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	345174	A. BUILDING _____ B. WING _____	C 03/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 02/09/23. Additional information was obtained offsite and onsite through 03/03/22. There were 6 allegations investigated. 2 of the 6 allegations investigated were substantiated and cited. Immediate Jeopardy was identified at: CFR 483. 12 at tag F600 at a scope and severity (K) CFR 483. 70 at tag F835 at a scope and severity (K) The tag F600 constituted Substandard Quality of Care. Immediate Jeopardy for F 600 began on 01/27/2022 and ended on 02/25/22. Immediate Jeopardy for F 835 began on 01/27/2022 and ended on 02/25/2022. A partial extended survey was conducted on 03/02/22.	F 000		
F 558 SS=G	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident,	F 558	Resident #2 was provided a wheelchair of	3/31/22

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

Electronically Signed | 03/27/2022

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F 558	Continued From page 1 staff, Therapy Director and Nurse Practitioner interviews the facility failed to provide a wheelchair that was the correct size to accommodate a resident for 1 of 3 residents reviewed for accommodation of needs (Resident #2). Resident #2 reported the wheelchairs were uncomfortable, felt too small, and sometimes painful which caused him to not want to get out of bed. The findings included: Resident #2 was admitted to the facility on 2/12/21 with diagnoses that included traumatic spinal cord dysfunction, quadriplegia, muscle weakness, and contracture to right hand. The quarterly Minimum Data Set (MDS) dated 9/7/21 indicated Resident #2 was cognitively intact and was total dependent with most activities of daily living (ADL). The MDS further indicated Resident #2 had an impairment on both upper and lower extremities. An interview conducted with Resident #2 on 2/9/21 at 1:00 PM revealed he did not have his own wheelchair and had been requesting one for several months. Resident #2 stated he did not like to get out of bed because the wheelchairs he was given by nursing staff were uncomfortable and felt too small. A phone interview conducted with Nurse Aide (NA) #3 on 2/9/22 at 1:45 PM revealed on 10/11/21 before Resident #2's outside of the facility appointment, she and other staff were unable to find a wheelchair with footrest and the resident was sent out in a high back wheelchair with no footrest with the Resident resting his right	F 558	correct size and comfort to accommodate his needs and preferences to transfer in/out of bed and to transport to appointments. Effective 3/31/22, the Director of Rehabilitation, Director of Nursing and Unit Manager visually observed and inspected all resident wheelchairs to ensure correct size and comfort to accommodate resident needs and preferences. Cognitively intact residents were interviewed to ensure chair is comfortable and allows for efficient mobility. Residents identified as needing more appropriate seating were referred to therapy for evaluation and appropriate transport equipment provided as necessary. All facility and agency nursing staff and therapy staff to be inserviced on how to identify inappropriate seating and reporting concerns to the licensed nurse who will notify the the Physician to obtain a Therapy evaluation referral to ensure accommodation of needs. This inservice will be completed by the Director of Nursing or the Unit Manager by 3-31-22. Newly hired facility and agency nursing and therapy staff will receive education during orientation. Effective 3/31/22, Therapy will conduct quarterly screens for appropriate transfer equipment for all residents requiring use of a wheelchair. Therapy will treat and make necessary recommendations as indicated. This will be overseen by the	

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F 558	Continued From page 2 leg over his left leg. A phone interview conducted with the Therapy Director on 2/10/22 at 9:35 AM revealed he did not recall what wheelchair Resident #2 was using on 10/11/21, but it should have been a bigger wheelchair seat with a high back and leg rest for both legs to support Resident #2 for his right-side weakness. It was revealed the therapy department had measured Resident #2 and sent multiple requests to Administrator #1 for Resident #2 to receive a chair that was appropriate for the resident since April 2021, but the facility had not filled the request. The Therapy Director further revealed Resident #2 had complained the wheelchairs nursing staff offered were uncomfortable and sometimes painful which caused him to not want to get out of bed. A phone interview with the Nurse Practitioner (NP) on 2/10/22 at 12:46 PM revealed Resident #2 had complained about not having a wheelchair that fit him comfortably since the NP had started working at the facility in March 2021. The NP stated Resident #2 would be more socially involved if he had a wheelchair that fit him right and was comfortable. A phone interview conducted with the prior Director of Nursing (DON) on 2/10/22 at 9:05 AM revealed she was made aware Resident #2 had an incident on 10/11/21. It was further revealed it was reported to the DON, Resident #2 was transported in a wheelchair without footrest and sustained an injury to his right ankle. The DON stated Resident #2 should have been in a wheelchair with footrest to both legs and expected for residents to be comfortable.	F 558	Director of Rehabilitation. The Director of Rehabilitation will submit a request to purchase form for any necessary equipment (for seating) to the Administrator. The Director of Nursing, Director of Rehabilitation, and/or Unit Manager will visually observe 5 residents using wheelchairs for proper seating. This observation will occur three times per week for twelve weeks. Residents identified as having needs for more appropriate seating will be referred to therapy for screening or evaluation and treatment as necessary. The Administrator or Director of Rehabilitation will report results of this monitoring to the Qaulity Assurance Process Improvement Committee monthly and will make adjustments to the plan as necessary to maintain compliance with reasonable accommodation of resident needs. Compliance date: 3-31-22	

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F 558	Continued From page 3 A phone interview conducted with Administrator #1 on 2/10/22 at 4:20 PM revealed Resident #2 did not have his own wheelchair because he rarely got out of bed and could not recall if therapy had given him a request for Resident #2 to receive his own chair prior to 10/11/21. Administrator #1 stated before he would order a new wheelchair for Resident #2 he would exhaust all efforts by finding a used chair or looking for one at a sister facility.	F 558		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.	F 580		3/31/22

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F 580	Continued From page 4 (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner, and Physician interviews the facility failed to notify the physician/medical provider when residents on the 200-hall missed all of their scheduled medications for 8:00 AM, 12:00 PM, and 2:00 PM on 1/29/22 for 9 of 11 sampled residents (Resident #5, Resident #7, Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14, and Resident #15). The findings included: Interview with Nurse #2 on 2/18/22 at 9:14 AM revealed the nurse scheduled for the 200 Hall on 1/29/22, (Nurse #5), never showed up for the	F 580	The cited deficiency for Resident #5, Resident #7, Resident #9, Resident #10, Resident #11, Resident #12, Resident #13, Resident #14 and Resident #15 could not be corrected due to the timeliness of the alleged deficient practice. The Director of Nursing (DON) and Unit Manager (UM) reviewed Medication Administration Records (MARs) from 3/1/22-3/27/22 to identify medications not documented as administered per physician orders and for notification to Medical Director (MD) and/or Nurse	

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F 580	Continued From page 5 7:00 AM through 3:00 PM shift. Nurse #2 stated she was not sure of the proper chain of command because there was no Director of Nursing (DON) at the time, so she called Administrator #1 and the Scheduler at 11:30 AM to notify them the Nurse #5 was still not in the building, and no one had been medicated on her assignment. Nurse #2 revealed no one came into the facility to pass medications to the 23 residents on the 200-hall on 1/29/22 for the entire first shift from 7:00 AM through 3:00 PM. Nurse #2 stated she did not notify the Nurse Practitioner (NP) or the Physician about the residents not receiving their medications. Interview with the Nurse Practitioner (NP) on 2/18/22 at 4:00 PM revealed staff did not report to her about 23 residents on the 200-hall missing their medications on 1/29/22 during the 7:00 AM to 3:00 PM shift. The NP stated she found out about it when Resident #15 told her on 1/31/22 she had missed some of her medications over the weekend. The NP revealed she notified Administrator #1 as well as the Physician about the residents missing medications on 1/29/22. A follow up interview with the NP on 2/21/22 at 12:57 PM revealed as far as she knew the facility had not called any on-call provider over the weekend to notify them of the missed medications for residents on the 200 Hall. The NP stated a medical provider should have been notified. Interview with the Physician on 2/20/22 at 7:14 PM revealed he had been notified of the residents on the 200 Hall missing their medications on 1/29/22 by the NP.	F 580	Practitioner (NP). MD/NP was notified as appropriate. Audit completed on 3/27/22. Effective 3/31/22, the Director of Nursing (DON) and/or Unit Manager (UM) provided education to current facility and agency Licensed Nurses and Medication Aides on medication administration per physician orders and documentation in the MAR. Education included the importance of notifying the MD/NP immediately when medications are not administered as ordered and receiving follow-up instructions and/or orders and completing documentation in the medical record. Newly hired facility and agency Licensed Nurses and Medication Aides will receive education upon hire and prior to working. The DON and/or UM will monitor the electronic MAR during daily (M-F) clinical meeting for medication administration compliance. Omissions will be validated with the Licensed Nurse or Medication Aide if the medication was actually not given or if medication was given and not documented accordingly. If medication was administered, a late entry will be completed by administering Licensed Nurse or Medication Aide. If medication was not administered, MD/NP notification will be verified through documentation in the medical record. If there is nothing confirming that the MD/NP was notified, notification will occur immediately by the DON or UM and follow-up instructions and/or orders obtained as appropriate. Reeducation and/or disciplinary action will	

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F 580	Continued From page 6 Interview with Administrator #1 on 2/21/22 at 4:14 PM revealed he had been notified of Nurse #5 not showing up to work on the 200 Hall on 1/29/22 by the Scheduler and he was told part of the hallway missed a medication pass. Administrator #1 also stated he did not know when the NP and Physician were notified of the missed medications, but he did believe they had been notified. Administrator #1 revealed he expected the NP and Physician would be called about the missed medications on 1/29/22 within 24 hours.	F 580	be provided for failure to notify MD/NP of medications not administered as ordered. The DON and/or UM will audit five (5) resident MARs for medication administration per physician orders and MD/NP notification for omissions. Monitoring will be completed at a frequency of five (5) times weekly for twelve (12) weeks. The DON will present results of monitoring to the Quality Assurance Process Improvement (QAPI) committee monthly and make changes to the plan as necessary to maintain compliance with notification to MD/NP for medications not administered as ordered. Compliance date: 3/31/22	
F 600 SS=K	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;	F 600		3/31/22

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F 600	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director and Nurse Practitioner interviews, the facility neglected to implement effective interventions to protect a resident from an unintentional overdose. There was a total of three incidents with Resident #1, the first incident occurred when staff found narcotic pain medication that was not prescribed by the facility Physician. Interventions were not implemented following the initial incident. On 1/27/22 a second incident occurred; Resident #1 was found with 16 bottles of medications not prescribed by the attending physician. On 2/3/22 Resident #1 experienced an unintentional overdose on narcotic pain medication from an outside source requiring two doses of the antidote Narcan (a medication used to treat narcotic overdose in an emergency), and the resident was transported to the hospital. This was for 1 of 3 residents reviewed for neglect. Immediate Jeopardy began on 01/27/22 when the facility neglected to protect Resident #1 from an unintentional overdose. Immediate Jeopardy was removed on 02/25/22 when the facility implemented an acceptable credible allegation on Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not Immediate Jeopardy to ensure education is completed and monitoring systems put in place are effective. Findings included: Resident #1 was admitted into the facility on 11/04/21 with diagnosis which included laryngeal	F 600	* Correction action for Residents # 1 and 4 were achieved on 2-24-22 and 2-11-22 , respectively. * The Director of Nursing (DON) completed questionnaires with all current facility and agency staff to determine if they had witnessed any suspicious drug-seeking activities or conversations to obtain illegal drugs or meds not prescribed by the Medical Director or if they had seen any pill bottles or unknow substances or residents self-medicating. This was completed by 2-24-22 by the DON and there were no reported instances. On 3-24-22, the Regional Director of Clinical Services (RDCS) completed an audit of all facility residents asking about the same issues as the DON did with the staff. This audit was conducted on residents with a BIMs of 10 or greater and there were also no other reported instances. * Measures put into place include: 1) on 2-24-22, the RDCS completed an audit identifying residents with a dx of psychoactive substance abuse and/or illegal drug abuse and of residents with reported behaviors of suspicious drug-seeking activities such as conversations with others to obtain illegal drugs or medications not prescribed to them by the facility MD. These residents were added to a monitoring form to ensure that their diagnosis is in the electronic medical record (EMR), a	

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F 600	Continued From page 8	F 600		

cancer, gastrostomy tube (G-tube), anxiety and depression.

Resident #1's quarterly Minimum Data Set (MDS) dated 01/07/21 revealed he was cognitively intact. Resident #1 answered during the pain assessment interview that he frequently experienced moderate pain. He was coded as receiving nutrition through a nasogastric or abdominal feeding tube. Resident #1 had received opioid medication on all 7 days during the look back period.

Resident #1's care plan initiated on 10/11/21 and revised on 12/01/22 revealed a focus area for pain. The goal was for Resident #1 to remain free from signs of pain such as grimacing, crying, moaning, or guarding through the next review date. Interventions included administer medications for pain and observe for ineffectiveness to physician. Encouraging the resident to request medication at the onset of pain and to monitor for any adverse side effects of the medication.

Resident #1 did not have a care plan related to self-medicating.

Resident #1's Medication Administration Record dated January 2022 revealed an order initiated on 11/05/21 for Oxycodone (opioid medication used for treatment of moderate to severe pain) 5 milligrams (mg) give 10 milliliters (ml) via G-tube every 6 hours as needed for pain. The discontinue date for the medication was 01/08/22. The review revealed a second order initiated on 01/08/22 for Oxycodone 5 mg/ml give 10 ml by mouth every 4 hours as needed for pain. The discontinue date for the medication was 01/31/22.

Behavior Monitor is in the EMR, appropriate care plan is implemented, behaviors noted on the MDS, MD/NP notified and the Administrator and DON are notified. This monitor is maintained by the DON
2) A monitor implemented ensuring that all newly admitted residents and/or their responsible party receive the Responsibility and Rules of Residency as it relates to drug use, medications other than those prescribed by the facility MD. This is an on-going monitor/checklist maintained by the admission director.
3) All staff inserviced by the DON and/or the Unit Manager (UM) and/or Administrator regarding what to do when/if a resident is observed with illegal drugs and/or medications not prescribed by their MD as well as drug-seeking or suspicious behaviors. This inservice was presented to all active staff starting 2-24-22 by the DON and or UM and/or Administrator and will be ongoing so that new facility and agency staff can be inserviced on day one of their employment by the DON and or UM.
4) On 2/28/22, the DON and/or Administrator began Monday-Friday (5 days/week)observational monitoring for suspicious drug-seeking activities or conversations to obtain illegal drugs or medications that are not prescribed by the Medical Director at the nursing home any for any signs of medication bottles, pills or other unknown substances or residents self-medicating. The results of this monitor was reviewed at the QAPI meeting on 3-24-22 and the QAPI team

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F 600	Continued From page 9 Resident #1's Medication Administration Record dated February 2022 revealed an order initiated on 01/31/22 for Oxycodone 10 (mg) tablet given via his G-tube every 4 hours as needed for moderate to severe pain. The instructions were to crush the medication and put it in Resident #1's G-tube. On 02/09/22 at 11:46 AM an interview was conducted with Nurse Aide (NA) #1. She stated there were 3 occasions where she found medication in Resident #1's room. She stated the first incident occurred in mid-January when she went into Resident #1's room and was asked by him to obtain an item from his bedside dresser. Once she opened the dresser, she saw 5-6 pills inside the dresser. The interview revealed she left the room and told Unit Manager #1 who went into the room and put the medication into a cup and removed them from the room. She stated most of the pills were pink, one was white, and one was yellow. NA#1 did not know what medications the pills were. She stated she and Unit Manager #1 had searched the resident's room after the pills had been removed and found no other medication. She stated Administrator #1 was not in the building the day of the first incident and the only person she reported what she found to was Unit Manager #1. On 02/09/22 at 11:24 AM an interview was conducted with Unit Manager #1. During the interview she stated in mid-January Nurse Aide #1 came to her and stated she had found a couple of pink pills which she later identified as Oxycodone in Resident #1's bedside dresser. She stated she went into the room with NA #1, and they placed the 5 to 6 pills into a cup. Unit	F 600	felt that the frequency of the rounding could be reduced to 3 times per week. 5) The DON and/or administrator began a monitor in which 5 random staff were interviewed daily (M-F) on what to do and how to respond to a situation in which illegal drugs or medications not prescribed to the resident were identified. This began on 2-28-22. The results of this monitor were reviewed by the QAPI team at the meeting on 3-34-22 and it was determined that the frequency would change so that 15 random staff per week would be interviewed instead of 5 random staff daily (M-F). * The results of the monitors described in Measures # 1, 2, 4, and 5 will be presented by the DON or the Administrator at the monthly QAPI meeting starting in April. These monitors will continue for a period of 3 months and longer as deemed appropriate by the QAPI team until compliance is achieved. * Compliance date: 3-31-22	

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Manager #1 stated she, and the former Director of Nursing disposed of the medication into the "drug buster" which is a device used to discard narcotic medication in the facility. The interview revealed after the first incident of finding medication in Resident #1's room in mid-January the facility was not monitoring the residents' visitors that came in the facility. She stated the new Director of Nursing was supposed to follow up on the incident, but she had left the facility after 3 days.

On 02/10/22 at 9:30 PM an interview was conducted with the former Director of Nursing. She stated she had been the DON for a 3-day period in mid-January. The DON stated she was asked by Unit Manager #1 to discard some medication found in Resident #1's room. She stated she did not go into Resident #1's room, notify the Administrator or notify the Nurse Practitioner of the medication being found.

On 02/10/22 at 4:30 PM an interview was conducted with the Nurse Practitioner (NP). The NP stated she remembered Resident #1 being found with medication on two occasions on 01/27/22 and 02/03/22. She stated she nor the Medical Director were notified of the first incident occurring in mid-January. The NP stated she wished someone had notified her of the first incident in mid-January so interventions could have been put into place sooner.

On 02/09/22 at 12:16 AM an interview was conducted with Administrator #1. During the interview he stated he was not told about the first incident of NA #1 finding medication in Resident #1's room in mid- January.

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Review of Resident #1's nursing progress notes from January 2022 revealed no notes regarding the incident.

Review of Resident #1's physician progress notes from January 2022 revealed no notes regarding the incident.

On 02/09/22 at 11:24 AM an interview was conducted with Unit Manager #1. During the interview she stated she was suspicious Resident #1 may have more medications in the room, so she told NA #1 next time the resident went out to an appointment to search his room. Unit Manager #1 stated on 01/27/22 while Resident #1 was out of the facility at an appointment NA #1 went into his room, opened his bedside dresser and saw some pink pills located in the dresser. Unit Manager #1 was notified, and they completed a thorough search of the resident's room finding a total of 16 bottles of medication including Morphine Sulfate (pain medication) and Valium (a benzodiazepine used to treat anxiety). She stated the former Director of Nursing kept a list of what was found in the bag in the residen's room, and they locked the medication in her office. The interview revealed the bottles of medications they found in his room were being prescribed from an outside provider. She stated she thought he was having someone go and pick up the medication for him and they were delivering it to the facility.

On 02/09/22 at 11:46 AM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated on 01/27/22 when Resident #1 was out of the facility at an appointment, and she went into the room with the Maintenance Director to search the room. She stated she opened his top drawer where she had previously found medication and

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saw some pink pills. She then went told Unit Manager #1 and Administrator #1 what she had found. The Administrator and Unit Manager #1 returned to Resident #1's room and began to search the room. They found a plastic bag that was located in the floor in his room that contained bottles of medications. NA #1 stated the Unit Manager had written down two pages worth of medication they had found in Resident #1's room.

On 02/09/22 at 12:16 AM an interview was conducted with the Administrator #1. The interview revealed on 01/27/22 NA #1 came to him and said she had found some medication in Resident #1's room. He stated the reason she was in Resident #1's room was because they were suspicious of the resident having medication and one of the nurses had asked NA #1 to search his room if he went out to an appointment. The Administrator stated the medication that was initially found in Resident #1's room was Valium and Oxycodone. He stated they had found a bag of medication on the resident's floor that contained medication bottles. The interview revealed they notified the Nurse Practitioner of what they had found, completed an inventory list of the medication found and locked the medication in the Director of Nursing's office. When Resident #1 returned to the facility he and the Nurse Practitioner had a conversation with Resident #1 and told him that he could not self-medicate while in the facility. Resident #1 was told the facility was going to hold onto the medication that was found in his room and what was in his drawer was destroyed.

On 02/10/22 at 4:30 PM an interview was conducted with the Nurse Practitioner (NP). The NP stated she remembered Resident #1 being

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found with medication in his room on 01/27/22. The interview revealed when she was notified of the incident on 01/27/22 she looked into the database for controlled substances and discovered Resident #1 was being prescribed the medication by his Oncologist, but she thought it was odd because the resident had no recent oncology appointments. On 01/27/22 she discussed with Resident #1 that he could not self-medicate or have the medication while in the facility. The NP stated she discussed with him that doing so could lead to death. She then notified the oncology office to stop prescribing the medication on 01/31/22. They then began urine drug screening on 01/27/22 which was positive for benzodiazepines which Resident #1 was not prescribed and negative for opiates, a medication he was receiving scheduled daily in the facility. Resident #1 was retested on 01/31/22 and 02/02/22 and was negative for both benzodiazepines and opiates. She stated she felt the nurses in the facility were not completing witnessed urine drug screening and it was reported Resident #1 was putting milk in his urine to skew the specimen.

Review of a Nurse Practitioner note dated 01/31/22 revealed Resident #1 was evaluated on this date for management of pain medication. The note revealed the resident was receiving a prescription of Valium from another provider. Resident #1 was also receiving the prescription Oxycodone from the same outside provider as well as his prescribed pain medication in the facility. The NP documented she had contacted the outside providers office and notified them that the facility would be providing Resident #1's pain medication prescriptions.

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On 02/09/22 at 11:46 AM an interview was conducted with Nurse Aide (NA) #1. NA #1 stated she went into Resident #1's room on 02/03/22 because his call light was on. She stated she entered the room and Resident #1 told her he wanted a shower cap. She stated she noticed he had a blanket on his lap that contained 20-25 pink pills. The interview revealed Resident #1 tried to cover the pills with his blanket when he saw NA #1 looking at them. She stated she also saw a cup with approximately 9 pink Oxycodone pills in the bottom of the cup and the liquid in the cup was clear. She stated she left the room to tell Unit Manager #1 what she had seen. They both went and got Administrator #1 before returning to the room. NA #1 stated when they reentered the room the resident was drinking from the cup with the medication in it and the liquid was pink in color because of the medication dissolving and he was also chewing on some pills. The Administrator removed the cup the resident was drinking from. She stated when they pulled the blanket back the pills were gone, and Resident #1 was trying to hide the medication underneath himself. The Unit Manager #1 notified the Medical Director who was in the building. She stated Resident #1 began to become drowsy when the Medical Director came into the room. The staff called EMS and NA #1 recalled Resident #1's skin color was turning grayish/ashen. She stated EMS was having to rub on his sternum and had administered Narcan to him while in the facility.

A nursing progress note dated 02/03/22 at 1:25 PM written by Unit Manager #1 revealed NA #1 had informed Unit Manager #1 that she had seen pink pills in Resident #1's lap. Unit Manager #1 informed the Administrator and the Unit Manager #1, Nurse Aide #1 and Administrator #1 entered

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Resident #1's room to find 6-7 pink pills dissolving in a cup of water Resident #1 was drinking. The Administrator removed the cup of liquid. A cup with pink residue was also noted to be in the trash can by Resident #1's bed. The Medical Director was in the building and called to the resident's room. Several more Oxycodone were found in Resident #1's bed along with one 5 milligram (mg) Percocet (a narcotic used to treat moderately severe pain) and a bottle (60 count) of 5 mg Valium (sedative used to treat anxiety). The antidote Narcan was removed from the medication room and taken to the room by Nurse #1. Emergency Medical Services was called after the Medical Director gave a verbal order to send Resident #1 to the hospital due to becoming more lethargic. EMS arrived in the parking lot and was at bedside before Narcan was administered.

On 02/09/22 at 11:24 AM an interview was conducted with Unit Manager #1. She stated on 02/03/22 NA #1 went into Resident #1's room to change his sheets and noticed pink pills in his blanket and saw the resident soaking 6-7 pink (Oxycodone) pills in water in a cup, along with 20-25 pills in his lap along with a cup in the trash can with pink residue. She stated after NA #1 came and got her, they got Administrator #1 and they all went to Resident #1's room. Unit Manager #1 stated EMS was called due to the resident becoming drowsy and he was transported to the hospital.

On 02/09/22 at 12:16 AM an interview was conducted with the Administrator #1. He stated on 02/03/22 NA #1 and Unit Manager #1 came to him and NA #1 stated she had found medication in Resident #1's room. He stated when he went into the room, he saw Resident #1 with a cup that

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was full of pink liquid because the resident was dissolving pain medication in water and drinking it. The Administrator stated Resident #1 had Oxycodone 10 mg pills in the bed and on his lap. He stated he removed the medication from the resident and also found a cup in the trash can with pink residue. The Medical Director was in the building and was asked to come assess Resident #1. He stated EMS arrived and took over care for Resident #1. He was transported to the hospital and had not returned back to the facility. The interview revealed the intervention that they had completed was having the conversation with Resident #1 following the second incident of finding the medication in his room.

On 02/09/22 at 10:55 AM an interview was conducted with Nurse #1. During the interview she stated she was working on the 200-hall with Resident #1 on 02/03/22. She stated she had gone on her lunch break, when she returned, she was told by Administrator #1, Unit Manager and Nurse Aide #1 that Resident #1 was found with medication in his shirt and was soaking medication in a cup while drinking the liquid. Nurse #1 stated the Administrator called her into the room to come see the resident. She stated when she entered the room Resident #1 was unresponsive but breathing and slumped over in the bed. Nurse #1 was instructed by the Medical Director who was in the room to go and get the medication Narcan. She stated when she returned to the room, she was followed by EMS who instructed her to let them handle the situation and to not administer Narcan. Nurse #1 stated looking back at the situation Resident #1 hadn't asked her for his prescribed pain medication the two days prior which she felt was odd because he usually requested it every 4 hours as needed.

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Review of the Medical Director's note dated 02/03/22 revealed Resident #1 was evaluated after he was found ingesting unprescribed pills. The note revealed the resident had a visitor earlier in the day, and a staff member had walked in the room to find the resident with a large number of pills estimated between 25-50 oxycodone pills plus some Percocet pills sitting on his lap. The note stated some pills had been crushed already and were dissolved in a cup of water which he had ingested. The MD documented he was notified and went to the bedside to find the resident lethargic with progressive decline in neurologic status eventually to an unresponsive state. Resident #1's respirations became slow and shallow progressing to Cheyne-stroke respirations (abnormal breathing often including periods of stopped breathing). The Medical Director gave orders to the staff to call emergency medical services and send the resident to the hospital for an evaluation.

Review of the hospital records dated 2/3/22 revealed Resident #1 presented to the emergency department with agonal respirations (abnormal breathing pattern characterized by gasping, labored breathing) following an unintentional opiate overdose requiring Narcan administration by EMS and in the emergency room. The notes revealed Resident #1 was found with a cup filled with 20-25 Oxycodone 10 mg tablets next to his bed. Resident #1 continued to remain lethargic (sluggish or tired) and was unable to provide any information to the hospital staff. Resident #1's sodium level was 120 when it was usually 126-128. He was admitted to the hospital with diagnosis of hyponatremia (low

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sodium level), unintentional opiate overdose, elevated thyroid stimulating hormone, leukocytosis (low white blood cell count) and hypertension (high blood pressure).

Administrator #2 was notified of Immediate Jeopardy on 02/23/22 at 3:54 PM.

Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance:

The facility neglected to implement interventions to prevent a resident from acquiring and taking medications that were not prescribed by the Medical Director (MD) at the nursing home. This deficient practice affected Resident #1. There were three incidences where Resident #1 had medications in his room not prescribed by the MD/Nurse Practitioner (NP) at the nursing home. The first incident for Resident #1 occurred in mid-January and was not reported to the Administrator or recorded. A second incident occurred on 1/27/22. Staff searched his room finding more of the pain medication Oxycodone along with 16 bottles of medication including the pain medication Morphine. The Administrator and Nurse Practitioner talked to the resident once he returned from his appointment and the Nurse Practitioner told him that day he couldn't self-medicate and told him these drugs could kill him. On 1/27/22, the MD spoke with the prescribing Physician named on the retrieved medications and discussed incident and they agreed Medical Director will continue to be the only prescribing Physician for Resident #1. The third incident occurred on 2/3/22 when Resident #1 unintentionally overdosed on prescription medications not prescribed by the MD.

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Resident #1's care plan updated on 2/24/22 for the behavior of obtaining medications not prescribed by the Medical Director at the nursing home with interventions of observing for behavior changes, changes in mental status, mood changes or suspicious activities to obtain medications from outside sources and 1:1 staff supervision during visitation.

Because all residents are at risk for acquiring and taking medications that were not prescribed by the Medical Director at the nursing home, the following plan has been devised:

By 2/22/22, the Director of Nursing completed questionnaires and education with all alert and oriented residents and by 2/24/22 completed questionnaires with all current facility and agency staff to determine if they had witnessed any suspicious drug-seeking activities or conversations to obtain medications that are not prescribed by the Medical Director at the nursing home or if they had seen any signs of medication bottles, pills or other unknown substances or residents self-medicating. No concerns were reported. During questionnaires with alert and oriented residents, the Director of Nursing also provided education on the facility no-tolerance illegal drug policy, only obtaining medications that are prescribed to them by the facility Physician, not to self-medicate unless otherwise ordered by the Medical Director and to report to the Administrator any suspicious drug-seeking activities or conversations to obtain medications that are not prescribed by the attending Medical Director at the nursing home or if they had seen any signs of medication bottles, pills or other

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unknown substances or residents self-medicating.

Effective 2/24/22, the Regional Director of Clinical Services completed an audit of all facility residents in their rooms and in facility common areas to observe for suspicious drug-seeking activities or conversations to obtain medications that are not prescribed by the Medical Director at the nursing home and to monitor resident rooms for any signs of medication bottles, pills or other unknown substances. No additional concerns were identified or observed.

Effective 2/24/22, the Regional Director of Clinical Services completed an audit of current residents with a diagnosis of psychoactive substance abuse and of residents with reported behaviors of suspicious drug-seeking activities such as conversations with others to obtain illegal drugs or medications that are not prescribed by the Medical Director at the nursing home. Nine residents were identified with diagnosis of psychoactive substance abuse and/or illegal drug abuse and care plans updated to include monitoring for behavior changes, changes in mental status, mood changes or suspicious activities to obtain medications that are not prescribed by the Medical Director at the nursing home. No additional residents identified with behaviors of suspicious drug-seeking activities such as conversations with others to obtain illegal drugs or medications that are not prescribed by the attending Medical Director at the nursing home.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and

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when the action will be complete:

On 2/24/2022, the Administrator, Director of Nursing, Director of Regulatory and Risk Management, Activities Director, Unit Manager and Medical Director conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to discuss root cause analysis of the facility failure to implement interventions to prevent two residents from acquiring and taking medications that were not prescribed by the Medical Director at the nursing home and from obtaining illegal drugs. Root cause analysis determined that facility failed to educate staff on the roles and responsibilities of reporting and responding to suspicion of, acquiring of or consumption of medications that are not prescribed by the Medical Director at the nursing home.

A plan was formulated by the QAPI committee to address the identified issues to include a review of education, audit/monitoring needs, roles and responsibilities of facility staff and QAPI committee responsibilities in reviewing for continued compliance.

On 2/24/22, the Director of Nursing (DON) completed education to current facility and agency staff in all departments to ensure understanding of roles and responsibilities in identifying, reporting and responding to residents who exhibit behaviors of seeking, acquiring and self-medicating with illegal drugs or medications not prescribed by the attending physician at the nursing home. Education included the following: a) dangers of self-medicating including serious adverse side effects and death, b) observing for medications in resident's room or in resident

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possession that are not prescribed by the nursing home MD/NP and responding by remaining with resident, calling out for nursing assistance for assessment and safe collection of substances and follow-up reporting by the licensed nurse to the MD/NP and to the Administrator or DON, c) intervening and asking to search resident with suspicious activity d) ensuring resident safety by remaining with resident and calling for licensed nurse assistance, e) licensed nurse assessing resident for safety and s/s of potential self-medication such as changes in vital signs or altered mental status, visual observation of consumption f) response in the event of resident self-medication to include; immediate removal of substance from resident to stop ingestion if possible, then providing emergency medical care as necessary and remaining with resident, calling MD/NP for new orders and calling 911 if indicated, then removing, counting and securing under double lock and key any medications/illegal substances with a second licensed nurse witness, then notification to the DON and Administrator for further investigation and follow-up, g) revising resident care plan to reduce risk of reoccurrence h) education of the facility abuse and neglect policy and i) reporting immediately to the charge nurse if they hear or suspect a staff member is self-medicating or has an illegal substance in the facility. This education and facility responsibility was communicated to the Administrator and DON by the Director of Regulatory and Risk on 2/24/22. All staff not educated by 2/24/22 will be prohibited to work until education completed. The DON will be responsible for tracking education to ensure completion. Education will also be included during orientation for all newly hired staff and agency staff.

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Effective 2/24/22, newly admitted residents and resident representatives will receive and acknowledge responsibilities and rules of residency related to medications other than those prescribed by the facility physician, are not allowed in the facility or on facility grounds.

Effective 2/24/22, residents admitted with a history of substance abuse or residents who exhibit behaviors of attempting to acquire or consume medications that are not prescribed by the Medical Director at the nursing home will have a care plan with interventions implemented to reduce resident risk of harm from self-medicating.

Effective 2/24/22, the Administrator or Director of Nursing will complete observation rounds to identify behaviors of acquiring and taking medications that were not prescribed by the Medical Director at the nursing home.

Effective 2/24/22, the Administrator or Director of Nursing will complete staff interviews to ensure ongoing understanding of roles and responsibilities of reporting and responding to suspicion of, acquiring of or consumption of medications that are not prescribed by the Medical Director at the nursing home.

Effective 2/24/2022, the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 2/25/22

On 03/02/22, the facility's credible allegation of immediate jeopardy removal was validated by

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F 600	Continued From page 24 review of documentation regarding staff training on the systems and interventions to prevent residents from self-medicating with medications not prescribed by the nursing home Medical Director or Nurse Practitioner. Staff interviews revealed receipt of training related to abuse, neglect and exploitation policy. The facility's date of immediate jeopardy removal of 02/25/22 was validated.	F 600		
F 608 SS=D	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee	F 608		3/31/22

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F 608	Continued From page 25 rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to report finding marijuana in a resident's room to police and flushed it down the commode for 1 of 1 resident, (Resident #4). The findings included: Resident #4 was admitted to the facility 9/21/21. Resident #4's quarterly Minimum Data Set (MDS) dated 11/3/21 revealed Resident #4 was cognitively intact, made himself understood, and understood others. Interview with Resident #4 on 2/17/22 at 11:57 AM revealed he previously had marijuana in his room but had never smoked it. Resident #4 stated the Administrator and Director of Nursing (DON) had spoken to him about why he could not have illegal substances in the facility when they confiscated the marijuana. Interview on 2/18/22 at 4:00 PM with the Nurse Practitioner (NP) revealed she saw marijuana on Resident #4's lap on 12/20/21. The NP stated she stayed in the room and called Administrator #1 and DON from her cell phone. The NP revealed when the marijuana was confiscated by the Administrator, she asked him if he was going to call the police. The NP stated Administrator #1 said he was going to flush it and she told him he should call the police because marijuana was	F 608	1) On 3/29/22, the Administrator notified the police of incident on 12/20/21 when Resident #4 was observed with marijuana in his room. 2) Effective 3/31/22, the Director of Nursing (DON) and/or Unit Manager (UM) completed an audit via questionnaires during inservices with all current facility and agency staff to ensure no additional incidence of suspicious criminal activity have occurred at the facility that have not been reported to the police by administration. No additional criminal activity identified. On 3/22/22, the Social Worker completed an audit via questionnaire of residents with a BIMs 10 or greater to ensure no additional incidence of suspicious criminal activity have occurred at the facility that have not been reported to the police by administration. No additional criminal activity identified. 3) On 3/29/22, the Director of Regulatory and Risk Management inserviced the Administrator and DON on reporting requirements related to reasonable suspicion of a crime. Education included reporting to police immediately. Effective 3/31/22, the DON and/or the UM	

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F 608	Continued From page 26 illegal in North Carolina. The NP also stated she did not know what happened after that, but she did not believe the police were called. Interview with Administrator #1 on 2/21/22 at 4:14 PM revealed he had been notified Resident #4 had marijuana in a baggy in his room. Administrator #1 stated Resident #4 handed the marijuana to him and said his friends left it there. Administrator #1 revealed he took the marijuana and flushed it down the commode. Administrator #1 stated the police had not been called when the marijuana was found.	F 608	inserviced current facility and agency staff on reporting suspicion of a crime to the Administrator or DON immediately. Newly hired facility and agency staff with receive education during orientation. Effective 3/31/22, the Administrator or DON will report reasonable suspicion of a crime to the police immediately. 4) Five residents with a BIMs of 10 or greater and Staff (at random) will be interviewed 3 times per week by either the Social Worker or the Activity Director regarding reports of suspicious criminal activity. If reported,audit will include confirmation that the police was notified accordingly. Results of monitoring will be reported by the Administrator to the QAPI Committee and changes will be made to the plan as necessary to maintain compliance with reporting of reasonable suspicion of a crime. Compliance date: 3-31-22	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		3/31/22

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F 689	Continued From page 27 Based on record review, resident interview, and staff interviews the facility failed to transport a resident in a wheelchair without causing injury to 1 of 3 residents reviewed for accidents (Resident #2). Resident #2's right foot became entangled with the wheelchair wheel resulting in a fracture to the right tibial shaft. The findings included: Resident #2 was admitted to the facility on 2/12/21 with diagnoses that included traumatic spinal cord dysfunction, quadriplegia, depression, muscle weakness, and contracture to right hand. The quarterly Minimum Data Set (MDS) dated 9/7/21 indicated Resident #2 was cognitively intact and was total dependent with most activities of daily living (ADL). The MDS further indicated Resident #2 had an impairment on both upper and lower extremities. Review of progress note dated 10/11/21 revealed Nurse Aide informed the Nurse the Nurse Aide had rolled over Resident #2's foot while wheeling him into the eye appointment. The note further revealed the Nurse assessed Resident #2 foot and ankle and no bruising was noted. The note indicated Resident #2 stated the foot hurt "a little bit" and that it was an accident. The hospital discharge summary dated 10/12/21 revealed Resident #2 sustained a fracture of shaft of the unspecified tibia. The discharge summary further revealed Resident #2 was to wear a splint and follow up with orthopedics. A review of an incident report entitled, "High Risk Event- Investigative Summary", completed by the	F 689	* Corrective action for Resident #2 was achieved by placing the resident in a more suitable wheel chair when getting up and for transports. His care plan was updated by the MDS nurse to reflect this on 10-14-21 * A visual observation will be completed on all residents using wheelchairs by the Director of Nursing (DON), Director of Rehabilitation (DOR) and/or Unit Manager (UM) and this will be completed by 3-31-22. Residents identified as needing more appropriate seating will be referred to therapy for an evaluation so that proper seating can be achieved. * Measures implemented to prevent this same alleged deficient practice include: 1) All staff will be inserviced on identifying unsafe situations including but not limited to seating (residents). This inservice will cover how and to whom issues should be reported. Completion date of 3-31-22 by the DON and/or UM. New employees, including agency staff will be inserviced about this upon hire starting 3-31-22 by the DON and/or UM. 2) Therapy will conduct quarterly screens for safe seating for all residents using wheelchairs starting 3-31-22. Therapy will treat and make necessary safety recommendations as necessary. This will be overseen by the DOR. The therapy dept may also be involved in any other identified situations that could possibly be viewed as unsafe such a room arrangement. 3) If equipment is necessary to prevent	

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F 689	Continued From page 28 prior Director of Nursing (DON) dated 10/13/21 revealed Resident #2 required transport on 10/11/21 to an ophthalmology appointment in which his usual means of locomotion-Geri chair, could not be utilized. Resident #2 was placed in a borrowed wheelchair without footrests by the Nurse Aide #2 (NA) who accompanied Resident #2 to the appointment. The investigation summary revealed Resident #2 had slid down slightly in his wheelchair and caused his feet to rest on the ground. The investigative summary further revealed Resident #2's right foot became entangled with the wheelchair wheel. Resident #2 did not complain of pain at the time of incident but did later that evening and the Nurse Practitioner was consulted, and an x-ray order was obtained. The Investigative Summary indicated the x-ray company could not perform the x-ray until the following day on 10/12/21 and Resident #2 had agreed. The Investigative Summary revealed later the same night Resident #2's pain had increased, and the on-call provider was contacted, and Resident #2 was ordered additional dose of pain medicine and an x-ray the following day. On 10/12/21, the x-ray company had not arrived, and the facility Nurse Practitioner ordered Resident #2 be transported to the hospital to be evaluated. Resident #2 was diagnosed with a fracture to the right tibial shaft. The Investigation Summary revealed the lack of footrests on the wheelchair was the main factor to the incident. Review of a Nurse Practitioner note dated 10/13/21 revealed Resident #2 was seen for follow up on a nondisplaced tibia fracture to the right ankle. The note further revealed Resident #2 was transferred to the hospital on 10/12/21 and was diagnosed with the fracture and sent back to	F 689	accidents or hazardous situations, the appropriate equipment will be implemented. If the Facility does not have the necessary equipment, a purchase request form will be completed by either the DON or DOR and submitted to the administrator. 4) A monitor will be conducted in which 5 wheelchair residents, at random, will be observed for safe seating. This will be done three times per week by the DON, UM, and /or DOR starting 3-31-22. * Results of this monitor will be presented by the DOR at the monthly QAPI meeting starting with the month of April. This will continue for 3 months or longer if necessary to achieve compliance. * Compliance date: 3-31-22	

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the facility in a splint.

An interview conducted with Resident #2 on 2/9/21 at 1:00 PM revealed on 10/11/21 he had gone to an appointment in a wheelchair without a footrest and had to balance his right leg over his left leg so that his foot would not drag the ground. Resident #2 revealed during his appointment NA #2 pushed the resident towards the entrance door and his left leg became tired and his right foot dropped to the ground and became entangled in the wheelchair wheel. Resident #2 indicated he immediately felt discomfort and told NA #2. Resident #2 stated his discomfort and pain was relieved with pain medication until he was transported to the hospital on 10/12/21 and an x-ray noted a fracture to the right ankle. Resident #2 revealed he did not have his own wheelchair and had been requesting one for several months.

A phone interview conducted with NA #3 on 2/9/22 at 1:45 PM revealed on 10/11/21 before Resident #2's appointment she assisted to get Resident #2 ready for his appointment. NA #3 further revealed nursing staff was unable to find a chair with footrest and the resident was sent out in a high back wheelchair with no footrest with the Resident resting his right leg over his left leg. NA #3 could not recall why Resident #2 did not have his own wheelchair but stated the wheelchair Resident #2 was transported in was not adequate for the resident because Resident #2 was weak on the right side.

A phone interview with conducted with NA #2 on 2/10/22 at 9:03 AM revealed she assisted Resident #2 to the appointment on 10/11/22 in another resident's high back wheelchair with no footrests. NA #2 revealed Resident #2 did not

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have his own chair and nursing staff could not find a wheelchair that Resident #2 needed to be transported for his appointment. NA #2 stated she was pushing Resident #2 to the entrance of his appointment and Resident #2 became tired from holding his foot up and dropped it to the ground and Resident #2 stated "ouch". NA #2 revealed she stopped to ask Resident #2 if he was okay and assessed his foot and saw no bruising or swelling. NA #2 indicated Resident #2 complained of pain during his appointment and NA#2 reported to Nurse #4 once they returned to the facility so Resident #2 could be assessed.

A phone interview conducted with Nurse #4 on 2/10/22 at 9:15 AM revealed on 10/11/22 Nurse #4 recalled nursing staff trying to find Resident #2 a chair before an appointment but could not find a wheelchair with footrests for Resident #2. Nurse #4 stated NA#2 had reported the incident after Resident #2 came back from the appointment and Nurse #4 reported it to the Unit Manager immediately. Nurse #4 revealed Resident #2 was assessed and recalled no signs of bruising or swelling. Nurse #4 indicated several residents in the facility did not have their own wheelchair and sometimes finding wheelchairs for residents was difficult.

A phone interview was conducted with the Therapy Director on 2/10/22 at 9:35 AM revealed he does not recall what wheelchair Resident #2 was in on 10/11/21, but it should have been a bigger wheelchair seat with a high back and leg rest for both legs to support Resident #2 for his right-side weakness. It was revealed the therapy department had sent multiple requests to Administrator #1 for Resident #2 to receive a chair that was appropriate for the resident, but the

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F 689	Continued From page 31 facility had not done so. The Therapy Director further revealed Resident #2 had complained the wheelchairs that were used for appointments prior were uncomfortable and did not fit him. A phone interview was conducted with the prior Director of Nursing (DON) on 2/10/22 at 9:05 AM revealed she was made aware Resident #2 had an incident on 10/11/21. It was further revealed it was reported to the DON Resident #2 was transported in a wheelchair without footrest and sustained an injury to his right ankle. The DON stated Resident #2 should have been in a wheelchair with footrest to both legs. A phone interview was conducted with Administrator #1 on 2/10/22 at 4:20 PM revealed nursing staff failed to transport Resident #2 in a wheelchair with footrests on 10/11/21. Administrator #1 further revealed Resident #2 did not have his own wheelchair because he rarely got out of bed and could not recall if therapy had given him request for Resident #2 to receive his own chair prior to 10/11/21. Administrator #1 stated it was expected for residents to be transported in a wheelchair that was adequate.	F 689		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		3/31/22

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F 725	Continued From page 32 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record reviews, the facility failed to maintain sufficient nursing staff to ensure residents received their medications as ordered during day shift on 1/29/2022. This affected 9 of 11 residents whose medications were reviewed. (Resident #5, #7, #9, #10, #11, #12, #13, #14, and #15). Findings included: This tag is cross-referenced to: F-760: Based on resident, staff, Nurse Practitioner and Physician interviews, and record reviews, the facility failed to prevent significant medication errors when medications were not administered as ordered for 9 of 11 sampled residents whose medications were reviewed (Residents #5, #7, #9, #10, #11, #12, #13, #14,	F 725	* The incident was in the past and can not be corrected * The Director of Nursing DON) has reviewed nursing schedules for the month of March and no other incidents like this have occurred. * Measures put into place to prevent this same alleged deficient practice include: 1) Inservice the professional nurses and the facility scheduler on the significance of this citation by 3-31-22 by the DON and/or Unit Manager (UM)and that nurses cannot leave their assignment until their replacement has arrived and they have counted off the medications and the keys have been given to the oncoming nurse. 2) The DON developed an "On Call"	

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F 725	Continued From page 33 and #15). Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed there was not a nurse or Medication Aide (MA) to give medications on the 200 hall for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 reported the Nurse Aide (NA) #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or Medication Aide (MA) on the 200 hall. Nurse #2 further reported she was not sure of the proper chain of command for who to call and there was no Director of Nursing (DON) at that time, so she called Administrator #1 to see what needed to be done. Nurse #2 indicated the Administrator told her he would call her back, but she did not receive a return call from him. An interview on 2/18/2022 at 11:13 AM with NA #1 revealed on 1/29/2022 she worked on the 200 hall and there was not a nurse or MA on the 200 hall to give medications for 7:00 AM- 3:00 PM shift. NA #1 indicated she went over to the 100 hall around 10:00 AM on 1/29/2022 to let Nurse #1 know there was not a nurse or MA on the 200 hall and the residents needed their medications. NA #1 reported Nurse #1 told her she would come over to help when she was done with the residents on 100 hall. NA #1 further reported Nurse #2 did come over to the 200 hall to give Resident #1 his medication about 2:30 PM and that was the only time she had seen a nurse on the 200 hall from 7:00 AM to 3:00 PM on 1/29/2022.	F 725	program for professional nurses. This will be effective 3-31-22. The nurses and the scheduler will be inserviced on this program and be presented with the On Call Policy by 3-31-22 by the DON. Every effort will be made by the scheduler and DON to get nurse coverage through the bonus program and agency staff The On Call program is the back-up plan. 3) The DON will notified any time the On Call back up plan is used by the nurse providing the coverage and/or the scheduler. 4) The DON will keep a log of the date and shifts which the On Call back up program was used. This log will be reviewed with the Administrator weekly. 5) Daily (M-F), the DON and/or UM will monitor the nursing schedule for the following day to anticipate and ensure that all nursing shifts were covered. Starting 3-31-22 * The DON will present the results of log and the monitor (measures #4 and #5) to the QAPI team at the monthly meeting starting in April. This will continue for a period of 3 months and possibly longer as necessary to achieve compliance. If the QAPI team feels that compliance has been achieved, the frequency of the monitoring will change from 5 times a week to 3 times a week. * Compliance Date: 3-31-22	

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F 725	Continued From page 34	F 725		

An interview on 2/18/2022 at 11:59 AM with MA #2 revealed when she arrived to work on 1/29/2022, she counted off the 200-hall medication cart with the Scheduler that morning because they thought Nurse #5 was on her way to work. MA #2 revealed she was assigned to work the top of 100 hall and did not give any medications on 200 hall during first shift on 1/29/2022. MA #2 reported she had given the keys to Nurse #2 not long after she had counted the 200-hall medication cart with the Scheduler.

Interviews conducted with the Scheduler on 2/18/2022 at 4:39 PM and 6:02 PM revealed there were usually 4 med aides and at least 1 or more nurses in the facility on the weekends. The Scheduler indicated she had worked the night shift prior to 1/29/2022 and as she was leaving to go home, she texted all the staff scheduled on 1/29/2022 to ensure they were coming in to work because it was icy outside. The Scheduler further indicated Nurse #5 (assigned to 200 hall that day) had texted that she was on her way in to work so the Scheduler left to go home and sleep. The Scheduler reported she received a call from MA #2 at about 12:00 PM on 1/29/2022 who told her Nurse #5 had not shown up for work that day. The Scheduler further reported she called some nurses at that time to see if they could work and did not receive a response back. The Scheduler indicated she called the facility back to see if the missed medications could be given to the residents and was told they could not, so she let staff know she would come in to work the 200 hall and start the next medication pass. The Scheduler reported she arrived to work around 3:00 PM that day.

An interview with Administrator #1 on 2/21/2022

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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 725	Continued From page 35 at 4:16 PM revealed he was notified of the staffing issue and missed medications late in the afternoon on 1/29/2022 for the 200 hall. Administrator #1 further revealed he could not remember the exact time of the notification, but it was too late to do anything about the staffing issue on first shift by the time he was notified. Administrator #1 reported he would have wanted the staff to notify him of the staffing issue sooner in the day so something could have been done. An interview was conducted on 2/22/2022 at 11:32 AM with Nurse #5 who was assigned to 200 hall on 1/29/2022. Nurse #5 revealed she had called and spoke to the Scheduler at around 7:00 AM on 1/29/2022 and called out of work. Nurse #5 indicated there had been a miscommunication between the staffing agency and the facility because she was not supposed to work at all on 1/29/2022.	F 725		
F 755 SS=D	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 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		3/31/22

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F 755	Continued From page 36 §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 and staff and Consultant Pharmacist interviews the facility failed to report a suspected drug diversion to the Consultant Pharmacist for 2 of 2 residents (Resident #2 and Resident #16). The findings included: Review of the facility policy "Discrepancies, Loss And/Or Diversion of Medications," dated 2006, revised January 2018, revealed "immediately upon the discovery or suspicion of a discrepancy, suspected loss of diversion, the Administrator, Director of Nursing (DON), and Consultant Pharmacist are notified and an investigation conducted." a. Resident #2 was admitted to the facility on 5/15/18. Diagnoses included contracture of the right hand, osteoarthritis, and chronic pain.	F 755	1) On 3/29/22, the Administrator notified the Consultant Pharmacist of a suspected drug diversion during the weekend of 11/20/22-11/22/22 for Residents # 2 and # 16. Resident # 2 and # 16 will continue to receive medications as ordered by the Licensed Nurse and/or Medication Aide (MA) and administration will be documented at time of administration on the Medication Administration Record. (MAR) 2) The Director of Nursing (DON) and/or Unit Manager completed an audit of narcotic sign out sheets on 3/30/22 for residents with prescribed narcotics to ensure no additional instances of suspicious drug diversions identified. Monitoring included validation that the assigned Licensed Nurse/MA for the resident was working at time	

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F 755	Continued From page 37 The Quarterly Minimum Data Set (MDS) dated 11/5/21 for Resident #2 revealed Resident #2 was cognitively intact, made himself understood, and understood others. Resident #2 was coded for receiving opioids 7 out of 7 days during the asessment period. Review of Resident #2's medical record revealed a physician order dated 10/12/21 for oxycodone-acetaminophen (a narcotic used to treat pain) tablet 10-325 mg, give 1 tablet by mouth every 4 hours as needed for pain. Interview with Resident #2 on 3/2/22 at 10:26 AM revealed there was a male nurse working in November 2021 that Resident #2 believed was taking his pain medication. Resident #2 stated he recalled the nurse giving him medication one day and all of the pills were not there that he should have received. b. Resident #16 was admitted to the facility on 10/8/19. Diagnoses included contracture of the left lower leg muscle, low back pain, migraines, and history of malignant neoplasm of the uterus. The Quarterly Minimum Data Set (MDS) dated 10/4/21 for Resident #16 revealed Resident #16 was cognitively intact, made herself understood, and understood others. Resident #16 was coded as receiving opioids 7 out of 7 days during the assessment period. Review of Resident #16's medical record revealed a physician order dated 10/22/21 for oxycodone (a narcotic used to treat pain) hydrochloride (HCL) tablet extended release (ER) 10 milligrams (mg), give 1 tablet by mouth two times a day for pain.	F 755	administration was documented. Any identified discepencies will be investigated and reported to the MD/NP and Consultant Pharmacist as appropriate. On 3/30/22, the Social Worker and/or Activities Director completed an audit via questionnaire to residents with a BIMs of 10 or greater and who are prescribed narcotics for pain, if they were receiving their medications as ordered. Any concerns will be reported to the Director of Nursing for follow-up as appropriate. 3) The DON and/or UM will inservice all facility and agency Licensed Nurses and MAs on the policy regarding identifying and reporting suspicion of drug diversion and on policy of documenting medications at the time of administration. Completion date 3-31-22 New employed nurses and agency nurses will be inserviced on this upon hire. Effective 3/31/22, the DON will thoroughly investigate any suspicion of drug diversion and report suspicion to the Consultant Pharmacist promtly. Investigation will include validation that the assigned Licensed Nurse/MA for the resident was working at time administration was documented. The DON/UM will complete an audit of 5 residents with prescribed narcotics to ensure no suspicion of drug diversion and documentation on sign-out sheets match Licensed Nurse/MA assigned. Monitoring	

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F 755	Continued From page 38 Review of Resident #16's medical record revealed a physician order dated 10/29/21 for oxycodone HCL tablet 5 mg, give 1 tablet by mouth every 6 hours as needed for pain. Interview with Resident #16 on 3/2/22 at 10:50 AM revealed she had asked for her pain medicine that weekend on 11/21/21 and 11/22/21 and it had taken forever to get any. Resident #16 revealed she thought she eventually got her pain medication from staff. Interview with Medication Aide # 1 on 2/20/22 at 3:15 PM revealed she had worked with Nurse #6 (the former Weekend Unit Supervisor) over the weekend of 11/20/21 through 11/22/21. Medication Aide #1 stated she realized on 11/22/21 after Nurse #6 had left for the day around 2:30 PM that he had signed out narcotics for Resident #2 and Resident #16 at times either when he had not been in the building that weekend or when she had the medication cart keys. Medication Aide #1 asked Resident #2 and Resident #16 if they had received their pain medications from Nurse #6 and both residents denied receiving any from him. Medication Aide #1 stated she notified Administrator #1 that day. Interview with the Consultant Pharmacist on 2/21/22 at 3:34PM revealed he was not notified of any possible drug diversion at the facility in November 2021. The Consultant Pharmacist stated the facility should have called the pharmacy about the suspected drug diversion. Interview with the former Director of Nursing (DON) #1 on 2/21/21 at 4:01 PM revealed she was on vacation for 2 weeks during the time	F 755	will be completed at a frequency of five (5) weekly for twelve (12) weeks. The DON will present the results of monitoring to the QAPI Committee monthly and makes changes to the plan as necessary to maintain compliance with Pharmacy Services and reporting suspicion of drug diversion to the Consultant Pharmacist. * Compliance date: 3-31-22	

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F 755	Continued From page 39 when Nurse #6 was suspected of drug diversion. The former DON #1 stated the Administrator #1 had called her while she was on vacation to let her know about what had happened. The former DON #1 revealed the Administrator #1 had put Nurse #6 on suspension and he never came back to the facility. The former DON #1 stated she did not think the Consultant Pharmacist was called, but she was not sure what happened since she was not at the facility during that time. Interview with Administrator #1 on 2/21/22 at 4:14 PM revealed the possible drug diversion had been brought to his attention because the former DON #1 was on vacation at that time. Administrator #1 stated that narcotic pain medication had been signed out but there was a concern from staff of whether or not it had been given to Resident #16 and Resident #2. Administrator #1 revealed he had brought Nurse #6 in for questioning on 11/22/21 and had him write a statement. Administrator #1 stated he told Nurse #6 that since he was not a clinician, he would have to put him on suspension until the former DON #1 was able to look into things further. Administrator #1 revealed on 11/23/21 at 4:55 PM Nurse #6 texted him and said he was going to resign. Administrator #1 stated he did not call the Consultant Pharmacist. Administrator #1 also stated from what he recalled about the incident, there was suspicion of diversion, but nothing was recorded as missing. Nurse #6 was unable to be reached for interview.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its-	F 760		3/31/22

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F 760	Continued From page 40 §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident, staff, Nurse Practitioner and Medical Director interviews, and record reviews, the facility failed to prevent significant medication errors when medications were not administered as ordered for 9 of 11 sampled residents whose medications were reviewed (Residents #5, #7, #9, #10, #11, #12, #13, #14, and #15). Findings included: 1. Resident #5 was admitted to the facility on 12/31/2021 with diagnoses which included Type 2 Diabetes Mellitus (DM), pain, and Epilepsy. An admission Minimum Data Set (MDS) assessment dated 1/4/2022 revealed Resident #5 was cognitively intact. Physician's orders reviewed and revealed an order dated 12/29/2021 for Levetiracetam 500 mg to give 1 tablet by mouth two times a day for seizures and an order dated 1/26/2022 for Acetaminophen 500 mg- give 2 tablets by mouth three times a day for pain Medication Administration Record (MAR) review revealed the Levetiracetam 500 mg, scheduled for 8:00 AM, was not documented as given on 1/29/2022 and the Acetaminophen 500mg, scheduled for 8:00 AM and 2:00 PM was not documented as given on 1/29/2022. Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall	F 760	1) Corrective action for Residents # 5, 7, 9, 10, 11, 12, 13 14 and 15 could not be achieved as this was a time sensitive situation. 2) The facility recognizes that all residents in the facility could be affected by this same alleged deficient practice however, in reviewing the MARs, this has not occurred recently. The Director of Nursing (DON) and Unit Manager (UM) reviewed the MARs of active residents 3/1/22-3/27/22 and no additional significant medication errors occurred. 3) Effective 3/31/22, all facility and agency Licensed Nurses and Medication Aides (MA)were inserviced by the DON and/or UM on the significance of ensuring residents are free from significant medication errors and that medications are to be administered as ordered by the physician and if medications are not administered as ordered, the MD/NP must be notified immediately. Education included the process by which the oncoming Licensed Nurse/MA will review and validate with the previous shift Nurse/MA the MARs of assigned residents ensuring that all medications were administered as ordered or reported the the MD/NP accordingly. This is a part of the SHIFT REPORT and is mandatory. Newly hired facility and agency Licensed	

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F 760	Continued From page 41 on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed the Nurse Aide (NA) #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or Medication Aide (MA) on the 200 hall where Resident #5 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #5 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall. 2. Resident #7 was admitted to the facility on 12/29/2021 with a diagnosis of Type 2 Diabetes (DM). An admission Minimum Data Set (MDS) assessment dated 1/4/2022 revealed Resident #7 was cognitively intact. Physician's orders for Resident #7 were reviewed and revealed the following: -Lyrica 150 mg- give 1 capsule by mouth two times a day for pain dated 12/29/221 -Admelog Solostar 100 units/mL- inject 25 units at noon SQ one time a day for DM dated 1/13/2022 -Admelog Solostar 100 units/milliliter (mL)- inject 30 units subcutaneously (SQ) one time a day for DM at 8:00 AM dated 1/14/2022 -Insulin Glargine 100 units/mL- inject 30 units SQ one time a day for DM at 8:00 AM dated 1/26/2022 The Janurary 2022 MAR was reviewed and revealed the following were not documented as given/checked on 1/29/2022:	F 760	Nurses and MAs will receive education during orientation and prior to working. The Licensed Nurse/MA will administer medications as ordered by the physician to ensure residents are free from significant medication errors. Daily, before the end of each shift, nurses and MAs will check their assigned resident Medication Administration Records (MAR) to ensure that all ordered medications have been administered and if not, then validate that the MD/NP was notified. 4) The DON and/or UM will complete an audit of five (5) resident MARs for previous day to ensure that all ordered medications were administered or that the MD/NP was notified of medications that were not given as ordered. If any are identified as being non-compliant, it will be resolved immediately and the nurse/MA will receive re-educated and/or disciplinary as necessary by the DON and/or UM. The results of this monitor will be presented by the Administrator or DON to the QAPI committee and changes will be made to the plan as necessary to maintain compliance with ensuring residents are free from significant medication errors. Compliance date: 3-31-22	

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-Scheduled for 8:00 AM

-Admelog Solostar 100 units/mL- 30 units
- Insulin Glargine 100 units/mL- 30 units
-Lyrica 150 mg

-Scheduled for 12:00 PM

-Admelog Solostar 100 units/mL- 25 units

An interview with Resident #7 on 3/2/2022 at 10:34 AM revealed she was not able to recall if she received her medications on the day of 1/29/2022.

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #7 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #7 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

3. Resident #9 was admitted to the facility on 7/29/2021 with a diagnosis of longstanding persistent Atrial Fibrillation.

A quarterly MDS assessment dated 1/8/2022 revealed Resident #8 was cognitively intact.

Physician's orders review revealed an order

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dated 7/29/2021 for Apixaban 5 mg- give 1 tablet by mouth two times a day for Atrial Fibrillation

MAR review revealed the Apixaban 5 mg, scheduled for 8:00 AM, was not documented as given on 1/29/2022

An interview with Resident #9 on 3/2/2022 at 10:33 AM revealed she could not recall the day of 1/29/2022 but did remember a morning when she did not receive her medications and could not remember the date. Resident #9 further revealed she did not recall having any adverse effects due to not receiving her medications.

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #9 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #9 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

4. Resident #10 was admitted to the facility on 12/14/2021 with diagnoses which included Acute Respiratory Failure with Hypoxia, anxiety disorder, and pain.

An admission MDS dated 12/24/2021 revealed Resident #10 was severely cognitively impaired

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Physician's orders review revealed the following:

-Gabapentin 100 mg- give 1 capsule by mouth two times a day for pain dated 1/20/2022
-Hydromorphone 1 mg/mL- give 1 mL by mouth four times a day for pain/dyspnea (difficulty breathing) dated 1/28/2022
-Lorazepam 1 mg- give 1 mg by mouth two times a day for anxiety dated 1/28/2022

MAR review revealed the following medications were not documented as given on 1/29/2022:

-Scheduled for 8:00 AM

-Hydromorphone 1 mg/mL- 1 mL
-Lorazepam 1 mg
-Gabapentin 100mg

-Scheduled for 12:00 PM

-Hydromorphone 1 mg/mL- 1 mL

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #10 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #10 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

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5. Resident #11 was readmitted to the facility on 11/14/2013 with diagnoses which included Epilepsy and Rheumatoid Arthritis. Resident #11 was diagnosed with a Deep Venous Thrombosis (DVT) and Pulmonary Embolism (PE) in 12/2018.

A quarterly MDS assessment dated 1/9/2022 revealed Resident #11 was cognitively intact.

Physician's orders review revealed the following:

-Keppra 750 mg- Give 1 tablet by mouth two times a day for seizures dated 7/6/2021
-Eliquis 2.5 mg- Give 1 tablet by mouth two times a day for history of DVT/PE, prophylaxis dated 7/6/2021
-Phenytoin Sodium Extended Capsule 100 mg- Give 1 capsule by mouth two times a day related to Epilepsy dated 12/20/2021

MAR review revealed the following medications, scheduled at 8:00 AM, were not documented as given on 1/29/2022:

-Phenytoin Sodium Extended Capsule 100 mg
-Keppra 750 mg
-Eliquis 2.5 mg

An interview with Resident #11 on 3/2/2022 at 10:50 AM revealed she was not able to recall the day of 1/29/2022.
Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there

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was not a nurse or MA to give medications on the 200 hall where Resident #11 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #11 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

6. Resident #12 was admitted to the facility on 8/13/2021 with diagnoses including Type 2 DM and pain

A quarterly MDS assessment dated 12/2/2021 revealed Resident #12 was cognitively intact

Physician's orders review revealed an order dated 11/3/2021 for Metformin 500 mg- give 1 tablet by mouth two times a day and an order dated 11/3/2021 for Gabapentin 800 mg- give 1 tablet by mouth three times a day.

MAR review revealed the Metformin 500 mg, scheduled for 8:00 AM was not documented as given on 1/29/2022 and the Gabapentin 800 mg, scheduled for 8:00 AM and 2:00 PM was also not documented as given on 1/29/2022.

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #12 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not

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give any medications to Resident #12 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

7. Resident #13 was admitted to the facility on 12/18/2021 with diagnoses including Epilepsy and pain.

An admission MDS assessment dated 12/24/2021 revealed Resident #13 was cognitively intact.

Physician's orders review revealed the following:

-Levetiracetam 500 mg- give 1 tablet by mouth two times a day for seizure dated 12/18/2021
-Gabapentin 300 mg- give 1 capsule by mouth three times a day for pain dated 12/18/2021

MAR review revealed the following medications were not documented as given on 1/29/2022:

-Scheduled for 8:00 AM
-Levetiracetam 500 mg
-Gabapentin 300mg

-Scheduled for 2:00 PM

-Gabapentin 300 mg

An interview with Resident #13 on 3/2/2022 at 10:25 AM revealed he did recall not receiving his morning medications on 1/29/2022. Resident #9 further revealed he did not recall having any adverse effects due to not receiving his medications.

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Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #13 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #13 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

8. Resident #14 was admitted to the facility on 11/30/2018 with diagnoses including Polyneuropathy, pain in right and left knee, and PE (diagnosed on 5/20/2021).

A quarterly MDS assessment dated 1/28/2022 revealed Resident #14 was moderately cognitively impaired.

Physician's orders review revealed the following:

-Gabapentin 600 mg- give 1 tablet by mouth three times a day for neuropathy dated 7/6/2021
-Tramadol 50 mg- give 0.5 tablet by mouth two times a day for pain dated 10/22/2021
-Eliquis 2.5 mg- give 1 tablet by mouth two times a day for PE

MAR review revealed the following medications were not documented as given on 1/29/2022:

-Scheduled for 8:00 AM

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-Eliquis 2.5 mg
-Gabapentin 600 mg
-Tramadol 50 mg (0.5 tablet)

-Scheduled for 2:00 PM

-Gabapentin 600 mg

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #14 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #14 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

9. Resident #15 was readmitted to the facility on 1/25/2022 with diagnoses including Type 2 DM, chronic pain, Methicillin Resistant Staphylococcus Aureus (MRSA) Bacteremia, and DVT.

A significant change MDS assessment dated 1/4/2022 revealed Resident #15 was cognitively intact.

Physician's orders review revealed the following:

-Gabapentin 800 mg- give 1 tablet by mouth three times a day for pain dated 1/26/2022
-Novolog Flexpen 100 units/mL- inject as per

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sliding scale SQ before meals and at bedtime dated 1/27/2022

-Xarelto 15 mg- give 1 tablet by mouth two times a day dated 1/26/2022

-Daptomycin Solution Reconstituted- use 1 GM IV every 24 hours to treat/prevent infection dated 1/27/2022

MAR review revealed the following medications were not documented as given on 1/29/2022:

-Scheduled at 7:30 AM

-Novolog Flexpen 100 units/mL- sliding scale insulin

-Scheduled at 8:00 AM

-Gabapentin 800 mg
-Xarelto 15 mg

-Scheduled at 11:30 AM

-Novolog Flexpen 100 units/mL- sliding scale insulin. Next documented blood sugar on 1/30/2022 at 7:30 AM was 147- no sliding scale insulin given at that time per order.

-Scheduled at 2:00 PM

-Gabapentin 800 mg

-Scheduled for every 24 hours

-Daptomycin 1 GM

Resident #15 discharged from the facility on 1/31/2022. Attempted to contact Resident #15 on 2/19/2022 at 2:01 PM and on 2/21/2022 at

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11:25AM. Messages left requesting a return call with no response.

Interviews were conducted with Nurse #2 on 2/17/22 at 4:09 PM and 2/18/2022 at 9:14 AM which revealed she was assigned to the 100 hall on 1/29/22 and the nurse who was assigned to the 200 hall did not show up for work that day. Nurse #2 further revealed NA #1 from 200 hall came to her at about 11:30 AM and told her there was not a nurse or MA to give medications on the 200 hall where Resident #15 resided, for all of first shift which was 7:00 AM to 3:00 PM on 1/29/2022. Nurse #2 indicated that she did not give any medications to Resident #15 on 1/29/2022 because she was administering medications to residents on the lower end of the 100 hall.

Interviews were conducted with the Nurse Practitioner (NP) on 2/18/2022 at 3:57 PM and 2/21/2022 at 12:57 PM which revealed the NP was not aware of the missed medications for the residents on the 200 hall until 1/31/2022 when Resident #15 notified her. The NP further revealed she had checked in with all the staff when she was notified, and no negative outcomes or ill effects were reported due to the missed medications. The NP stated most of the medications the residents were on were medically necessary and should have been administered to the residents as ordered.

An interview with the former Director of Nursing (DON) #2 on 2/18/2022 at 5:48 PM revealed she was the interim DON on 1/29/2022. The former DON #2 indicated she was not called on 1/29/2022 regarding the staffing issue and was not made aware of the missed medications or

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F 760	Continued From page 52 staffing issues until 1/31/2022. The former DON #2 further indicated she was not sure what she would have done if she was called on 1/29/2022 as she was out of town. An interview with the Medical Director (MD) on 2/20/2022 at 7:14 PM revealed that on 1/29/2022 he was not made aware of the missed medications for the residents on the 200 hall. The MD stated medications such as IV medications, blood thinners, pain medication, seizure medication, and insulin that were missed were significant medication errors. The MD indicated he was not aware of any falls, seizure episodes, low or high blood sugars due to the residents missing their medications on 1/29/2022. The MD stated the residents should have received the medications as ordered on 1/29/2022. An interview with Administrator #1 on 2/21/2022 at 4:16 PM revealed he was notified of the staffing issue and missed medications late in the afternoon on 1/29/2022 for the 200 hall. Administrator #1 further revealed he could not remember the exact time of the notification, but it was too late to do anything about the staffing issue on first shift by the time he was notified. Administrator #1 reported he would have wanted the staff to notify him of the staffing issue sooner in the day so something could have been done.	F 760		
F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial	F 835		3/31/22

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F 835	Continued From page 53 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director and Nurse Practitioner (NP) interviews, the facility failed to provide leadership and oversight to ensure effective systems were in place to prevent a resident from acquiring and taking medications that were not prescribed by the attending physician at the nursing home which resulted in an unintentional overdose. This deficient practice affected 1 out of 3 residents (Resident #1) reviewed for neglect. The facility also failed to provide a wheelchair that was the correct size for 1 of 2 residents reviewed for accomodation of needs (Resident #2) and transport a resident in a wheelchair without causing injury to 1 of 3 residents reviewed for accidents (Resident #2). In addition, the facility failed to report finding marijuana in a resident's room to police and flushed it down the commode for 1 of 1 resident, (Resident #4), have a facility-wide assessment available or a transfer agreement with the local hospital. Immediate Jeopardy began on 01/27/22 when the facility neglected to protect Resident #1 from acquiring and taking medications that were not prescribed by the attending physician at the nursing home. Immediate Jeopardy was removed on 02/25/22 when the facility implemented an acceptable credible allegation on Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure education is completed and monitoring systems put in place are effective.	F 835	* The Facility Administration failed to provide effective oversight and leadership to 1) ensure effective systems were in place to prevent a resident from acquiring and taking medications that were not prescribed by the attending physician at the nursing home that resulted in an unintentional overdose and this affected resident #1, 2) the Facility failed to provide a wheelchair that was the correct size for a resident (resident #2) (reasonable accommodation), 3) Failure to report finding marijuana in a resident's room (resident #4) to the local police, 4) failure to have a facility-wide assessment, and 5) failure to have a Transfer Agreement. On 2-24-22, the Regional Director of Clinical Services educated the Facility's Administrative Staff on the significance of this citation F 835. On 2-24-22, an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting was held by the Administrator and the Regional Director of Clinical Services (RDCS) to discuss the Root Causes of these alleged deficient practices. However at the time of the meeting, there was only of the above noted examples that had been cited (number 1). Root Cause identified for the #1 example was determined to be Failure to monitor staff understanding of roles and responsibilities in identifying, report to,	

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F 835	Continued From page 54 Example # 2 and # 3 are at scope and severity of "G," actual harm that is not immediate jeopardy. Example # 5 and # 6 are at a scope and severity of "F," no actual harm with potential for more than minimal harm that is not immediate jeopardy. Example # 4 is cited at a scope and severity of "D," no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings included: This tag is cross referred to: 1. F 600- Based on record review and staff, Medical Director and Nurse Practitioner interviews, the facility neglected to implement effective interventions to protect a resident from an unintentional overdose. There was a total of three incidents with Resident #1, the first incident occurred when staff found narcotic pain medication that was not prescribed by the facility Physician. Interventions were not implemented following the initial incident. On 1/27/22 a second incident occurred; Resident #1 was found with 16 bottles of medications not prescribed by the attending physician. On 2/3/22 Resident #1 experienced an unintentional overdose on narcotic pain medication from an outside source requiring two doses of the antidote Narcan (a medication used to treat narcotic overdose in an emergency), and the resident was transported to the hospital. This was for 1 of 3 residents reviewed for neglect. Administrator #2 was notified of Immediate Jeopardy on 02/23/22 at 3:54 PM. The facility submitted the following immediate jeopardy removal plan.	F 835	and responding to residents who exhibit behaviors of seeking, acquiring, and self-medicating with illegal drugs or medications not prescribed by their attending MD. Another QAPI meeting was held on 3-25-22 to address the other citations identified on the 2567 which included the examples noted in this citation and listed above (examples #2, 3, 4, and 5) and to review the Plan of Correction with the Administrative Staff. This was held by the Administrator. * On 2-24-22, ab ad hoc QAPI meeting was held by the Administrator, RDCS and the administrative staff to re-assess effective oversight and leadership to ensure that 1) a system is implemented to prevent residents from acquiring and taking medications that were not prescribed by their attending physician at the nursing home. On 3-25-22 another QAPI meeting was held with the administrative staff (by the administrator) to review the other identified tags as well as the examples noted above #2-5). * On 3-21-22, the RDCS educated the Administrator on the importance of 1) developing and implements an effective system to prevent residents from acquiring and taking meds not prescribed for them and/or illegal drugs, 2) Reasonable Accommodations, 3) Reporting suspicious criminal Activity, 4) Facility Assessment and 5) Transfer Agreement.	

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F 835	Continued From page 55 Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: Administration failed to have effective systems in place to prevent a resident from acquiring and taking medications that were not prescribed by the Medical Director (MD) at the nursing home. This deficient practice affected Resident #1. This failure occurred due to administration not effectively monitoring staff understanding of roles and responsibilities in identifying, reporting and responding to residents who exhibit behaviors of seeking, acquiring and self-medicating with illegal drugs or medications not prescribed by the attending physician at the nursing home. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: On 2/24/2022, the Administrator, Director of Nursing (DON), Director of Regulatory and Risk Management, Activities Director, Unit Manager and Medical Director (MD) conducted an Ad Hoc QAPI (Quality Assurance Performance Improvement) meeting to discuss root cause analysis of Administration failure to prevent and implement interventions to prevent a resident from acquiring and taking medications that were not prescribed by the MD. Root cause analysis determined that administration failed to implement a facility process that ensures all facility and agency staff are knowledgeable and understand their roles and responsibilities of maintaining a heightened awareness and immediately responding to and reporting such	F 835	* Numerous monitors and checklists have been developed by the Administrator and RDCS to ensure that all of the above noted alleged deficient practices are in place and effective for: F 558, F 600, F 608, F838 and F 843. The Administrator, Director of Nursing and Unit Manager are all involved in these monitors and the results are being presented to the QAPI team for review. These monitors will be reviewed monthly for a period of 3 months and longer if deemed necessary by the QAPI team to achieve compliance. * Compliance date 3-31-22	

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incidents to ensure resident safety. Administration reviewed CMS regulations and company policies on abuse and Illegal Drug Use and developed a revised facility process to include robust ongoing staff education and ongoing administrative monitoring for continued compliance. Administration will be responsible for completing a thorough investigation if a resident is identified self-medicating with medications from an outside source/provider or obtaining illegal drugs to determine root cause and ensure effective interventions are implemented to protect the resident. If such incidents occur, the QAPI committee will review facilities process and make changes to processes as necessary.

On 2/24/22, the Director of Regulatory and Risk Management provided education to facility administration (Administrator, DON, Unit Manager, Housekeeping/Laundry Director, Therapy Director, Activity Director, Minimum Data Set Nurse, Business Office and Dietary Manager) on maintaining an effective training and monitoring system and the roles and responsibilities of facility administration in reviewing for continued compliance.

Administration is responsible for ensuring all staff are knowledgeable and have heightened awareness of recognizing and responding to residents who exhibit behaviors indicative of acquiring and taking medication not prescribed by the attending physician of the nursing home or illegal drugs. The licensed nurse is responsible for notifying MD/NP and all staff are responsible for notifying DON/Administrator per the Abuse and Neglect policy. The DON/Administrator is responsible for reporting incidents of abuse and neglect to the Corporate Risk Department and for

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completing a thorough investigation and ensuring appropriate follow-up interventions are implemented to minimize risk to resident. The QAPI committee is responsible for monitoring the effectiveness of this plan and making changes to the plan as necessary to maintain compliance.

Effective 2/24/22, the Administrator or Director of Nursing will complete observation rounds to identify behaviors of acquiring and taking medications that were not prescribed by the attending physician at the nursing home and from obtaining illegal drugs.

Effective 2/24/22, the Administrator or Director of Nursing will complete staff interviews to ensure ongoing understanding of roles and responsibilities of reporting and responding to suspicion of, acquiring of or consumption of medications that are not prescribed by the attending physician at the nursing home and of illegal drugs.

Effective 2/24/24, the Corporate Risk Department will review and make recommendation for all allegations of abuse and neglect reported by the facility to ensure appropriate investigation and interventions are completed to maintain resident safety.

Effective 2/24/2022, the Administrator will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 2/25/22

On 03/02/22, the facility's credible allegation of immediate jeopardy removal was validated by

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review of documentation regarding system and interventions to prevent residents from self-medicating with medications not prescribed by the nursing home physician. A root-cause analysis outlined how the facility failed to monitor staff understanding of roles and responsibilities in identifying, reporting to and responding to residents who exhibit behaviors of seeing, acquiring and self-medicating with medications not prescribed by the facility. Administrative staff interviews revealed receipt of training related to the documentation.

The facility's date of immediate jeopardy removal of 02/25/22 was validated.

This tag is also cross referred to:

2. F 558- Based on observations, record reviews, resident, staff, Therapy Director and Nurse Practitioner interviews the facility failed to provide a wheelchair that was the correct size to accommodate a resident for 1 of 3 residents reviewed for accommodation of needs (Resident #2). Resident #2 reported the wheelchairs were uncomfortable, felt too small, and sometimes painful which caused him to not want to get out of bed.

3. F 689- Based on record review, resident interview, and staff interviews the facility failed to transport a resident in a wheelchair without causing injury to 1 of 3 residents reviewed for accidents (Resident #2). Resident #2's right foot became entangled with the wheelchair wheel resulting in a fracture to the right tibial shaft.

4. F 608- Based on record review, resident and staff interviews, the facility failed to report finding

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	345174	A. BUILDING _____ B. WING _____	C 03/03/2022

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CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

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F 835	Continued From page 59 marijuana in a resident's room to police and flushed it down the commode for 1 of 1 resident, (Resident #4). 5. F 838- Based on record review and staff interview the facility failed to provide evidence a facility-wide assessment had been conducted to determine what resources were necessary to care for its residents competently during day-to-day operations. This had the potential to affect all residents. 6. F 843- Based on record review and staff interview, the facility failed to have a transfer agreement in place for transferring residents to the local hospital for evaluation and treatment, which had the potential to affect all the residents in the facility.	F 835		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's	F 838		3/31/22

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F 838	Continued From page 60	F 838		

resident capacity;
(ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
(iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
(iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
(v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

§483.70(e)(2) The facility's resources, including but not limited to,
(i) All buildings and/or other physical structures and vehicles;
(ii) Equipment (medical and non- medical);
(iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
(iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
(v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
(vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

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F 838	Continued From page 61 §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide evidence a facility-wide assessment had been conducted to determine what resources were necessary to care for its residents competently during day-to-day operations. This had the potential to affect all residents. Findings included: During a complaint survey that began on 2/9/2022 and ended on 3/3/2022, the facility was unable to provide the facility assessment. Interviews with Administrator #2 took place on 03/02/22 at 9:50 AM, 11:32 AM, 3:56 PM and 4:15 PM. During the interviews, the Administrator reported that she had been employed at the facility for about a week and had not been able to locate the facility assessment. Administrator #2 also reported she contacted Administrator #1 regarding the facility assessment and was told the facility assessment had been packed in a box due to renovations. Administrator #2 revealed she was aware the facility assessment was supposed to be in the facility, but she had not been able to locate it.	F 838	* Corrective action: Facility Assessment located by Administrator on 3-3-22. Placed in a folder and secured in the administrator's office. * Recognizing that all residents have the potential to be affected by this same alleged deficient practice, the administrator made a copy of the Facility Assessment to be kept in the Director of Nursing's office, in a notebook in the Administrator's office as well as in a folder. The Regional Director of Operations will also maintain an electronic copy of the Facility Assessment so that it will not be misplaced in the future. This was completed by 3-4-22 * Measures put into place to ensur3e that this same alleged deficient practice will not recur include: 1) Admin and DON to be inserviced on the importance of the Facility Assessment and it's contents by the Regional clinical Nurse. This will be completed by 3-22-22. 2) Electronic copy to be maintained by Regional Director of Operations, Director of Nursing to have hard copy, and Administrator to have a copy in the file cabinet and in a notebook in the administrator's office (as of 3-4-22), 3) Weekly, administrator and Director of Nursing will complete a checklist validating that they possess copies of the Facility Assessment. 4) if any of the three	

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F 838	Continued From page 62	F 838	copies are identified as being missing, it will immediately be replaced using one of the other copies in the facility and if none can be located, the Regional Director of Operations will be contacted to send a copy via email (as of 3-4-22). 5) The administrator will be responsible for updating the Facility Assessment at least annually. * Results of this monitor/checklist will be presented by the administrator to the QAPI team monthly. This will continue for a period of 3 months or longer if necessary to achieve compliance. * Compliance Date: 3-31-22	
F 843 SS=F	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for	F 843		3/31/22

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F 843	Continued From page 63 determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to have a transfer agreement in place for transferring residents to the local hospital for evaluation and treatment, which had the potential to affect all the residents in the facility. Findings included: The facility transfer agreement was reviewed and revealed the agreement was between the local hospital and another facility in the same corporation. An interview with Administrator #2 on 3/2/2022 at 3:56 PM revealed she was not sure why the transfer agreement was for a different facility, but it was the only one she was able to locate. Follow up interviews on 3/3/2022 at 9:30 AM and 12:31 PM further revealed she had reached out to the local hospital to see if they had a copy of the transfer agreement, however she was not able to get anyone at the hospital to assist her with the agreement.	F 843	* Transfer Agreement secured and signed between Carolina Pines of Asheville and MH Mission Hospital, LLP on 3-4-22. * This alleged deficient practice has the potential to affect all residents; however, it did not and a current Transfer Agreement is in place as of 3-4-22. * 1) Regional Clinical Director inserviced the Administrator and Director of Nursing on the importance of maintaining a current facility-specific Transfer Agreement (by 3-10-22). 2) Transfer Agreement place in Facility Contract book which is kept in the Adminstrator's office (3-4-22) 3) Additional copy kept in the filing cabinet in the Administrator's office (3-4-22), 4) Weekly, the administrator will complete a checklist validating that the Transfer Agreement is in the Contract Book and can be easily located and if not, a copy from the file cabinet will be made and that	

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F 843	Continued From page 64	F 843	copy placed in the Contract book by the administrator * Results of the validating checklist will be presented by the administrator to the QAPI monthly at the QAPI meeting. This will continue for 3 months or until compliance is achieved. * Compliance date 3-31-22	