STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345133	A. BUILDING _____ B. WING _____	C 05/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 05/23/22 through 05/26/22. The faciltiy was in compliance with requirment CFR 483.73, Emergency Preparedness Event ID: 0C2Z11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation was conducted from 05/23/22 through 05/26/22. There were four allegations investigated and one was substantiated. Intakes: NC00189295 and NC0018888 Event ID: 0C2Z11.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.	F 578		6/23/22

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

Electronically Signed | 06/23/2022

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F 578	Continued From page 1 (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to maintain accurate Advanced Directives throughout the Resident's medical record for 1 of 3 residents reviewed for Advanced Directives (Resident #64). The finding included: Resident #64 was admitted to the facility on 03/22/22. On 05/24/22 at 9:46 AM a review of Resident #64's electronic health record revealed an Advanced Directive order dated 03/22/22 for a Full Code status. A review of the Code Status notebook kept at the nursing station revealed there was no information in the notebook that indicated Resident #64's Advanced Directive for a Full Code status.	F 578	F578 " On 5.24.2022 Advance Directive was reviewed for resident #64. It was identified that the resident was not placed in the Advance Directive binder. Resident #64 code status was corrected and verified against the electronic health record. " On 5.24.2022, the Administrator completed house audit of advance directives for all current residents. Any identified residents that were not in the binder have been updated in both the advance directive binder and the electronic health record on the completed date 5.24.2022. " On 6.14.2022, the DON begin educating nursing staff and managers. The DON and nurse manager provided	

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F 578	Continued From page 2 A review of Resident #64's care plan dated 03/22/22 indicated the Resident was a Full Code status. On 05/24/22 at 2:56 PM an interview was conducted with Nurse #1 who explained that the residents' Advanced Directive was determined on admission and was documented in their electronic medical record as well as kept in a Code Status notebook at the nursing station. The Nurse continued to explain that it was important for both medical records to match because in the event she had to immediately determine whether or not to initiate CPR (cardiopulmonary resuscitation) on a resident she would look for the resident's Advanced Directive in the medical record nearest to her. On 05/25/22 at 11:50 AM during an interview with Unit Manager (UM) #1 she explained that the Advanced Directives were established on admission and maintained in the residents' electronic health record as well as in the Code Status notebook kept at the nursing station. An observation was made with the UM of Resident #64's electronic health record to verify the Resident's Advanced Directive status of a Full Code and asked the UM to find the Advanced Directive in the Code Status notebook. The Resident's Advanced Directive status was not in the Code Status notebook. The UM indicated that she thought it was the Social Worker's responsibility to maintain the system for the Advanced Directives. On 05/25/22 at 5:25 PM an interview was conducted with the Social Worker (SW) who explained that she had only been employed at the facility for about 2 weeks and stated her	F 578	ongoing education for newly hired facility and agency licensed nurses and nurse aides. The DON and nurse manager provided the education and orientation packet and conducted prior to working via in-person or phone. The admission coordinator will be responsible for getting resident code status upon admission and the social worker will be responsible for updating code status in the binder and care planning the resident code status. " The Social Worker or Administrator will monitor five (5) residents for concurrent advance directives between both the binder and EHR. Audits will be completed two (2) times weekly for 4 weeks, then one (1) time a week for 8 weeks. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with " Date of Compliance: 6.23.2022	

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F 578	Continued From page 3 background was not in long term care therefore she was still learning her duties at the facility. The SW stated that she would defer any questions to the Administrator. During an interview with the Interim Director of Nursing (DON) on 05/25/22 at 4:50 PM the DON explained that the Advanced Directives were established upon admission or shortly thereafter and stated if it was the facility's policy to maintain the Advanced Directives in the electronic health record as well as in the Code Status notebook then it was her expectation that the two areas matched. On 05/26/22 at 2:55 PM an interview was conducted with the Administrator with the Vice President of Corporate Compliance present. The Administrator explained that she understood the importance of making sure the two places the facility established for the residents' Advanced Directives matched (the electronic health record and the Code Status notebook) and that it was her expectation that the two places matched.	F 578		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 637		6/23/22

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F 637	Continued From page 4 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and facility staff interviews, the facility failed to complete a significant change Minimum Data Set Assessment for a resident who admitted to hospice care for 1 of 2 residents (Resident #16) reviewed for hospice. The findings included: Resident #16 was admitted to the facility on 09/13/21 with diagnoses that included anoxic brain damage. Resident #16's most recent quarterly Minimum Data Set Assessment dated 03/14/22 revealed her to be severely impaired for daily decision making. She was not coded as receiving Hospice Services. Resident #16's physician orders revealed an order dated 03/18/22 for admission to hospice care. Review of Resident #16's additional Minimum Data Set (MDS) Assessments revealed no significant change MDS Assessment was completed when Resident #16 began receiving Hospice care. During an interview with MDS Nurse #1 on 05/26/22 at 11:42 AM, she reported she was new to the position of MDS Nurse and stated when a resident was admitted to hospice care, a significant change MDS assessment must be completed within 14 days. She stated when	F 637	F637 " On 6.6.2022 MDS nurse reviewed and revised Resident #16 care plan to include Hospice information that is necessary for the care of the resident. " On 5.23.2022 MDS audited all residents who have been identified as having a significant change in condition between 12.01.2021 □ 5.23.2022. IDT assessed and care plans to ensure SCSA (Significant Change in Status Assessments) reflected the change within the 14 days. Corrections were made by the team on 5.23.2022 for seven residents who were deficient. " On 6.13.2022 the DON and nurse manager provided education to current facility and agency licensed nurses and IDT members on identifying and report significant change to the nurse leadership team in a timely manner. The DON and nurse manager provided education as ongoing for newly hired facility and agency licensed nurses and nurse leadership. The education will be a part of the orientation packet and conducted prior to working via in-person or phone. MDS will be responsible for initiating a comprehensive assessment within 14 days of change. " The MDS nurse will complete the monitoring of comprehensive assessments within the 14 days. Audits	

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F 637	Continued From page 5 Resident #16 admitted to hospice care, she updated Resident #16's care plan to reflect hospice care but "overlooked" the completion of a significant change MDS assessment. She reported she would complete a significant change MDS assessment and submit it to report the change in care. During an interview with the Director of Nursing on 05/26/22 at 2:21 PM, she reported any resident who had begun receiving hospice services should have a significant change MDS assessment completed and submitted. She reported she had only been in the facility a few days and she did not know why the significant change MDS assessment was not completed for Resident #16.	F 637	will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with comprehensive care plans. " Date of Compliance: 6.23.2022	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services.	F 655		6/23/22

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F 655	Continued From page 6 (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to initiate a base line care plan for a resident who was fed through a Gastrostomy tube (GT) and was to have nothing by mouth for 1 of 2 residents reviewed with a GT (Resident #76). The findings included: Resident #76 was readmitted to the facility on 05/20/22 with diagnoses that included cerebral infarction and Gastrostomy Tube (GT) status. Review of an Admission Assessment completed	F 655	F655 " On 5.25.2022, the Baseline Care Plan was reviewed and revised by the MDS as for Resident #76 on 5.25.2022 to include information necessary to care for resident. " On 6.13.2022 residents admitted from 5.30.2022 until 6.13.2022 were reviewed by the IDT to ensure baseline care plans completed to include information necessary to care for residents. Admissions that did not reflect a baseline care plan have been updated appropriately on 6.6.2022.	

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F 655	Continued From page 7 by Unit Manager (UM) #2 dated 05/20/22 indicate that Resident #76 had a GT tube and was to have nothing by mouth. Review of a Dietary communication form dated 05/20/22 read: nothing by mouth. Review of Resident #76's medical record on 05/23/22, 05/24/22, and 05/25/22 revealed no baseline care plan regarding her new GT status, feeding rate, water flushes or that Resident #76 was to have nothing by mouth. An interview with Minimum Data Set (MDS) Nurse #1 was conducted on 05/25/22 at 3:22 PM. MDS Nurse #1 stated that she was not responsible for completing baseline care plans, the admission nurse would be responsible for initiating and completing the baseline care plans. UM #2 was interviewed on 05/25/22 at 3:29 PM. UM #2 confirmed that she had completed the admission assessment on Resident #76 when she returned from the hospital. UM #2 stated that the MDS nurse would be responsible for initiating and completing the baseline care plan when Resident #76 returned to the facility after having a stroke. UM #2 confirmed that Resident #76 returned to the facility with a GT and was to have nothing by mouth which should have been included in her baseline care plan. The Director of Nursing (DON) was interviewed on 05/26/22 at 2:57 PM. The DON stated that she was the interim DON and had only been at the facility for a couple of weeks. She stated that what her understanding of the process was that the MDS nurses were responsible for initiating and completing the baseline care plans.	F 655	" On 6.13.2022 the DON and nurse manager provided education to current facility and agency licensed nurses and IDT members on completion of the baseline care plan within 48 hours of resident admission to include information necessary to care for resident. Information includes but, is not limited to initial goals of the resident, current medications, dietary orders, and any treatments or services necessary to meet resident care needs. Newly hired facility and agency licensed nurses and IDT members will receive education during orientation. The DON and nurse manager provided education and was conducted prior to working via in-person or phone. The licensed nurse will be responsible for initiating the Baseline Care Plan within 48 hours of admission and the IDT will review and revise for completeness and accuracy during morning clinical meeting. " The DON or nurse designee will complete monitoring of new admissions for baseline care plan completeness within 48 hours. Audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly, and changes will be made to the plan as necessary to maintain compliance with baseline care plans. " Date of Compliance: 6.23.2022	

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		6/23/22

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F 656	Continued From page 9 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to develop a comprehensive care plan for the use of supplemental oxygen for 1 of 5 residents reviewed for oxygen care plan (Resident #1) and also failed to develop a comprehensive and individualized care plan to address the use of antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #15). Findings included: 1. Resident #1 was admitted to the facility on 06/19/15 with a history of COVID-19. A physician's order dated 1/6/22 indicated oxygen was to be delivered at 2 liters (L) per nasal cannula continuously when saturations were less than 90%. Resident #1's comprehensive person-centered care plan did not include a respiratory care plan to include oxygen therapy. Observation on 5/23/22 at 11:06 AM, on 5/24/22 at 5:08 PM, and on 05/25/22 at 10:20 AM revealed Resident #1 was lying in bed on her right side with a nasal cannula located in her nose. The oxygen concentrator was located on the floor on Resident #1's right side. The machine's flow meter was set at 1.5 L. An interview on 05/25/22 at 10:30 AM with Nurse	F 656	F656 " Care plans for Resident #1 and Resident #15 were reviewed and updated on 6.13.2022 to reflect the Oxygen and Antipsychotic medications. " On 6.13.2022 house audit was completed by DON to identify the compliance of having the Oxygen and Antipsychotic medications accurately disclosed on the Comprehensive Care Plan. All individuals that have active orders for either Oxygen or Antipsychotic medications that have not been care planned have been identified and update accordingly on 6.13.2022. " On 6.13.2022 the ADON provided education to current facility and agency licensed nurses and IDT members on updating the care plan that is consistent measurable objectives and timeframes to meet the medical, mental, nursing and psychosocial needs to maintain or attain the resident□s highest practicable wellbeing. The licensed nurse will be responsible for updating the care plan at the time of change or during the resident scheduled care plan meeting the IDT will review and revise for completeness and accuracy during quarterly care plan meeting or in clinical morning meeting following a change in care. The DON and nurse manager provided education as ongoing for newly hired facility and agency licensed nurses and department heads.	

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F 656	Continued From page 10 #2 revealed she had been assigned to Resident #1 utilized oxygen therapy during her shifts from 5/23/22 to 5/25/22. An interview on 05/25/22 at 10:50 AM with the Director of Nursing and Administrator revealed they expected all residents who received oxygen therapy to have a comprehensive care plan to include oxygen usage. 2. Resident #15 was admitted to the facility on 09/27/21 with diagnoses that included dementia with behaviors and vascular dementia. Resident #15's physician orders revealed the following active order (initiated 09/27/21): Risperidone (antipsychotic medication) tablet 1 milligram - give one tablet by mouth two times a day Resident #15's quarterly Minimum Data Set Assessment dated 03/11/22 revealed him to be moderately impaired with no psychosis, behaviors, rejection of care, or instances of wandering. Resident #15 was coded as receiving antipsychotic medications 7 of 7 days during the lookback period. The antipsychotic medications were given on a routine basis with a gradual dose reduction last attempted on 02/15/22. Resident #15's active care plan revealed no individualized care plan for the use of antipsychotic medications. During an interview with MDS Nurse #1 on 05/26/22 at 11:42 AM, she reported when residents admit with orders for antipsychotic	F 656	The education will be a part of the orientation packet and conducted prior to working via in-person or phone. " The DON or nurse designee will be responsible for monitoring comprehensive care plan for updates and significant changes. Audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly, and changes will be made to the plan as necessary to maintain compliance with ensuring that Oxygen or Antipsychotic Medications are on the care plan. " Date of Compliance: 6.23.2022	

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F 656	Continued From page 11 medications, corresponding care plans should be developed. She reported she was not the MDS nurse for the facility when Resident #15 admitted, and she could not speak to why the antipsychotic medication care plan was not developed. She continued to state she would update Resident #15's care plan with an individualized antipsychotic care plan. During an interview with the Director of Nursing on 05/26/22 at 2:21 PM, she reported any resident using antipsychotic medications should have an individualized care plan in place for the use of antipsychotics. She stated she was not working at the facility at the time the care plan should have been created and reported it would be corrected.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, and Nurse Practitioner interview the facility failed to assess a resident for head injury, document the head injury, or determine the root cause of the head injury for 1 of 2 residents reviewed for accidents (Resident #42). During a transfer the moving part of the mechanical lift hit	F 684	F684 " On 6.13.2022 ADON educated the Unit Manager on completing an assessment of every head injury and immediately notifying the NP or MD. Resident continues to remain stable with no change noted.	6/23/22

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F 684	Continued From page 12 Resident #42, who was prescribed an anticoagulant (blood thinning medication) in the forehead causing an instant hematoma (pooling of blood outside of the blood vessels) the size of a grape with bruising to Resident #42's forehead. The findings included: Resident #42 readmitted to the facility on 02/24/22 with diagnoses that included chronic obstructive pulmonary disease, End Stage Renal disease, and others. Review of a physician order dated 02/24/22 read; Eliquis (anticoagulation) 2.5 milligrams (mg) by mouth twice a day. The comprehensive Minimum Data Set (MDS) dated 04/20/22 indicated that Resident #42 was cognitively intact and required 2-person assistance with transfers. The MDS further indicated that Resident #42 received 7 days of an anticoagulant medication during the assessment reference period. An observation and interview were conducted with Resident #42 on 05/25/22 at 4:26 PM. Resident #42 was resting in bed and was alert and verbal. She was observed to have a large egg size hematoma to her mid forehead that was noted to have a dark purple bruise in the center of the hematoma. Resident #42 stated that yesterday (05/24/21) Nurse Aide (NA) #1 and another staff member who she could not recall were transferring her to the shower chair and the middle part of the lift hit her forehead causing a "big bump" and as she touched the area with her hand she said, "oh that hurts if it I touch it."	F 684	" House audit completed by DON on 6.13.2022 for risk events related to head injuries and appropriate assessments and documentation after such injury. Findings indicated that assessments and notifications were appropriate for injuries. The licensed nurse for the resident is responsible for completing an assessment, documenting, initiating neurological checks and notifying the provider of all head injuries. " On 6.13.2022 the ADON provided education was conducted by ADON with the licensed nurses and agency nurses on the appropriate treatments, assessments, and notification following head injuries. All incidents will be reported, and documentation reviewed during the morning clinical by the IDT. The DON or nurse manager provided education as ongoing for newly hired facility and agency licensed nurses. The education will be a part of the orientation packet and conducted prior to working via in-person or phone. " The DON or ADON will be responsible for monitoring appropriate treatments, and notifications following head injuries and incidents. Audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with corporate policy. " Date of Compliance: 6.23.2022	

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F 684	Continued From page 13	F 684		

On 05/25/22 at 4:40 PM Resident #42's medical record was reviewed with no record of the incident that occurred on 05/24/22 with Resident #42 or the egg size hematoma to her forehead.

Unit Manager (UM) #1 was interviewed on 05/25/22 at 4:53 PM. UM #1 stated that she recalled being told by NA #1 on 05/24/22 that the lift had "bumped" Resident #42's head but told me there was no mark or anything "so I did not go and look at the area." UM #1 stated that she had not seen or observed Resident #42 on 05/25/22 because she had been out of the facility at her regularly scheduled dialysis treatment but stated she would go and look at the area.

NA #1 was interviewed on 05/25/22 at 5:22 PM via phone. NA #1 stated that on 05/24/22 at approximately 4:00 PM she and NA #2 were transferring Resident #42 from her wheelchair to the shower chair so they could take Resident #42 to the shower room. NA #1 stated the middle section of the lift hit Resident #42 in the forehead and Resident #42 said "ouch that hurt" and when asked if the lift had hit her she relied "yes" to NA #1. NA #1 stated she did not think that it had hit Resident #42 very hard because it happened so quickly but instantly there was a bump the size of a grape with a little bruise. NA #1 stated that she went to the hallway and the first person she saw was UM #1 and she told her the lift had accidentally hit Resident #42 in the forehead and she had a small bump and a bruise. NA #1 stated that after she reported the incident to UM #1, she saw Nurse #2 in the hallway who was responsible for Resident #42 and told her of the incident as well. NA #1 stated that Resident #42 denied any complaints and was taken to the shower room given her shower and then transferred back to

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bed without incident. NA #1 added that the bump to Resident #42's forehead did not change during the time that she was with her, it remained the size of grape with a bruise to the center of the area.

Attempts to speak to NA #2 were made on 05/25/22 and 05/26/22 were unsuccessful.

Attempts to speak to Nurse #2 were made on 05/25/22 and 05/26/22 were unsuccessful.

Nurse #3 was interviewed via phone on 05/25/22 at 5:44 PM. Nurse #3 confirmed that she had cared for Resident #42 on 05/24/22 at 7:00 PM to 7:00 AM on 05/25/22. She stated that she had received report from Nurse #2 when she arrived for her shift, but the report included nothing about any type of head injury with Resident #42. Nurse #3 stated that she medicated Resident #42 between 8:00 PM and 9:00 PM and did not notice any hematoma to her forehead and then answered her call light a couple during the night but again did not notice any hematoma to Resident #42's forehead. Nurse #3 also added that Resident #42 did not have any complaints during the night.

The Nurse Practitioner (NP) was interviewed on 05/25/22 at 5:00 PM. The NP stated she had just been made aware of the head injury on Resident #42. She stated she was on her way out of the facility when UM #1 called to tell her about it. The NP stated she went to assess the area. The NP stated she did not think Resident #42 needed a CT (special picture) scan of her head because she had no loss of consciousness, but she offered it to Resident #42 who declined. The NP did say that what they needed was neurological

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F 684	Continued From page 15 checks "but we needed them 24 hours ago" not now. A follow up interview was conducted with the NP on 05/26/22 at 11:23 AM. The NP indicated that Resident #42 was on an anticoagulant medication and that was "probably" what caused the bruise to Resident #42's forehead. She indicated that due to Resident #42's other medical issues she required the anticoagulation medication, but had she been made aware when the incident occurred, she would have ordered neurological checks to be completed per the facility ' s protocol. The neurological checks included vital signs, pupil response, and other things that we monitor for with head injury or trauma. The Director of Nursing (DON) was interviewed on 05/26/22 at 2:49 PM. The DON stated that she knew nothing about the incident with Resident #42's head injury until UM #1 told her late in the afternoon on 05/25/22. The DON stated that at the time the incident was reported the nurse should have done an initial head to toe assessment including neurological checks, completed the incident report, documented in the medical record, and notified the NP and family. The Vice President of Corporate Compliance was interviewed on 05/26/22 at 3:41 PM along with the Administrator. The Vice President of Corporate Compliance stated that the nursing staff should have notified the provider and completed neurological checks which were required with any head injury or unwitnessed fall.	F 684		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5)	F 693		6/23/22

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F 693	Continued From page 16 §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview the facility failed to administer the correct tube feeding formula at the correct rate per the physician's order for 1 of 2 residents reviewed with a Gastrostomy tube (GT) (Resident #76). The findings included: Resident #76 readmitted to the facility on 05/20/22 with diagnoses that included cerebral infarction and Gastrostomy tube (GT) status. Review of a physician order dated 05/20/22 read; Jevity (tube feeding formula) 1.5 at 45 milliliters	F 693	F693 " On 5.26.2022, the reviewed of the enteral tube feed order and recommendation for patient #76 was completed by DON. " House audit was completed on 6.13.2022 DON for all enteral feedings to ensure that all orders are accurate and are being administrated as ordered. The Unit Manager is responsible for entering all new admission orders and any new orders from the medical provider. No further deficiencies were noted at the time of the audit.	

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F 693	Continued From page 17 (ml) per hour 24 hour continuous. Review of a physician order dated 05/23/22 read; Jevity 1. 5 at 48 ml per hour 24 hour continuous. An observation of Resident #76 was made on 05/23/22 at 11:12 AM. Resident #76 was resting in bed with the head of bed elevated. She was observed to have a GT that was connected to a pump at bedside that was infusing Jevity 1.2 at 45 ml/hour (hr). An observation of Resident #76 was made on 05/24/22 at 9:24 AM. Resident #76 was resting in bed with the head of bed elevated. She was observed to have a GT that was connected to pump at bedside that was infusing Jevity 1.5 at 45 ml/hr. An observation of Resident #76 was made on 05/25/22 at 9:52 AM. Resident #76 was resting in bed with the head of bed elevated. She was observed to have a GT that was connected to pump at bedside that was infusing Jevity 1.5 at 45 ml/hr. An observation of Resident #76 was made on 05/25/22 at 11:57 AM. Resident #76 was resting in bed with the head of bed elevated. She was observed to have a GT that was connected to a pump at bedside that was infusing Jevity 1.5 at 45 ml/hr. The Assistant Director of Nursing (ADON) was interviewed on 05/25/22 at 2:53 PM. The ADON confirmed that she was responsible for Resident #76 at this time because Nurse #1 who had been working the unit had to emergently leave the facility. The ADON stated Resident #76 had	F 693	On 6.13.2022 education was provided by ADON to current facility and agency licensed nurses on the proper administration and care of the GTube. Education also consisted of dosage of the enteral feeding. Education will be ongoing for any newly hired facility and agency licensed nurses and will be part of their orientation. The DON or nurse education will be conducted prior to working via in-person or phone. The Unit Manager will be responsible for ensuring that all enteral feedings are properly entered into the medical record and any prior orders are discontinued. " The DON or nurse designee will complete monitoring of enteral feeds administration and the comparison to the orders. Audits will be completed 3 times weekly for 4 weeks, then 1 time a week for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with the administration of feeds. " Date of Compliance: 6.23.2022	

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F 693	Continued From page 18	F 693		

recently had a stroke which caused her to have trouble swallowing and so a GT was inserted. She stated that Resident #76's order had recently been increased to Jevity 1.5 at 48 ml/hr.

An observation of Resident #76 was made on 05/25/22 at 3:02 PM along with the ADON. The ADON confirmed that Resident #76's GT was infusing Jevity 1.5 at 45 ml/hr and it should be infusing at 48 ml/hr. The ADON stated that "was probably my fault because I put the feeding on hold for her medications and it probably defaulted back to the previous rate." The ADON was observed to change the rate of the tube feeding formula to 48 ml/hr.

Unit Manager (UM) #1 was interviewed on 05/25/22 at 3:57 PM. UM #1 stated that Resident #76 had recently had a stroke and had a GT inserted for nutrition. She recalled confirming the physician order to increase the rate from 45 ml/hr to 48 ml/hr and once confirmed the order would populate to the Medication Administration Record (MAR). She stated that Nurse #1 who was working that unit at the time should have gone to Resident #76's room and changed the pump to reflect the new order. UM #1 stated that the nursing staff should be checking the feeding that was infusing along with the rate each time they were in the room and should ensure both were correct per the physician order.

An attempt to speak to Nurse #1 who worked the unit where Resident #76 resided on 05/23/22, 05/24/22, and 05/25/22 was made on 05/25/22 at 4:40 PM and was unsuccessful.

The Director of Nursing (DON) was interviewed on 05/26/22 at 2:57 PM. The DON stated that the

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F 693	Continued From page 19 nurses on the hall should check the tube feeding formula and rate at least once per shift and should ensure that they were correct per the physician order.	F 693		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and resident and staff interviews, the facility failed to ensure oxygen therapy was delivered at the prescribed rate ordered for 3 of 5 residents reviewed for oxygen (Resident #1, Resident #54, and Resident #64). The facility failed to provide routine maintenance to oxygen concentrators to ensure the air filters were free from dust and debris for 4 of 5 residents reviewed for oxygen therapy (Resident #1, Resident #46, Resident #54, and Resident #64). Findings included: 1. Resident #1 was admitted to the facility on 06/19/15 with diagnosis that included a history of COVID-19. A physician's order dated 1/6/22 indicated oxygen 2 liters (L) per nasal cannula continuously was	F 695	F695 " On 5.26.2022 nurse leadership reviewed oxygen orders, administration of oxygen and ensured that respiratory equipment maintenance was corrected and completed for Resident #64, Resident #54, Resident #46, and Resident #1. All tubing, filters, and canisters were cleaned. Oxygen flow rate was adjusted to match the prescribed order. " On 5.26.2022 a house audit was completed by nurse leadership for all oxygen orders. Corrections were made to reflect the appropriate oxygen flow rate as well as a complete change out of tubing, canisters, and cleaning of filters. " On 6.13.2022 the ADON provided education to current facility nurses,	6/23/22

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delivered when saturations were less than 90%.

A quarterly Minimum Data Set (MDS) dated 2/26/22 indicated Resident #2 was moderately impaired for cognition and did not include oxygen usage.

According to the Medication Administration Record (MAR) dated May 2022, oxygen setup was to be performed weekly and was completed on 5/11/22 by Nurse # 5 and 5/18/22 by Nurse # 4. Oxygen saturations range between 94% to 98%.

An observation on 5/23/22 at 11:06 AM revealed Resident #1 was lying in bed on her right side with a nasal cannula located in her nose. The oxygen concentrator was located on the floor on Resident #1's right side. The machine's flow meter was set at 1.5 L. A rectangular shaped air filter, located on the right lower portion on the machine, contained a thick gray fuzzy substance covering the entire surface of the black filter.

An additional observation on 5/24/22 at 5:08 PM revealed Resident #1 was lying in bed on her right side with a nasal cannula located in her nose. The oxygen concentrator was located on the floor on Resident #1's right side. The machine's flow meter was set at 1.5 L. A rectangular shaped air filter, located on the right lower portion on the machine, contained a thick gray fuzzy substance covering the entire surface of the black filter.

An additional observation on 05/25/22 at 10:20 AM revealed Resident #1 was lying in bed on her right side with a nasal cannula located in her nose. The oxygen concentrator was located on

agency licensed nurses and all nurse aids on the administration of oxygen, care of the oxygen equipment and when routine maintenance will be. Newly hired facility nurses, agency licensed nurses and nurse aids will receive education during orientation. The DON or nurse manager provided education and conducted prior to working via in-person or phone. The night shift licensed nurse will be responsible for overseeing the completion of the routine maintenance of equipment and that the flow rate of the administrated oxygen coincides with the order.

" The Unit manager or nurse designee will complete the monitoring of the equipment maintenance as well as the administration of oxygen. Audits will be completed 5 times weekly for 4 weeks, then 3 times weekly for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with the prescribing orders.

" Date of Compliance: 6.23.2022

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the floor on Resident #1's right side. The machine's flow meter was set at 1.5 L. A rectangular shaped air filter, located on the right lower portion on the machine, contained a thick gray fuzzy substance covering the entire surface of the black filter.

Interview on 05/25/22 at 10:30 AM with Nurse #2 revealed she had been assigned to Resident #1 on day shift from 5/23/22 through 5/25/22. Nurse #2 indicated she had not looked at the concentrator to determine if Resident #1 had received the correct liters via nasal cannula nor had she personally checked Resident #1's oxygen saturation during her shifts. Nurse #2 also stated she was unsure how to clean the concentrator filter but did acknowledge it was covered with a thick gray fuzzy substance that was preventing a clear air flow.

An interview with the Unit Manager on 5/24/22 at 5:27 PM revealed all residents who received oxygen therapy should have their oxygen filters cleaned weekly on night shift UM #1 also stated that each nurse should check the oxygen concentrators' flow meter and the resident's oxygen saturations every shift to determine the correct dosage of oxygen was being delivered.

An interview on 05/25/22 at 10:17 AM with Nurse #5 revealed she had worked on 5/11/22 from 7P-7A and was assigned to Resident #1; however, she had not notice if the filter was cleaned, and she had not cleaned it herself due to the night shift being very busy. Nurse #5 stated she was unsure where the filter was located on the oxygen concentrator and had never been asked to clean it. Nurse #5 did not recall if she had checked the flow meter or her oxygen

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saturation to ensure Resident #1 was delivered the correct dosage of oxygen on that night.

Multiple attempts to contact Nurse #4 for interview were made without success.

An interview on 05/25/22 at 10:45 AM with the Regional Nurse Consultant revealed all oxygen concentrator filters should be cleaned weekly. She acknowledged a filter covered with the thick gray fuzzy substance would not allow for clear airflow.

An interview on 05/25/22 at 10:50 AM with the Director of Nursing and the Administrator was conducted. The DON indicated each nurse assigned to a resident on oxygen therapy should verify the correct dosage is being delivered and check oxygen saturations each shift. The DON and Administrator explained the policy should be followed to include weekly filter cleaning.

2. Resident #54 was admitted to the facility on 2/26/22 with chronic obstructive pulmonary disease and status post a cardiac catheterization.

A physician's order dated 6/11/21 indicated oxygen was to be delivered at 3 liters (L) per nasal cannula continuously for COPD.

A quarterly Minimum Data Set (MDS) dated 5/5/22 indicated Resident #54 was cognitively intact and oxygen therapy was in use.

According to the Medication Administration Record (MAR) dated May 2022, oxygen setup was performed weekly and was completed on 5/11/22 by Nurse #5 and 5/18/22 by Nurse #3.

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An observation on 05/23/22 at 2:11 PM revealed Resident #54 lying in bed with a nasal cannula intact to her nostrils. The oxygen concentrator flow meter indicated she was delivered 3 L/ NC and the filter is dirty with a thick layer of a gray fuzzy substance covering it.

An observation on 05/24/22 at 5:11 PM revealed Resident #54 lying in bed with a nasal cannula intact to her nostrils. The oxygen concentrator flow meter indicated she was being delivered 2.5 L/NC and the filter was dirty with a thick layer of a gray fuzzy substance covering it.

An observation on 05/25/22 at 9:50 AM revealed Resident #54 lying in bed with a nasal cannula intact to her nostrils. The oxygen concentrator flow meter indicated she was being delivered 2.5 L/NC and the filter is dirty with a thick layer of a gray fuzzy substance covering it.

An observation and interview with Nurse #2 was conducted on 05/25/22 at 10:30 AM. Nurse #2 indicate she had not checked Resident #54's oxygen concentrators flow meter to determine if the correct dosage of oxygen was being delivered and she was unable to vocalize the correct dose and stated she had personally not checked Resident #54's oxygen saturation. She indicated she had not been instructed to clean the filters and therefore she had not noticed the filter was dirty.

An observation and interview on 05/25/22 at 10:45 AM with the Corporate Nurse Consultant revealed the oxygen concentrator filter was covered with a thick gray fuzzy substance and Resident #54 was currently being delivered oxygen at 2.5 L/NC. She indicated filters should

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be cleaned weekly. She also indicated all nurses should ensure each resident who is ordered oxygen therapy have the correct dosage delivered and their oxygen saturations obtained each shift.

An interview on 05/25/22 at 10:50 AM with the Director of Nursing and the Administrator was conducted. The DON indicated each nurse assigned to a resident on oxygen therapy should verify the correct dosage is being delivered and check oxygen saturations each shift. The DON and Administrator explained the policy should be followed to include weekly filter cleaning.

3. Resident #46 was admitted to the facility on 04/19/21 with diagnoses that included traumatic brain injury and respiratory failure that required a tracheostomy.

The significant change Minimum Data Set (MDS) assessment dated 04/22/22 revealed Resident #46 had severe cognitive impairment and required total assistance with all activities of daily living. The MDS also indicated the Resident had a tracheostomy and required oxygen therapy.

A review of Resident #46's Physician orders revealed an order dated 04/18/22 for oxygen 6 liters per minute and mist collar (adds moisture to the air) setting at 28% continuously via tracheostomy.

On 05/23/22 at 11:37 AM an observation was made of Resident #46 lying in bed sleeping (respirations even and unlabored) with oxygen being delivered between 2-3 liters per minute and mist collar setting at 28% continuously via tracheostomy. The oxygen concentrator in use

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only had the potential to deliver up to 5 liters of oxygen.

An observation of Resident #46 on 05/24/22 at 3:11 PM was made of the Resident lying quietly with oxygen being delivered between 2-3 liters per minute and mist collar setting at 28% continuously via tracheostomy.

On 05/24/22 at 4:10 PM an interview was conducted with Nurse #2 who cared for Resident #46 on 05/24/22 and 05/23/22. The Nurse explained that Resident #46's oxygen should be set on 4 liters and stated she checked it every time she went into his room to do his trach care which was first thing in the mornings. The Nurse was asked to check the Resident's Physician order for the oxygen order which she did and found the order was for 6 liters per minute. Nurse #2 accompanied Surveyor to Resident #46's room to find the oxygen setting between 2-3 liters per minute and noted that the oxygen concentrator being used only went up to 5 liters. The Nurse stated she would need to get a concentrator that delivered more than 5 liters of oxygen for Resident #46.

On 05/25/22 at 11:14 AM during an interview with Unit Manager (UM) #1 she explained that the nurses should have noticed Resident #46's oxygen was not set on the correct setting and if they had they would have noticed that the oxygen concentrator did not go up to 6 liters. The UM continued to explain that the oxygen order was changed that morning to 4 liters per minute and indicated the Resident was doing well with the lesser amount of oxygen flow.

During an interview with the Nurse Practitioner on

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05/25/22 at 3:30 PM she stated it was her expectation that Resident #46's oxygen be delivered at the order prescribed by the Physician.

On 05/25/22 at 5:05 PM an interview was conducted with the Interim Director of Nursing (DON) who indicated that if the nurses were checking the oxygen order against the concentrator they would have noticed that the concentrator could not deliver 6 liters of oxygen and hopefully it would have motivated them to get a concentrator that would deliver the 6 liters per minute. The DON stated she expected the nurses to follow the Physician's orders.

On 05/26/22 at 2:44 PM during an interview with the Administrator and the Vice President of Corporate Compliance the Administrator explained that she was aware of Resident #46's oxygen situation and the oxygen orders had been "changed". The Administrator stated she expected the oxygen be delivered at the rate prescribed by the Physician.

4. Resident #64 was admitted to the facility on 03/22/22 with diagnoses that included heart failure and chronic obstructive pulmonary disease.

The admission Minimum Data Set (MDS) assessment dated 03/29/22 revealed Resident #64 was cognitively intact and received oxygen therapy.

A review of Resident #64's Physician ordered dated 05/05/22 revealed an order for 3 liters per minute of oxygen with humidification. There was no order to change the oxygen tubing or clean the

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concentrator filters.

A review of Resident #64's May 2022 Medication Administration Record and Treatment Administration Record revealed an order to administer oxygen at 3 liters with humidification. There was no order to change the oxygen tubing or clean the concentrator filters.

During an observation and interview of Resident #64 on 05/23/22 at 11:55 AM the Resident was lying in bed receiving oxygen therapy via a nasal canula that was dated 04/26/22 and initialed with Nurse Aide (NA) #3's initials. The oxygen setting was on 1.5 liters per minute. There was no humidification attached to the concentrator. The side filters on the oxygen concentrator had a whitish buildup of dust that rolled when touched. The Resident explained that he thought the oxygen was supposed to be on 3 liters and that he did not know when the tubing was last changed. Resident #64 stated he did not adjust the oxygen setting.

On 05/24/22 at 3:20 PM during an interview with Medication Aide (MA) #1 who medicated Resident #64 on 05/24/22 and 05/23/22 she explained that as a Medication Aide she was not allowed to adjust the oxygen flow rate and the nurse that "covered" the Resident was responsible for the Resident's oxygen therapy. The MA stated the only thing she could do was to put their oxygen canula back into their nose. The MA stated she thought the oxygen tubing and cleaning the filters was done once a week, but she did not know when or by whom.

An observation was made of Resident #64 on 05/24/22 at 4:26 PM. The oxygen setting was on

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1.5 liters per minute, the oxygen tubing was dated 04/26/22 and initialed with NA #3's initials and the whitish dust build up remained on the filters.

On 05/24/22 at 5:42 PM during an interview with Nurse #1 she confirmed that she worked with Resident #64 on 05/23/22 and 05/24/22 and stated that she had not checked on the Resident's oxygen that shift. The Nurse explained that the nurse aides and medication aides could not adjust the oxygen settings but could change the tubing and clean the filter. The Nurse reviewed the Resident's oxygen order and stated it should be on 3 liters per minute then accompanied the Surveyor to Resident #64's room to observe the oxygen setting. The Nurse stated the oxygen was set on 2 liters and adjusted the setting to deliver 3 liters per minute. The Nurse did not comment on the dated oxygen tubing, no humidification or the dirty filters on the concentrator.

During an interview with Unit Manager (UM) #1 on 05/25/22 at 5:50 PM the UM explained that the oxygen tubing should be changed, and the concentrator filters should be cleaned once a week on Sunday by the night shift staff. The UM accompanied the Surveyor to Resident #64's room and noted the oxygen tubing dated 04/26/22 and initialed with NA #3's initials and the dirty concentrator filters and stated the tubing needed to be changed and the filters looked as if there was more than a week's worth of dust build up present.

An interview was conducted with the Nurse Practitioner (NP) on 05/25/22 at 4:04 PM. The NP stated she expected the oxygen be delivered at the rate prescribed by the Physician and the care

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F 695	Continued From page 29 of the oxygen be done per the facility policy. During an interview with the Interim Director of Nursing (DON) on 05/25/22 at 5:05 PM the DON indicated the staff should be checking Resident #64's oxygen setting for the correct setting every time they go into the room and the humidification should be changed when it ran out. The DON explained that she would have to defer to the facility policy as to when the tubing was changed, and the filters were cleaned but stated if the filters had visible buildup of dust then they should be cleaned more often. An interview was conducted with Administrator with the Vice President of Corporate Compliance present on 05/26/22 at 2:55 PM. The Administrator explained that she was already aware of the oxygen situation and had completed an audit on the oxygen, the humidification, the tubing changes and the cleaning of the filters. She continued to explain that there would be changes made to the oxygen process as far as who would be responsible for the care of the oxygen tubing and filters and how often it would be done. The Administrator indicated she expected the nurses to ensure the residents' oxygen was being delivered at the rate prescribed by the Physician.	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.	F 698		6/23/22

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F 698	Continued From page 30 This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner (NP) interview the facility failed to transcribe and carry out treatment order for a resident's new dialysis access site for 1 of 2 dialysis residents reviewed (Resident #42). The findings included: Resident #42 readmitted to the facility on 02/24/22 with diagnoses that included end stage renal disease. Review of the comprehensive Minimum Data Set (MDS) dated 04/20/22 revealed that Resident #42 was cognitively intact and received dialysis during the assessment reference period. Review of a Care Area Assessment (CAA) dated 04/21/22 read in part; Resident #42 recently had a hemodialysis catheter placed in her left upper chest and a fistula (tube) created in her left lower arm for dialysis that was completed on 04/07/22 both healing well with no signs or symptoms of infection. Review of a consultation note dated 05/17/22 from the local Dialysis Access Center read in part; "Fistula infected. Not ready for cannulation." The recommendations read: Keflex (antibiotic) 500 milligrams (mg) by mouth twice a day for 5 days. Wet to dry dressing x 5 days (saline and gauze) Review of Resident #42's Medication Administration Record (MAR) dated 05/01/22 through 05/31/22 indicated that Resident #42 had received the Keflex 500 mg by mouth twice a day as ordered.	F 698	F698 " On 5.24.2022 the Wound Care nurse identified that the wound for Resident #42 has been healed so that the fistula can be placed. No infection noted as of 6.13.2022. " House audit retro-dating back to 5.17.2022 was completed by DON on 6.13.2022 for all dialysis patients to evaluate orders and to ensure that any new orders are transcribed accordingly. " On 6.13.2022, the DON/ADON educated Licensed Nurses on the dialysis communication tool and transcribing orders upon the return of the dialysis resident. The licensed nurse is responsible for ensuring that the dialysis communication form is reviewed upon return of the dialysis patient and that all orders are transcribed into the medical chart. The DON or nurse education will be ongoing for newly hired facility and agency licensed nurses. The education will be a part of the orientation packet and conducted prior to working via in-person or phone. " The DON will complete the monitoring of the dialysis communication forms to confirm that all orders are accurately transcribed and up to date. Audits will be completed 3 times weekly for 4 weeks, then 1 time a week for 8 weeks, then randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as	

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F 698	Continued From page 31 Review of Resident #42's Treatment Administration Record (TAR) dated 05/01/22 through 05/31/22 revealed no order for the wet to dry treatment to Resident #42's left wrist area. An observation and interview were conducted with Resident #42 on 05/24/22 at 10:00 AM. Resident #42 was resting in bed and was alert. She stated she had gone to the doctor last week because they were preparing her for a dialysis access port to be placed in her left wrist, but it had gotten infected and had not healed. Resident #42 stated that they put her on an antibiotic and ordered a dressing to her left wrist everyday but that did not always happen. She stated that it had gone up to 3 days without the dressing being changed. Resident #42 held her left wrist up and it was observed a have dressing in place that appeared dry but contained no date of when it had been changed. Unit Manager (UM) #1 was interviewed on 05/24/22 at 5:27 PM. UM #1 stated that Resident #42 recently had a dialysis fistula placed in her left wrist and it got infected, so they put a chest port in to use until the left wrist was ready to be used. UM #1 stated that when Resident #42 returned from the doctor on 05/17/22 she recalled a prescription for the Keflex, and she recalled entering the order into the electronic medical record. She stated she did not recall seeing the consultation report or the orders that were on it including the treatment order to Resident #42's left wrist. UM #1 reviewed Resident #42's electronic record and could not locate any treatment order to her left wrist and stated, "it must have gotten missed."	F 698	necessary to maintain compliance with the prescribing orders. " Date of Compliance: 6.23.2022	

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The Wound Nurse (WN) was interviewed on 05/25/22 at 12:25 PM. The WN stated that Resident #42's left wrist where they were either putting in or removing a dialysis access port became infected and she had gone to the doctor and had been placed on an antibiotic. She stated that she never saw any paperwork from Resident #42's doctor's appointment on 05/17/22 and was not aware of any treatment orders. Normally the WN stated that when a resident went to a doctor's appointment the paperwork was placed into the UM's mailbox and then given to the Medical Records (MR) clerk to upload into the electronic medical record. The WN added, if she would have seen the consultation report she would have transcribed and performed the treatment orders as stated on the consultation form.

The Nurse Practitioner (NP) was interviewed on 05/26/22 at 11:23 AM. The NP stated that on 05/24/22 she became aware of the consultation report dated 05/17/22 from Resident #42's doctor appointment. She stated apparently the antibiotic came back on a prescription and was carried out and administered as ordered but the treatment order did not. The NP stated that she needed to read all reports of consultation and would have signed off indicating that she had reviewed them. Then NP stated had she seen the consultation report dated 05/17/22 she would have entered the orders or asked the WN to enter the order so that the treatment could have been completed as ordered. She added that she did get a lot of consultations to review so she was not sure why she did not get the one for Resident #42.

The MR clerk was interviewed on 05/26/22 at 12:03 PM. The MR clerk stated that when a resident returned from a doctor visit the UM or

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F 698	Continued From page 33 nurse would get any paperwork and pass them along to the NP or doctor and then give to me to scan into the electronic record and shred the original. The MR clerk stated that once the consultations were given to her, she assumed that they had been through the proper channels, and she would scan them into the record and dispose of the original copy. The Director of Nursing (DON) was interviewed on 05/26/22 at 2:49 PM. The DON stated she was the interim DON and had only been at the facility for a couple of weeks. The DON stated she knew very little about the consultation report for Resident #42 but stated what may have happened was that the consultation report went straight to medical records without going to the NP or through nursing and it should have so that all the orders could have been transcribed and carried out appropriately.	F 698		
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		6/23/22

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F 755	Continued From page 34 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to dispose of medications refused by a resident in a manner to prevent accidental exposure when a nurse was observed to throw medications in the waste basket on the medication cart which was easily accessible to cognitively impaired residents in the hallway on 1 of 4 hallways observed (B Hall). Findings included: Resident #35 was admitted to the facility on 10/05/21. An observation on 05/24/22 at 10:22 AM revealed Nurse #2 exit Resident #35's room holding a cup which contained multiple whole pills and approached the medication cart. Nurse #2 was observed to place the entire cup of pills into the waste basket located on the right side of the medication cart which lid was opened and	F 755	F755 " Nurse #2 was educated by DON on 6.13.2022 to review the proper means of disposal of medications and company policy. Nurse #2 is no longer employed at the facility. " The ADON or nurse manager will complete observational audits with current facility licensed nurses, agency nurses and medication aids by 6.13.2022 to validate medication disposal competency and practices as appropriate. " On 6.13.2022, the ADON began educating licensed nurses and medication aides on Medication disposal. Education will be ongoing for all newly hired licensed nurses, medication aides, and for agency licensed nurses. The education will be a part of the orientation packet and	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILKESBORO	1000 COLLEGE STREET WILKESBORO, NC 28697

(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 755	Continued From page 35 accessible to residents. There were several residents in the hallway near the medication cart. An interview on 05/24/22 at 10:25 AM with Nurse #2 revealed she had attempted to administer medications to Resident #35, but the resident had refused her morning medications. Nurse #2 indicated she discarded the medications refused by Resident #35 in the waste basket because they did not contain any narcotic medications which was the only type of medications, she had been trained had to be placed in the sharps box for disposal. An interview on 05/24/22 at 10:28 AM with Unit Manager #1 indicated all refused medications should be discarded in the pill buster device located in the medication room and should never be placed directly into the trash can when in whole pill format because there are multiple wandering residents known to rummage through the trash cans. An interview on 05/24/22 at 10:34 AM with the Corporate Nurse Consultant revealed all medications should be discarded in a pill buster device located in the medication room and never placed directly in the trash receptacle where residents could potentially gain access. An interview on 05/24/22 at 10:36 AM with the Director of Nursing revealed she was new to the facility; however, she had been trained medications should be discarded either in the sharps box or the pill buster device in the medication room. An interview on 05/24/22 at 10:40 AM with the Administrator revealed she expected all nurses or	F 755	conducted prior to working via in-person or phone. The ADON will be responsible for completing competencies for Medication disposal for facility licensed nurses and medication aides upon hire, annually and as needed to maintain proper medication disposal practices. " ADON or nurse designee will be responsible for conducting observational audits for 1 Medication Aides or licensed nurses 5 times weekly for 4 weeks, then twice weekly for 8 weeks and randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with medication disposal practices. " Date of Compliance: 6.23.2022	

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F 755	Continued From page 36 medication aides to follow the facility policy for medication destruction and discard refused medications as well as keep all medications out of the reach of residents.	F 755		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure controlled substances were stored and secured using a double locked feature for 1 of 2 medication	F 761	F761 " Nurse #2 was educated by DON on 6.13.2022 to review the proper handling of	6/23/22

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F 761	Continued From page 37	F 761		

storage refrigerators. Additionally, the facility also failed to remove a local anesthetic patch placed at bedside for 1 of 1 resident (Resident #63).

Findings included:

1. An observation of the medication storage room located on the corner of A and B hall on 05/26/22 at 1:15 PM with Unit Manager #1 revealed a miniature refrigerator was left unlocked. The mini refrigerator contained a mounted bracket to enable it to be locked; however, the key lock was not attached to bracket which would allow the refrigerator to be fully locked. Inside the refrigerator were multiple medications to include the following items:

a) An orange-brown plastic bag which contained 10 individually wrapped doses of Ativan/Benadryl/Haldol (ABH) gel 0.5 milligram (mg)/12.5mg/1mg labeled for a resident.

b) A clear plastic box labeled Fridge Kit #5200 which contained various unopened insulin pens for house stock as well as 2 unopened single use vials of Ativan 2mg/ml injectable medication.

An interview on 05/26/22 at 1:15 PM with Unit Manager (UM) #1 revealed all controlled substances should always be secured under double lock and key when not in use. UM #1 stated she was unsure who was the last person to retrieve items from the refrigerator and had not applied new red zip ties to the plastic box to reseal it nor who had not applied the key lock back across the brackets to ensure the fridge was securely locked. UM #1 attempted to use her assigned key to unlock the lock hanging in the locked position on the bracket, but her key was

medications and to ensure that medications are secured according to medication class. Nurse #2 is no longer employed at the facility.

" The ADON or nurse manager will complete observational audits with current facility licensed nurses, agency nurses and medication aids by 6.13.2022 to validate secure medication storage competency and handling practices as appropriate.

On 6.13.2022, the ADON began educating licensed nurses and medication aides on Medication storage and disposal. Education will be ongoing for all newly hired licensed nurses, medication aides, and for agency licensed nurses. The ADON will be responsible for completing competencies for ensuring that medications are handled and stored appropriately. Education will be ongoing for all newly hired facility licensed nurses and medication aides as well as agency nurses. The DON or nurse education will be a part of the orientation packet and conducted prior to working via in-person or phone.

" ADON or nurse designee will be responsible for conducting observational audits for 1 Medication Aides or licensed nurses 5 times weekly for 4 weeks, then twice weekly for 8 weeks and randomly thereafter. Results of audits will be reviewed during QAPI monthly and changes will be made to the plan as necessary to maintain compliance with medication storage and handling

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F 761	Continued From page 38 unable to unlock it. An interview on 05/26/22 at 3:30 PM with the DON revealed she expected the medication refrigerator to be locked when not in use. She indicated nurses were educated that all controlled substances were to be secured under double lock and key and was not aware until after the observation with the UM that the key was not compatible with the lock attached to the refrigerator. 2. Resident #63 was admitted to the facility on 8/14/20 with diagnosis that include low back pain. A quarterly Minimum Data Set (MDS) dated 5/12/22 revealed Resident #63 was cognitively intact. A review of the Medication Administration Record (MAR) for May 2022 indicated Resident #63 was to receive a Lidoderm 5% topical patch (Lidocaine 5%) daily on for 12 hours and off for 12 hours. An observation and interview on 05/23/22 at 1:56 PM revealed Resident #63 sitting in her wheelchair in front of an overbed table sewing squares of cloth together. A white rectangular shaped item with "5/23" written on it in black magic marker was observed on the overbed table. Resident #63 stated Nurse #2 had entered her room around noon because Nurse #2 was late giving medications that morning and laid the pain patch on the table and administered her oral medications. According to Resident #63, Nurse #2 left her and walked over to her roommate and administered her roommates' medication then left the room. Resident #63 stated she had thought	F 761	practices. " Date of Compliance: 6.23.2022	

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F 761	Continued From page 39	F 761		

the nurse would come back to apply her pain patch after she threw away the medication cups, but Nurse #2 had not returned.

An observation and interview were conducted with Nurse #2 on 05/23/22 at 2:02 PM in Resident #63's room. Nurse #2 entered Resident #63's room where the Lidoderm patch remained on the overbed table. Resident #63 asked Nurse #2 if she was going to apply her patch to her back. Nurse #2 stated she had laid the patch on the overbed table when she administered Resident #63 her oral medications and was not paying attention and overlooked the patch on the table because "it blended in with the other square pieces of cloth Resident #63 was sewing". Nurse #2 further stated she was usually unable to access the area where the patch was to be applied when Resident #63 was already in her wheelchair and would leave the patch in Resident #63's room until she rang her call light to let Nurse #2 know that she was getting up and ready for it to be applied.

An interview on 05/25/22 at 10:50 AM with the Director of Nursing and Administrator revealed all nurses or medication aides who are assigned to administer medications to residents should ensure the orders are followed as written and medications should never be left at bedside.