medication, not touching medication with the bare hand. On 6/22/21 Housekeeper #1 was provided a one to one educational in-service by the Director of Clinical Consulting regarding adhering to the Enhanced Droplet Precaution sign for donning PPE when entering the room with the signage and preforming handwashing when exiting the room. 2. Residents residing in the facility have the potential to be affected. 3. On 6/22/21 Licensed Nurses and Certified Medication Aides were educated by the Director of Clinical Consulting	

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F 880	Continued From page 34 of blood-borne pathogens." Under Guidelines the policy read:" 1. Always wear the appropriate protective gear, including disposable gloves. 2. Clean the outside of the blood glucose meter with a lint-free cloth dampened with soapy water or isopropyl alcohol to remove dirt, blood or other body fluids. 3. Disinfect by using a commercially available EPA (Environmental Protection Agency)-registered disinfectant detergent or germicide wipe. 3a. Open disinfectant package. Follow product label instructions to disinfect the meter. Allow to air dry." Resident #18 was admitted to the facility on 11/12/17 and had a diagnosis of type 2 diabetes mellitus. There was a physician's order dated 3/25/21 to perform finger stick blood sugars before meals and at bedtime. On 6/16/21 at 7:50 AM, Nurse #1 was observed to perform a finger stick blood sugar on Resident #18. The nurse returned to the medication cart, removed the glucometer from her pants pocket, donned gloves and removed a "bleach" wipe from a cannister and wiped down the glucometer for approximately 10-15 seconds. The nurse then placed the glucometer on the top of the medication cart, removed the gloves and disposed of the gloves and the wipe in the trash. On 6/16/21 at 8:15 AM Nurse #1 was asked about the cleaning procedure for the glucometer. The Nurse stated she did not count how long she cleaned the glucometer but wiped it down real good with a bleach wipe and let it air dry. The bleach wipes cannister noted to wipe the surface until completely wet and wait for the contact time of 3 minutes for all pathogens.	F 880	regarding storing and disinfecting glucometers. On 6/22/21 Licensed Nurses and Certified Medication Aides were educated by the Director of Clinical Consulting regarding proper administration of oral medication, not touching medication with the bare hand and to adhere to infection control practices during medication administration. On 6/22/21 all staff education was provided by the Director of Clinical Consulting regarding adhering to the NC Statewide Program for Infection Control and Epidemiology (SPICE) Enhanced Droplet Precaution Signage for donning PPE when entering the room with the signage and preforming handwashing when exiting the room. On 7/14/21 Licensed Nurses and Certified Medication Aides were educated by the Infection Preventionist using the Center of Disease Control Video on Keep Covid-19 Out! related to not touching medication with bare hands and adhering to infection control practices during medication administration pass. On 7/14/21 Licensed Nurses and Certified Medication Aides were educated by the Infection Preventionist using the Center of Disease Control Video on Inside Infection Control – the difference between cleaning and disinfection (for glucometer cleaning). On 7/14/21 all staff education was provided by the Infection Preventionist using the Center of Disease Control Video on Covid-19 Demonstration of Donning Personal Protective Equipment and Center of Disease Control Video on Covid-19 Prevention Messages for	

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F 880	Continued From page 35 On 6/17/21 at 8:39 AM an interview was conducted with the staff development coordinator (SDC). The SDC stated the glucometer was to be cleaned by manufacturer's instructions and they used a germicidal wipe that had to be in contact with the meter for 3 minutes. The SDC stated residents in the facility did not have their own glucometer but there were 2 glucometers on each medication cart. The SDC further stated they currently did not have any residents in the facility with blood borne pathogens. On 6/18/21 at 11:52 AM the Director of Nursing (DON) stated in an interview it was her expectation the nurse follow the manufacturer's guidelines and at this facility it was for the meter to be in contact with the germicidal wipe for 3 minutes. The DON further stated the nurse should not have put the glucometer in her pocket for infection control purposes. The DON stated they did not currently have any residents with known blood borne pathogens in the facility. 2. The facility's Medication Administration policy dated 2007 did not specifically address a procedure for removing medications from the medication punch cards but did talk about breaking tablets and to avoid hand contact with the tablet. Resident #36 was admitted to the facility on 2/27/19 and had a diagnosis of tremors, hypertension, seizures, diabetes mellitus and depression. On 6/16/21 at 9:00 AM, Nurse #2 was observed to prepare medications for Resident #36. The nurse was observed to remove a medication card containing Amantadine 100mg (milligrams) and	F 880	Frontline Long-Term Care Staff Clean Hands – Combat Covid-19. 4. Twice weekly for a minimum of twelve weeks the Director of Clinical Consulting, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing or Unit Manager will observe one finger stick blood sugar per nursing unit to validate the glucometer is disinfected per manufacturer's guidelines and stored appropriately. The Staff Development Coordinator or Director of Nursing will present the result of the twice weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. Weekly for a minimum of twelve weeks the Director of Clinical Consulting, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing or Unit Manager will observe medication administration pass by at minimum one Licensed Nurse or Medication Aid per nursing unit to validate oral medications are not touched with the bare hand and infection control is maintained during medication administration. The Staff Development Coordinator or Director of Nursing will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance	

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F 880	Continued From page 36 punched out one tablet into her bare hand and then put in a medication cup. The Nurse was observed to use the computer mouse to scroll down on the computer screen and then used her hands to look through the medication cards to find Amlodipine 5mg and punched the medication out into her bare hand and placed the medication into a medication cup. The nurse again used the computer mouse to scroll down the computer screen for the next medication. The nurse was observed to use her hands to look through the medication cards in the drawer of the medication cart to find Keppra 500mg and punched out one tablet into her bare hand and then placed the Keppra in the medication cup. The nurse used the computer mouse to scroll down the computer screen for the next medication and then used her hands to look through the medication cards in the drawer of the medication cart to find Metformin 500mg and punched out 1 tablet into her bare hand and put the pill in the medication cup. The nurse then looked through the cards to find Escitalopram 5mg and punched one tablet into her bare hand and put in the medication cup. On 6/16/21 at 9:20 AM an interview was conducted with Nurse #2. The Nurse stated she should not have put the medications in her hand and proceeded to demonstrate the "correct" way by placing the punch card over the medication cup and punching out the medication directly into the medication cup. When asked why she punched the medications out into her hand during the medication pass, the Nurse stated she was nervous. The Nurse further stated she should not have put the medications in her hands because it was an "infection control issue with possible cross contamination."	F 880	Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. Five times a week for a minimum of twelve weeks the Director of Clinical Consulting, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, Unit Manager, Housekeeping Supervisor or NHA will observe staff entering a resident room, of a resident who is on Enhanced Droplet Precautions, to validate staff are adhering to the Enhanced Droplet Precaution signage for donning Personal Protective Equipment (PPE) when entering the room with the Enhanced Droplet Precaution signage and that staff are preforming handwashing when exiting the room. The Director of Nursing, Staff Development Coordinator, Housekeeping Supervisor or NHA present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making recommendations as needed, to assure compliance is sustained ongoing. The NHA and DON are responsible for the execution of the plan of correction.	

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On 6/17/21 at 8:09 AM the Staff Development Coordinator stated in an interview the nurse should not have put the medications in her hand and it was an infection control issue.

3. A review of the facility policy titled, "Isolation-Categories of Transmission Based Precautions, revised October 2018, under Contact Precautions, bullet #4, reads as: "Staff and visitors will wear gloves when entering the room. Gloves will be removed, and hand hygiene performed before leaving the room. #5 Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room.

Resident #56 was admitted to the facility on 5/26/21 from the hospital. Covid-19 test performed on 5/26/21 revealed Resident #56 was negative for the virus.

During an observation of the new admission unit on 6/14/21 at 10:49 AM Housekeeper #1 was observed entering the new admission unit through the closed isolation zippered door. The sign on the zipper wall read "Isolation unit, no admission." An enhanced droplet-contact isolation sign was posted outside each room and a pocket bag that contained PPE (gowns and gloves) was hung on the door to Resident #56 ' s room. The enhanced droplet-contact isolation sign had the following instructions: "Perform hand hygiene, N95 (may use KN95), eye protection, gown when entering room, gloves when entering room." Housekeeper #1 approached Resident #56 ' s room and wore a face mask. She entered the room with clothing

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on a hanger and closed the door. She did not put on a gown or gloves before she entered the room. Resident #56 was observed in the room prior to when the housekeeper closed the door. Housekeeper #1 exited the room pushed the clean clothes rack down the hall. She did not perform hand hygiene when she exited Resident #1 ' s room. Housekeeper #1 was observed to leave the new admissions unit and enter the general population wing of the facility. Housekeeper #1 was observed to enter room #63 wearing the same facemask, she had clothing on a hanger and did not perform hand hygiene before she entered the room.

Housekeeper #1 was interviewed on 6/14/21 at 10:53 AM. She confirmed she had not worn a gown when she entered Resident #56's room. She stated as a housekeeper no one had told her she needed to wear a gown to hang clothing in a resident ' s closet. Housekeeper #1 stated "she should have used alcohol-based hand sanitizer." She revealed the facility did not need to tell her to use hand hygiene, as she knew to use hand hygiene when leaving a residents room.

On 6/17/21 at 11:21 AM the housekeeping/ laundry manager was interviewed. She stated all staff had been trained on infection control and she would retrain her staff.

On 06/17/21 at 4:24 PM The Director of Nursing (DON) was interviewed. She stated the staff had been In-serviced on PPE and to use hand hygiene when exiting a resident ' s room.

On 6/18/21 at 12:21 PM the Clinical Consultant provided documentation the facility had an AD HOC QAPI meeting on 6/11/21, identified and

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F 880	Continued From page 39 took action to ensure staff were performing hand hygiene and using PPE. The staff education took place on 6/11/21, this incident occurred on 6/14/21, after the training.	F 880		