| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| E 000 | Initial Comments<br><br>An unannounced recertification and complaint investigation? survey was conducted on10/18/22 through 10/31/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #HEOF11. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>A recertification and complaint investigation survey was conducted from 10/18/22 through 10/31/22. Event ID# 4NEN11.<br><br>Immediate Jeopardy was identified at CFR 483.25 at tag F689 at a scope and severity (J). This tag constituted Substandard Quality of Care.<br><br>Immediate Jeopardy began on 7/29/22 and was removed on 10/28/22. An extended survey was conducted.<br><br>The following intakes were investigated NC00191904 and NC00194332.<br><br>Three of the 4 complaint allegations were substantiated resulting in deficiencies (F689). | F 000 | | |
| F 584 SS=B | Safe/Clean/Comfortable/Homelike Environment<br>CFR(s): 483.10(i)(1)-(7)<br><br>§483.10(i) Safe Environment.<br>The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>The facility must provide-<br>§483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent | F 584 | | 11/15/22 |

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

Electronically Signed | 11/11/2022

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| F 584 | Continued From page 1<br>possible.<br>(i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.<br>(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.<br><br>§483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;<br><br>§483.10(i)(3) Clean bed and bath linens that are in good condition;<br><br>§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);<br><br>§483.10(i)(5) Adequate and comfortable lighting levels in all areas;<br><br>§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and<br><br>§483.10(i)(7) For the maintenance of comfortable sound levels.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to clean the Packaged Terminal Air Conditioner (PTAC) units (a type of heating and air conditioning system used in a single living space) in residents' rooms (rooms # 501, 503, 505, 506, 510, 511, 515, 401 and 408) and failed to replace and to maintain filter in good condition (room 408) on 9 of 21 rooms observed. | F 584 | On 10/21/2022, the Maintenance Director cleaned the Packaged Terminal Air Conditioner (PTAC) units indentified 401, 408, 501, 503, 505, 506, 510, 511 and 515.<br>All PTAC units were audited for cleanliness and filters by the Maintenance Director on 10/24/2022. 39 units were | |

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| F 584 | Continued From page 2<br><br>Findings included:<br><br>1.On 10/18/22 at 10:35 AM, initial tour of residents' rooms was conducted. The PTAC units in rooms 501, 503, 505, 506, 510, 511 and 515 were dirty with dust and debris noted on the vents.<br><br>On 10/19/22 at 2:30 PM and on 10/20/22 at 11:05 AM, the PTAC units were observed on same condition, dirty with dust and debris on the vents.<br><br>On 10/21/22 at 9:25 AM, a tour of residents' rooms was conducted with the Maintenance Director. Rooms 501, 503, 505, 506, 510, 511 and 515 were observed and the Maintenance Director acknowledged that the units were dirty and needed to be cleaned. He stated that he started as the Maintenance Director of the facility 3 months ago and he was not aware that the PTAC units were dirty. He added that he was responsible for cleaning the vents of the units and he was by himself, and he needed help.<br><br>On 10/21/22 at 9:50 AM, the Administrator was interviewed. She stated that the Maintenance Director needs help in cleaning the PTAC units and she was trying to hire an Assistant Maintenance Director to help him out.<br>2. On 10/18/22 from 12:15 PM to 12:26 PM, the following was observed on the 400 hall:<br><br>" In room 401, the Packaged Terminal Air Conditioner (PTAC) unit had multiple dried white particles and dried plant leaves inside the vents.<br>" In room 408, the PTAC unit had multiple areas of a white substance as well as multiple particles of what resembled a graham cracker | F 584 | identified that needed cleaning and 13 units were identified to need filters.<br>All units indentified were cleaned and filters placed on 10/28/2022 by the Maintenance Director and/or Maintenance Assistant.<br>The Administrator educated the Maintenance Director and Maintenance Assistant on the proper cleaning process for PTAC units on 11/9/2022.<br>The Administrator or designee will audit 10 PTAC units per week for 12 weeks for cleanliness and filters.<br>The audit will be reviewed in facility QAPI meeting monthly for the duration of the monitoring. | |

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| F 584 | Continued From page 3<br>inside the vents. There was one missing filter, and the other filter had a thick gray substance with multiple frayed areas.<br><br>On 10/21/22 at 9:20 AM, an interview with observations of the PTAC units was conducted with the Maintenance Director. He explained he became the Director of Maintenance three months ago and was the only one responsible for the department at that time. He continued to explain that he took the PTAC covers off to clean the vents/coils and filters at least monthly but was unaware the PTAC's observed were in need of cleaning or that the filter was missing and in need of changing.<br><br>An interview was conducted with the Administrator on 8/21/22 at 9:49 AM, who stated she expected the PTACs to be cleaned, as well as the filters to be clean and in good repair. She further stated the facility was getting ready to hire a Maintenance Assistant that will assist the Maintenance Director in cleaning the PTAC units and filters on a regular monthly schedule. | F 584 | | |
| F 641 SS=B | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of cognition (Resident #17), accidents (Resident #17) and behaviors (Resident #16). This was for 2 of 16 residents who MDS assessments were | F 641 | On 11/8/2022 the MDS Coordinator modified assessments for Resident #17 dated 9/21/2022 and 7/26/2022 and assessment dated 7/17/2022 for Resident #16.<br>All MDS assessments completed since | 11/15/22 |

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| F 641 | Continued From page 4<br>reviewed.<br><br>The findings included:<br><br>1a. Resident #17 was admitted to the facility on 7/20/22 with diagnoses that included dementia and depression.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 9/21/22 indicated Resident #17 had clear speech and sometimes was able to make self-understood and sometimes understood others. Section C, the Cognitive Patterns section, was not accurately assessed for Resident #17. Question C0100 was coded to indicate Resident #62 was rarely/never understood and the Brief Interview for Mental Status (BIMS- questions C0200-C0400) was marked as not assessed.<br><br>On 10/20/22 at 10:10 AM, an interview occurred with the Activities Director, who indicated she completed Section C on Resident #17's quarterly MDS assessment dated 9/21/22. She stated she attempted to the complete Section C but Resident #17 was not able to answer the questions appropriately, therefore marking the assessment as not assessed. The Activities Director stated she was unaware of the coding instructions specified in the Resident Assessment Instrument (RAI) manual for completion of the resident interviews in Section C.<br><br>On 8/21/22 at 9:49 AM, the Administrator stated it was her expectation for all residents to be assessed accurately in the area of cognition.<br><br>1b. Resident #17 was admitted to the facility on 7/20/22 with diagnoses that included dementia, | F 641 | 10/1/2022 will be reviewed by the Director of Nursing/designee by 11/11/2022 to ensure appropriate coding for sections C,E and J. Any assessments that are noted to be incorrect will be modified by the facility Minimum Data Set(MDS)nurse. The Director of Nursing will re-educate the facility MDS nurse, Social Worker and Director of Rehabilitation(DOR) on accurate MDS assessments and documentation as it relates to the resident cognition, behaviors and accidents by 11/11/2022.<br>An audit will be completed by the DON/designee weekly to ensure each resident MDS assessments are accurate for sections C,E, and J prior to submission. The audit will be completed for 12 weeks and reviewed in resident review meeting weekly and monthly in QA meeting for the duration of the monitoring. The plan of correction may be changed or extended to ensure ongoing compliance. | |

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| F 641 | Continued From page 5 | F 641 | | |

unsteadiness on feet, recent history of left hip fracture and muscle weakness.

A review of Resident #17's medical record revealed she had a fall on 8/5/22 with no injury, 8/14/22 with no injury, 8/15/22 with a minor injury and 9/3/22 with a minor injury since the Admission Minimum Data Set (MDS) assessment on 7/26/22.
2.Resident #16 was admitted to the facility on 1/30/2020 with diagnoses that included dementia.

The resident's medical record included a progress note dated 7/14/2022 by Nurse #7. The note indicated Resident #16 was crying due to the belief her family was killed. The resident was started on ABH (Ativan, Benadryl, Haldol) gel for agitation.

The resident also had a progress note dated 7/15/2022 by Nurse #8 indicating the resident refused all oral medications.

The resident's quarterly Minimum Data Set (MDS) dated 7/17/2022 indicated the resident was severely cognitively impaired, required extensive assistance with all activities of daily living, and received antianxiety, antidepressant, and antipsychotic medications 7out of 7 days during the assessment period. The MDS also indicated the resident did not display physical or verbal behaviors not directed toward others and did not reject care during the assessment period.

On 10/20/2022 at 10:08 AM an interview was conducted with the Social Worker (SW). regarding MDS section E for 7/17/2022. Stated she had not completed sec E for the 7/17/2022 assessment period. It was completed by the

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| F 641 | Continued From page 6<br>previous SW. The SW stated she reviewed a resident's progress notes to determine if the resident had any behaviors during the assessment period. The previous SW should have coded the MDS to indicate the resident had both behaviors not directed toward others and rejection of care.<br><br>An interview was conducted with the Administrator on 10/21/2022 at 9:52 AM. She stated she expected the MDS to be coded accurately to reflect the resident's behaviors. | F 641 | | |
| F 657 SS=D | Care Plan Timing and Revision<br>CFR(s): 483.21(b)(2)(i)-(iii)<br><br>§483.21(b) Comprehensive Care Plans<br>§483.21(b)(2) A comprehensive care plan must be-<br>(i) Developed within 7 days after completion of the comprehensive assessment.<br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br>(A) The attending physician.<br>(B) A registered nurse with responsibility for the resident.<br>(C) A nurse aide with responsibility for the resident.<br>(D) A member of food and nutrition services staff.<br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. | F 657 | | 11/15/22 |

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| F 657 | Continued From page 7<br>(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and resident and staff interview, the facility failed to review and revise the care plan for 3 of 16 sampled residents reviewed (Residents # 18, # 51 & #13).<br><br>Findings included:<br><br>1. Resident #18 was admitted to the facility on 5/3/17 with multiple diagnoses including 0bstructive sleep apnea.<br><br>Resident #18 had a doctor's order dated 3/3/20 for Continuous positive airway pressure (CPAP), a machine that uses mild air pressure to keep breathing airways open while you sleep and used to treat obstructive sleep apnea, on at bedtime and off in the morning. This order was discontinued on 7/13/21.<br><br>The annual Minimum Data Set (MDS) assessment dated 7/27/22 indicated that Resident #18's cognition was intact.<br><br>Resident #18's care plan with the revision date of 8/1/22 was reviewed. One of the care plan problems was "the resident has altered respiratory status/difficulty breathing related to sleep apnea and uses CPAP". The goal was "resident will maintain normal breathing pattern as evidenced by normal respirations, skin color and respiratory rate/pattern". The approaches included to clean CPAP as ordered, and CPAP | F 657 | The care plans were corrected by the MDS nurse on 11/11/2022 for residents #18, #51 and #13.<br><br>The Interdisciplinary team(IDT) which includes Administrator, DON, MDS Nurse, Social Worker, Dietary, Activities, Rehab and Unit Manager will review each resident's care plan by 11/13/2022 and make necessary changes to ensure each care plan reflects each resident's individual needs.<br><br>The DON will re-educate the IDT team members on ensuring care plan accuracy and updating the care plans during the Clinical morning meeting by 11/13/2022.<br><br>The 24 Hour Report and the Order Listing Report will be audited 5x week by the DON/designee for 12 weeks to identify changes in condition and necessary care plan updates. The audits will be reviewed weekly in resident review meeting for 12 weeks and monthly in QAPI meeting for the duration of the audits. The QAPI team may extend or modify the plan of action to ensure ongoing compliance. | |

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| F 657 | Continued From page 8 | F 657 | | |

setting per order.

Resident #18 was interviewed on 10/21/22 at 9:10 AM. He reported that he was using a CPAP machine in the past but that was discontinued last year.

Nurse #2 was interviewed on 10/21/22 at 9:12 AM. She stated that Resident #18 was not using a CPAP machine.

The MDS Nurse was interviewed on 10/21/22 at 9:38 AM. She reported that the previous MDS Nurse had reviewed the resident's care plan on 8/1/22 and she should have resolved/deleted the care plan for the use of the CPAP, but she did not. The MDS Nurse verified that the CPAP had already been discontinued and she would delete the care plan for the use of CPAP.

The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that she expected the care plans to be reviewed and revised as needed. She reported that one MDS Nurse had resigned in August 2022, and she just hired a brand new MDS Nurse who was still in training.

2.Resident # 51 was admitted to the facility on 4/29/22 with multiple diagnoses including chronic respiratory failure with hypoxia.

Resident #51 had a doctor's order dated 6/25/22 for oxygen at 2liters (L) per minute via nasal canula and to change the canula/tubing and clean the filter weekly. This order was discontinued on 8/29/22.

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| F 657 | Continued From page 9 | F 657 | | |

The quarterly Minimum Data Set (MDS) assessment dated 8/29/22 indicated that Resident #51's cognition was intact.

Resident #51's care plan with the revision date of 9/3/22 was reviewed. One of the care plan problems was "resident is on oxygen therapy for shortness of breath (SOB)". The goal was "resident will be free from signs and symptoms of hypoxia". The approaches included "administer oxygen as ordered, assess pulse oximetry as indicated, oxygen care as ordered and provide portable oxygen for ambulatory resident".

Resident #51 was observed on 10/19/22 at 12:40 PM and on 10/20/22 at 12:36 PM, he was not on oxygen. On 10/21/22 at 9:01 AM, Resident #51 reported that he was on oxygen in the past and the oxygen was discontinued since he did not need it anymore.

Nurse #2, assigned to Resident #51, was interviewed on 10/21/22 at 9:15 AM. The Nurse stated that Resident #51 did not have an order for oxygen.

The MDS Nurse was interviewed on 10/21/22 at 9:38 AM. She reported that the previous MDS Nurse had reviewed the resident's care plan on 9/3/22 and she should have resolved/deleted the care plan for oxygen, but she did not. The MDS Nurse verified that the oxygen had already been discontinued and she would delete the care plan for the use of oxygen.

The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that she expected the care plans to be reviewed

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| F 657 | Continued From page 10<br>and revised as needed. She reported that one MDS Nurse had resigned in August 2022, and she just hired a brand new MDS Nurse who was still in training.<br>3. Resident #13 was originally admitted to the facility on 7/11/22 with diagnoses that included dysphagia (difficulty swallowing) and history of a stroke.<br><br>A nursing progress note dated 9/6/22, revealed Resident #13 had pulled out his feeding tube and the physician ordered to leave the tube out due to increased oral intake and weight gain.<br><br>A review of Resident #13's active care plan, last reviewed on 10/11/22 by the Minimum Data Set (MDS) Nurse, included a problem area for required a feeding tube.<br><br>An interview was conducted with Nurse #4 on 10/18/22 at 12:20 PM and confirmed Resident #13 no longer had a feeding tube and received all meals, snacks, fluids, and medications orally.<br><br>The MDS nurse was interviewed on 10/20/22 at 10:20 AM and reviewed Resident #13's active care plan and medical record. She indicated the care plan should have been revised since the resident no longer had a feeding tube and felt it was an oversight. | F 657 | | |
| F 689 SS=J | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and | F 689 | | 11/15/22 |

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| F 689 | Continued From page 11<br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews, Medical Director interview, and record review, the facility failed to secure Resident #82 in a sit to stand lift per manufacturer's instructions and failed to provide a safe transfer which resulted in a fall. This was for 1 of 8 residents reviewed for accident hazards, supervision, and devices. Resident #82 sustained a left shoulder fracture. After a pulmonary evaluation, it was determined Resident #82's acute on chronic decline was due to her underlining severe Chronic Obstructive Pulmonary Disease (COPD), complicated by lung collapse likely due to decreased mobility from recent fall and from her baseline muscle weakness from prior stroke. Noninvasive ventilation was used in attempt to bring her back to her baseline; however, Resident #82's respiratory condition was not able to improve. Resident #82 was discharged from the hospital on 08/14/22 and transferred to hospice due to progressive respiratory failure.<br><br>Immediate jeopardy began on 07/29/22 when the facility failed to secure Resident #82 in a sit to stand lift per manufacturer's instructions and failed to provide a safe transfer which resulted in a fall with major injury. Immediate jeopardy was removed on 10/28/22 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower harm level 2 (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure the facility complete all staff training and ensure | F 689 | The facility failed to secure Resident #82 in the sit to stand lift per manufacturer's instructions and failed to provide a safe transfer which resulted in a fall with injury. Resident is no longer in the facility. Employee was removed from the schedule and re-education was provided 8/1/2022. Employee no longer works in the facility.<br><br>On 10/27/2022 the Director of Nursing reviewed all witnessed falls that occurred after July 20,2022 to determine if any were a result of improper securement. No other incident were identified during the chart reviews. Current residents were assessed by the DON on 10/27/2022 to ensure there were no injuries of unknown origin that may have been a result of an improper transfer with no injuries identified.<br><br>The Director of Nursing and Unit Manager will re-educate all Nursing Assistants and Nurses, to include agency staff, by 11/13/2022 on the proper sit to stand transfers according to the manufacture's instructions with return demonstration. Any staff member that is unable to be re-educated will be removed from the working schedule until the education and return demonstration can be validated by the DON or designee. All newly hired nursing assistants and nurses will be | |

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| F 689 | Continued From page 12<br>monitoring systems put into place are effective.<br><br>The findings included:<br><br>A review of the manufacturer's instruction manual for the sit to stand lift revealed the lower leg straps are to be used to ensure the lower parts of the resident's legs stay close to the knee support. The straps pass around the knee supports, then around the resident's lower calves. The foot operated rear castor brakes are to keep the sit to stand lift in position. The support strap should be placed around the resident's lower back. The support strap should be secured by pressing the buckles together.<br><br>Resident #82 was admitted to the facility on 03/14/2019 with multiple diagnoses that included osteoarthritis, disorder of bone density and structure, personal history of COVID-19, chronic respiratory failure, stroke, COPD, and muscle weakness.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 05/02/22 indicated resident was cognitively intact and required extensive assistance with two staff members for transferring. Resident #82 was coded as having no falls since prior assessment.<br><br>Review of the care plan dated 05/02/22 revealed Resident #82 had a focus area of having a self-care deficit due to a history of a stroke with left sided muscle weakness. The goal indicated Resident #82's needs would be met daily through the next review. Interventions included assist with activities of daily living which include dressing, grooming, toileting, feeding, oral care as needed as well as resident to be transferred with a sit to | F 689 | educated by the DON or designee on proper sit to stand transfers according to the manufacture's instructions with return demonstration prior to taking a resident care assignment.<br><br>Nursing administration will do a visual audit to validate proper sit to stand transfers for 5 transfers a week for 8 weeks, then 1 transfer a week for 4 weeks for a total of 12 weeks. Audits will be reviewed weekly in resident review and monthly Quality Assurance Performance Improvement meeting. The plan may be altered or modified based on QAPI team recommendations. | |

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stand lift with two staff member assistance.

A review of Resident 82's Kardex (an electronic overview of each resident's care needs located on each hallway of the facility) indicated resident requires a lift with the assistance of 2 people.

A review of an incident report dated 07/29/22 completed by Nurse #5 revealed Resident #82 was being transferred via a sit to stand lift by Nurse Aide (NA) #1 when she slid out of the lift and was lowered to the ground by NA #1. No injuries were observed at the time of the incident.

A review of the written witness statement by NA #1 dated 07/29/22 revealed she used the sit to stand lift on Resident #82 to get her up for the morning. It indicated Resident #82 was properly strapped and secured when NA #1 began the transfer. However, Resident #82 slipped out of the sling while she provided personal care to Resident #82.

Several attempts to interview NA #1 were unsuccessful.

A telephone interview with Nurse #5 on 10/20/22 at 9:58 AM revealed she was an agency nurse who worked with resident on 07/29/22. She stated when she entered the room to assist Resident #82 after she had fallen, she noticed Resident #82 was not strapped into the sit to stand lift properly. She stated the leg straps were not buckled and the sling was loose. She indicated per her care plan Resident #82 required 2-person assistance with the sit to stand lift. She stated NA #1 used the lift by herself to transfer Resident #82. She stated she had sent Resident #82 to the hospital due to Resident #82's oxygen saturations

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dropping.

A review of the hospital records dated 08/14/22 revealed Resident #82 was admitted to the hospital on 07/29/22 with a diagnosis of acute on chronic respiratory failure. Resident #82 presented to the Emergency Room after a reported fall at the facility and noted increased shortness of breath. A chest x-ray determined Resident #82 had a left shoulder fracture, aspiration pneumonia, and pulmonary edema. Resident #82's orthopedic evaluation recommended non-operative management for the shoulder fracture. After a pulmonary evaluation, it was determined Resident #82's acute on chronic decline was due to her underlining severe COPD, complicated by lung collapse likely due to decreased mobility from recent fall and from her baseline muscle weakness from prior stroke. Noninvasive ventilation was used in attempt to bring her back to her baseline; however, Resident #82's respiratory condition was not able to improve. Resident #82 was discharged from the hospital and transferred to hospice on 08/12/22 due to progressive respiratory failure.

A telephone Interview with NA #4 on 10/20/22 at 9:24 AM revealed she was familiar with Resident #82's care needs. She indicated Resident #82 used a sit to stand lift for transfers. She stated any resident who utilized a lift required two-person assistance. She indicated she would always have a Nurse or another NA help with the transfer.

A review of the witness statement by the former Assistant Director of Nursing (ADON) dated 08/01/22 revealed she provided education to NA

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#1 on the use of a sit to stand lift after the incident.

A telephone interview with the former ADON on 10/20/22 at 11:58 AM revealed NA #1 was educated 48 hours after the incident on how to operate the sit to stand lift and made sure NA #1 was competent to use the lift prior to her going back to work. She indicated NA #1 was also educated on following the care plan.

A review of the undated witness statement by the former RN Supervisor revealed NA #1 was educated via demonstration on how to use the sit to stand after the incident. The statement indicated NA #1 failed to lock the castor wheels on the lift as well as failed to utilize the lower leg straps. During the demonstration, NA #1 was educated on the use of a sit to stand lift and education was provided to her regarding the presence of two people when using the lift.

Several attempts to interview the former RN Supervisor via phone were unsuccessful.

An interview with the Director of Rehab on 10/20/22 at 2:00 PM indicated the castor wheels on the sit to stand lift are to be locked when the staff member is lifting a resident from a seated position. She stated the resident should be able to bear some weight to be able to use the lift. She further indicated the sling supports the resident's upper body when they stand. She stated lift transfers evaluations are done when ordered if staff feel like a resident requires a lift for transfers.

Interview with the facility Medical Director on 10/26/22 at 1:24 PM revealed she was familiar

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with Resident #82's medical history and care needs. She stated she was notified by the facility the next business day of Resident #82's fall and was told she was sent to the Emergency Room for shortness of breath. She stated she saw Resident #82 the day prior to her fall for left knee pain. Resident #82 did not complain of shortness of breath during that time. She indicated Resident #82 was diagnosed with COVID-19 in January 2021, and this could have exacerbated her COPD; however, Resident #82 was at baseline prior to her fall and could not remember any significant respiratory decompensation.

An interview with the Administrator on 10/21/22 at 11:10 AM revealed NA #1 was trained on how to use the sit to stand lift prior to the incident but did not follow facility policy. She indicated all staff should use the sit to stand according to manufacturer's instructions to ensure safe transfers. She further indicated NA #1 did not follow Resident #82's care plan and all staff were to always follow residents' care plans.

Review of the undated Performance Improvement Plan (PIP) related to the incident revealed the resident had a fall from the sit to stand lift which resulted in a left shoulder fracture. Resident #82 was sent to the hospital and was diagnosed with acute on chronic respiratory failure and left shoulder fracture. Staff was reeducated concerning resident handling with specific focus on the use of the sit to stand lift. The PIP did not indicate how the facility would monitor staff regarding use of lifts according to manufacturer's instructions.

The Administrator was notified of immediate jeopardy on October 27, 2022, at 11:17 AM.

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The facility provided the following credible allegation for immediate jeopardy removal:

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

The facility did not secure Resident #82 in a sit to stand lift per manufacturer's instructions and did not provide a safe transfer which resulted in a fall with injury. Resident was sent to the hospital and was found to have sustained a left shoulder fracture. During her hospitalization, the resident's condition declined and she experienced aspiration pneumonia and pulmonary edema. After a pulmonary evaluation, it was decided the resident had acute on chronic decline which was due to her underlining severe Chronic Obstruction Pulmonary Disease, complicated by lung collapse likely due to decreased mobility from her recent fall. Noninvasive ventilation was used in attempt to bring her back to her baseline. The resident's respiratory condition did not improve, and she was transferred to hospice on 8/12/2022 and expired.

Residents in the facility that are transferred via lift have the potential to be affected. On 10/27/2022 each Electronic Medical Record was reviewed by the Director of Nursing to ensure the Kardex and care plan reflected the transfer status and the number of staff needed for each lift transfer. On 10/27/2022 the Director of Nursing reviewed all witnessed falls that occurred after July 20, 2022, to determine if any were a result of not using a lift or improper use of a lift. There were no other transfer incidents found during the review.

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Current residents, that require the use of a lift for transfer, were assessed by the Director of Nursing on 10/27/2022 to ensure there were no injuries of unknown origin that may have been a result of not using the lift or improper use of a lift. There were no injuries of unknown origin found during the assessments.

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 10/27/2022 all Nursing Assistants and Nurses, to include agency staff, were educated by the Administrative Nursing Team or Rehab staff on proper sit to stand transfers according to the manufacturer's instructions with return demonstration, the facility specific Mechanical Lift Policy and obtaining transfer status (to include the number of staff needed for the transfer and the type of lift or transfer) from the Kardex or Care plan. The Director of Nursing will supply a list of the re-educated individuals to the facility scheduler daily to ensure no licensed individuals work until they have been re-educated and the return demonstration has been validated.

All newly hired Nursing Assistants and Nurses will be educated by the Director of Nursing or designee on proper sit to stand transfers according to the manufacturer's instructions with return demonstration, the facility specific Mechanical Lift Policy and obtaining transfer status (to include the number of staff needed for the transfer and the type of lift or transfer) from the Kardex or Care plan prior to taking a resident care assignment. The Regional Director of Clinical Services notified the Director of Nursing

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| F 689 | Continued From page 19<br>on 10/27/2022 on the implementation for new hires.<br><br>AOC 10/28/2022<br><br>On 10/31/22, the facility's credible allegation for immediate jeopardy removal was validated by observations of a sit to stand lift transfer; multiple interviews with facility staff revealed they received training on how to use a sit to stand lift and were able to describe the facility's policy on where to look for the lift requirements a resident needs; review of the updated facility policy regarding resident handling, body mechanics, and lift transfers; and review of the education sign-off sheets regarding resident handling, proper body mechanics, and resident transfers. Immediate jeopardy was removed on 10/28/22. | F 689 | | |
| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an | F 690 | | 11/15/22 |

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| F 690 | Continued From page 20<br>indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, resident and staff interviews, the facility failed to follow up on laboratory results (Resident #50) for 1 of 6 reviewed for urinary tract infections.<br><br>The findings included:<br><br>Resident #50 was admitted to the facility on 10/10/2019 with diagnoses that included vascular dementia.<br><br>Resident #50's quarterly Minimum Data Set (MDS) dated 8/29/2022 indicated the resident was severely cognitively impaired, required extensive assistance with all activities of daily living, toileting, and personal hygiene. The resident was coded as always incontinent of urine and received diuretics 7out of 7 days during the assessment period. | F 690 | On 10/18/2022 the MD was notified of the UA results for resident #50. New order received for Keflex TID x7 days.<br><br>The DON will audit all labs ordered after 10/1/2022 by 11/13/22. Any lab results that are not in the medical record will be obtained from the lab company if available. Any lab that has not been collected will be reported to the MD to determine if the lab should still be collected.<br><br>Education will be provided to the nurses by the DON or designee by 11/13/2022 on lab orders and ensuring results are obtained utilizing the Lab Test Tracking tool daily. any employee not educated by 11/13/2022, will not be permitted to work until education is provided. | |

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| F 690 | Continued From page 21<br>Resident #50 was interviewed on 10/18/22 at 11:08 AM. She stated she did not feel well and thought she had a urinary tract infection (UTI). When asked if the staff had checked her for a UTI, she nodded yes. The resident stated the nurse did not know the results. The resident's son was bedside and stated he inquired about the resident's results on 10/17/2022 and Nurse #3 stated she would look for the results.<br><br>The resident's medical record indicated Nurse #2 noted the resident had increased confusion and restlessness on 10/16/2022 at 3:00 PM. Nurse #2 made the Medical Director (MD) aware and received new orders for urine analysis and culture with sensitivity. Nurse #2 documented she collected the sample and sent the sample to the laboratory.<br><br>10/20/22 09:33 AM interview was conducted with Nurse #3 who was assigned to resident on 10/17/2022 and 10/18/2022. She stated she was made aware on the morning of 10/17/2022, during shift report, the resident had labs completed on 10/16/2022 and the results had not been faxed to the facility. She stated urine analysis results usually post the same day and the results are faxed to a machine in the medication room. She stated she did check the fax on 10/17/2022 and 10/18/2022 but never saw any results for Resident #50. She stated she called the hospital lab on 10/18/2022 after a family member inquired about the results. Nurse #3 stated she called the MD with positive results and made the family aware the resident had a UTI on the afternoon of 10/18/2022.<br><br>Review of faxed results indicated the sample was received in the laboratory at 3:15 PM and resulted | F 690 | The DON or designee will review the lab test tracking tool, to include the resident's name,lab/test ordered, due date, date obtained, date of results, date MD/Nurse Practitioner(NP) notified, in PCC during morning clinical meetings.<br><br>DON/designee will review the Lab Test Tracking tool 5x week for 12 weeks. The Lab Test Tracking tool will be reviewed in resident review weekly and monthly in QA meeting for the duration of the monitoring. Changes may be made to the plan of correction or the audits may be extended to ensure ongoing compliance. | |

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| F 690 | Continued From page 22<br>at 8:35 pm on the same day 10/16/2022. The urine analysis revealed nitrites (used to diagnose bacterial infection) and white blood cells (indicate inflammation of the urinary tract).<br><br>On 10/21/2022 at 9:34 AM a phone interview was conducted with the MD. She stated expected the nurse to have followed up on the urine analysis on 10/17/2022. If the results were not faxed, she should have called the laboratory. The resident was started on antibiotics for her UTI on 10/18/2022. The MD stated the resident was doing well but anytime an elderly individual has a UTI that goes untreated, there is the risk of sepsis.<br><br>An interview was conducted with the Administrator on 10/21/2022 at 9:50 AM. She stated it was her expectation nurses follow up on laboratory results in a timely manner. Urine analysis results are typically resulted the same day. She stated Nurse #3 was a contract nurse and may not have understood the procedure for following up on results. | F 690 | | |
| F 727 SS=E | RN 8 Hrs/7 days/Wk, Full Time DON<br>CFR(s): 483.35(b)(1)-(3)<br><br>§483.35(b) Registered nurse<br>§483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>§483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. | F 727 | | 11/15/22 |

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| F 727 | Continued From page 23<br>§483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews, the facility failed to provide Registered Nurse (RN) coverage for at least 8 consecutive hours, 7 days a week for 3 of 30 days reviewed for staffing.<br><br>The findings included:<br><br>A review of posted daily Nurse Staffing sheet from 9/29/2022 through 10/17/2022 revealed the facility had not provided the required RN coverage (at least 8 consecutive hours per day 7 days a week) on the following dates:<br><br>Thursday 9/29/2022;<br>Thursday 10/13/2022; and<br>Saturday 10/15/2022.<br><br>On 10/20/22 at 9:26 am an interview was conducted with the Administrator. The Administrator reviewed the dates in question and confirmed there was no RN coverage on 9/29/2022, 10/13/2022, and 10/15/2022. She stated she completed the staff posting and staffing sheets since the previous DON left in mid-August. She further stated the facility used agency RNs to meet the 8-hour requirement and when they call out, she has no RN coverage. The Administrator stated the facility was in the process of orienting new staff, including RNs. | F 727 | The facility is unable to provide proof of RN hours for dates identified prior to 10/31/2022.<br><br>The nursing schedule since 10/31/2022 was reviewed on 11/11/2022 by the facility administrator to identify any other days that the facility was unable to provide 8 hours of RN coverage. There was one day there was not 8 hours of RN coverage.<br><br>The facility Administrator provided re-education to the Director of Nursing on 11/11/2022 on regulatory requirements of RN hours.<br><br>The Administrator or Designee will audit the RN hours daily for 12 weeks during the morning meeting to ensure the facility follows regulatory requirements. The Director of Nursing and the Administrator will meet weekly to review open RN positions and to ensure there is coverage. The audit will be reviewed in the facility QA meeting monthly for the duration of the monitoring. The plan of correction may be changed or extended to ensure ongoing compliance. | |
| F 756 SS=D | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review. | F 756 | | 11/15/22 |

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| F 756 | Continued From page 24<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews, staff and pharmacist | F 756 | Pharmacy recommendation for Resident | |

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| F 756 | Continued From page 25<br>interviews, the facility failed to acknowledge and act on the Consulting Pharmacist's recommendations for 2 of 6 residents (Resident #16, #51) reviewed for unnecessary medications.<br><br>The findings included:<br><br>Resident #16 was admitted to the facility on 1/30/2020 with diagnoses that included dementia.<br><br>Resident #16's quarterly Minimum Data Set (MDS) dated 7/17/2022 indicated the resident was severely cognitively impaired, required extensive assistance with all activities of daily living, and received antianxiety, antidepressant, and antipsychotic medications 7 out of 7 days during the assessment period.<br><br>Resident #16's medical record revealed a monthly medication review was conducted by the consulting pharmacist on 9/29/2022 and recommendations were made. Pharmacy recommendations for the 9/29/2022 review could not be found in the medical record.<br><br>On 10/19/2022, the facility provided surveyors a paper copy of the monthly medication review (MMR) completed by the pharmacist on 9/29/2022. The pharmacist recommended Resident #16's Risperdal (used to treat agitation) 0.5mg be reduced to 0.25mg at night with the goal of discontinuation. The recommendation was acknowledged on 10/19/2022 (the date it was requested by surveyors) and indicated the Medical Director (MD) agreed to lowering the Risperdal to 0.25mg.<br><br>On 10/21/2022 at 9:40 AM a phone interview was conducted with the MD. She stated she did not | F 756 | #16 was provided to the MD on 10/19/2022 by the DON. The pharmacy recommendation for Resident #51 was provided to the MD on 11/9/2022 by the DON.<br>All pharmacy recommendations for the month of August 2022, September 2022 and October 2022 will be audited by the DON/designee by 11/14/2022 to ensure each recommendation has been acknowledged by the MD or Nurse Practitioner(NP). Any recommendation that has not bee addressed will be reprinted and provided to the MD or NP.<br>Re-education was provided to the DON and Administrator on 11/7/2022 by the Regional Director of Clinical Services(RDCS) on monthly pharmacy recommendations, timely follow up and use of use of Omniview(pharmacy services reporting)to access monthly reports when necessary.<br>The DON/designee will audit pharmacy recommendations for three months using the report provided to the facility by Omnicare(pharmacy company). The audits will be reviewed monthly in the facility QAPI meeting. The plan of correction may be modified or extended if necessary to ensure ongoing compliance. | |

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| F 756 | Continued From page 26 | F 756 | | |

see the MMR dated 9/29/2022 until 10/19/2022. She stated she did expect to get pharmacy recommendations in a timely manner.

An interview was conducted with the Administrator on 10/21/2022 at 9:52 AM. She stated the MMRs got lost in the shuffle. They were found in the DON's office. The 9/29/2022 pharmacy recommendation was not addressed until 10/19/2022.

2. Resident # 51 was admitted to the facility on 4/29/22 with multiple diagnoses including anxiety.

Resident #51 had a doctor's order dated 5/18/22 for Xanax (an antianxiety medication) 0.5 milligrams (mgs) by mouth twice a day for anxiety.

Resident #51's medication regimen was reviewed by the Consultant Pharmacist on 8/23/22 and 9/28/22. On both reviews (8/23/22 and 9/28/22), the Consultant Pharmacist had recommended to the attending physician to consider decreasing the Xanax to 0.25 mgs in the morning and 0.5 mgs in the afternoon as it possibly causing or contributing to his falls on 8/20/22 and 9/17/22.

Review of the Consultant Pharmacist's consultation report dated 8/23/22 and 9/28/22, the Attending Physician did not address the recommendations regarding the dose reduction of Xanax.

The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that the DON was responsible for ensuring that the Pharmacist Consultation reports were responded/addressed by the physician. The

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| F 756 | Continued From page 27<br>Administrator reported that since the DON had resigned in August of 2022, the pharmacist's consultation reports were lost in the shuffle. | F 756 | | |
| F 757 SS=E | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to hold the blood pressure medication for 14 days as ordered for 1 of 5 sampled residents reviewed for unnecessary medications (Resident # 51).<br><br>Findings included: | F 757 | MD notified on 10/20/2022 that resident #51 was given blood pressure medication outside set perimeters. Order changed on 10/21/2022 to reduce dose of medication. The DON/designee reviewed the medication administration record(EMAR) on 11/11/2022 for each resident in the facility that had an order as it relates to | 11/15/22 |

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| F 757 | Continued From page 28<br>Resident # 51 was admitted to the facility on 4/29/22 with multiple diagnoses including hypertension.<br><br>Resident #51 had a doctor's order dated 5/19/22 for Lisinopril (blood pressure medication) 20 milligrams (mgs) by mouth in the morning for hypertension - hold for systolic blood pressure (SBP) of less than 120.<br><br>The quarterly Minimum Data Set (MDS) assessment dated 8/29/22 indicated that Resident #51's cognition was intact.<br><br>Resident #51's Medication Administration Records (MARs) were reviewed. The MARs revealed that Lisinopril was administered when the SBP was less than 120.<br><br>The September and October 2022 MARs revealed that Lisinopril was administered on:<br><br>9/18/22 - SBP of 118/66<br>9/20/22 - SBP of 117/60<br>9/15/22 - SBP of 115/56<br>10/5/22 - SBP of 108/58<br>10/8/22 - SBP of 119/63<br>10/9/22 - SBP of 110/58<br>10/10/22 - SBP of 110/60<br>10/11/22 - SBP of 108/59<br>10/14/22 - SBO of 109/58<br>10/15/22 - SBP of 110/61<br>10/16/22 - SBP of 118/60<br>10/17/22 - SBP of 107/59<br>10/19/22 - SBO of 113/62<br>10/20/22 - SBP of 108/60<br><br>Nurse #1 was interviewed on 10/20/22 at 11:16 AM. Nurse #1 was assigned to Resident #51 on | F 757 | the blood pressure perimeters. The DON/designee completed a 30 day look back and any issues identified were reported the MD on 11/11/2022.<br>Re-education will be provided by the DON to all nurses by 11/13/2022 on following physician orders with focus on following medication specific perimeters along with medication administration competency. All nurses not educated on 11/13/2022 will not be permitted to work until education is provided.<br>A list of residents that receive blood pressure medication with perimeters will be used to audit the EMAR to ensure the nurses are following the physician order 5 days a week for 4 weeks and 3 days a week for 8 weeks for a total of 12 weeks monitoring. The audits will be reviewed in resident review weekly for 12 weeks and monthly in the facility QAPI meeting. The plan may be altered or extended based on the QAPI team based on the QAPI team recommendations to ensure ongoing compliance. | |

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| F 757 | Continued From page 29<br>10/5/22, 10/10/22, 10/11/22, 10/14/22, 10/15/22, 10/16/22, 10/19/22 and 10/20/22. He reviewed Resident #51's doctor's orders and stated that he was not aware that there was an order to hold the Lisinopril when the SBP was less than 120. He added that the order was transcribed to the MAR, but he missed to read the parameter to hold if the SBP is less than 120 and he administered the Lisinopril by mistake.<br><br>Attempted to interview Nurse #4, assigned to Resident #51 on 9/25/22, 10/9/22 and 10/17/22 but she was not available.<br><br>The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that she expected the nurses to follow doctor's orders in holding blood pressure medications with parameters. | F 757 | | |
| F 758 SS=D | Free from Unnec Psychotropic Meds/PRN Use<br>CFR(s): 483.45(c)(3)(e)(1)-(5)<br><br>§483.45(e) Psychotropic Drugs.<br>§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br>(i) Anti-psychotic;<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that---<br><br>§483.45(e)(1) Residents who have not used | F 758 | | 11/15/22 |

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| F 758 | Continued From page 30<br>psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;<br><br>§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and<br><br>§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.<br><br>§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interviews, the facility failed to identify the need for an Abnormal Involuntary Movement Scale (AIMS) assessment for a resident receiving a daily antipsychotic medication for 1 of 6 residents whose medications were reviewed (Resident #17). | F 758 | AIMS assessment was completed for resident #17 on 10/20/2022.<br><br>The Regional Director of Clinical Services reviewed the medical record for each resident with an order for an antipsychotic | |

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| F 758 | Continued From page 31<br><br>The findings included:<br><br>Resident #17 was admitted to the facility on 7/20/22 with diagnoses that included dementia with behaviors and depression.<br><br>A quarterly Minimum Data Set (MDS) assessment dated 9/21/22 indicated Resident #17 was cognitively impaired and had no behaviors during the assessment period. She was coded as receiving an antipsychotic medication six days during the look back period.<br><br>A review of Resident #17's physician orders cited the following:<br>" An order from 8/20/22 to 9/20/22 for Zyprexa (an antipsychotic medication) 5 milligrams (mg) every night.<br>" An order from 9/20/22 to 10/4/22 for Risperdal (an antipsychotic medication) 0.5 mg every morning and night.<br>" An order dated 10/4/22 for Risperdal 1 mg every morning and night for Alzheimer's dementia with behaviors.<br><br>A medical record review did not yield any AIMS assessments that had been completed for Resident #17.<br><br>A phone interview was completed with the Consulting Pharmacist on 10/20/22 at 2:45 PM and explained she had left a nursing recommendation for the Director of Nursing (DON) that an AIMS assessment was needed for Resident #17's use of an antipsychotic medication on 8/23/22 and again on 9/30/22.<br><br>The Administrator was interviewed on 10/21/22 at | F 758 | medication on 11/11/2022. Any resident that did not have a completed AIMS assessment in the past 90 days was scheduled to be completed on 11/11/2022.<br><br>DON/designee will re-educate all nurses by 11/13/2022 on antipsychotic therapy and completed AIMS assessment per schedule.<br>All nurses not educated by 11/13/2022 will not be permitted to work until education is provided.<br><br>The Order Listing Report will be audited daily 5x week for 12 weeks to identify any new antipsychotic medication orders to ensure the AIMS assessment is scheduled quarterly. Audit will be reviewed weekly in resident review and monthly in QA meeting for the duration of the monitoring. The plan of correction may be changed or extended to ensure ongoing compliance. | |

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| F 758 | Continued From page 32<br>9:49 AM and stated she was unable to locate an AIMS assessment that had been completed for Resident #17. She explained the DON departed abruptly in August 2022 and the unit manager was out on medical leave so there was no one to enforce the assessments being completed. The Administrator added that typically the DON would ensure AIMS were completed for residents on antipsychotic medications. | F 758 | | |
| F 759 SS=D | Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1)<br><br>§483.45(f) Medication Errors.<br>The facility must ensure that its-<br><br>§483.45(f)(1) Medication error rates are not 5 percent or greater;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, observation and staff interview, the facility failed to ensure the medication error rate was below 5% as evidenced by 2 errors of 26 opportunities for error resulting in 7.69% error rate for 2 of 2 residents observed during the medication pass (Residents #56 & #44).<br><br>Findings included:<br><br>1.Resident #56 was admitted to the facility on 5/25/21.<br><br>Resident #56 had a doctor's order dated 8/2/22 for Artificial tears 2 drops in both eyes twice a day for dry eyes.<br><br>On 10/20/21 at 8:35 AM, Resident #56 was observed during the medication pass. Nurse # 3 | F 759 | On 10/20/2022 the MD was notified of medication errors for Residents #56 and #44. Nurses note was added on the EMAR on 11/11/2022. No new orders obtained.<br>The DON/designee will review all vitamin orders and cross check each medication cart by 11/13/2022 to ensure the correct vitamin is available for use. Any medication that is not available will be obtained. The DON/designee will assess each resident currently receiving eye drops by 11/11/2022 for redness or negative effects of incorrect eye drop administration. Any issues identified will be reported to the MD and/or NP.<br>Each nurse will be re-educated by the DON/designee on Medication Administration with competency | 11/15/22 |

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|---|---|---|---|
| | 345000 | A. BUILDING _____ B. WING _____ | C 10/31/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| AUTUMN CARE OF BISCOE | 401 LAMBERT ROAD BISCOE, NC 27209 |

| (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 |
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| F 759 | Continued From page 33<br>was observed to administer Artificial tears 2 drops in both eyes of Resident #56 without waiting at least 3 minutes between drops. The time for optimal eye- drop absorption is approximately 3-5 minutes.<br><br>Nurse #3 was interviewed on 10/20/22 at 10:10 AM. The Nurse verified that she administered Artificial tears 2 drops in both eyes of Resident #56. She indicated that she should have waited at least 5 minutes between drops, but she did not. She reported that the facility's policy on eye drop administration is to wait 5 minutes between drops.<br><br>The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that she expected the nurses to follow the facility's policy on eye drop administration that is to wait 5 minutes between eye drops.<br><br>2. Resident #44 was admitted to the facility on 12/2/21.<br><br>Resident #44 had a doctor's order dated 9/27/22 for Multivitamin 1 tablet by mouth twice a day.<br><br>On 10/20/21 at 8:21 AM, Resident #44 was observed during the medication pass. Nurse # 2 was observed to administer Multivitamin with minerals 1 tablet by mouth to Resident #44.<br><br>Nurse #2 was interviewed on 10/20/22 at 10:05 AM. The Nurse verified that she administered Multivitamin with minerals to Resident #44. When she checked the doctor's order, she stated that she didn't realize that the order was plain | F 759 | verification by 11/13/2022. Any nurse that is not educated by this date will be re-educated with competency verification prior to taking another resident assignment.<br>DON/designee will supervise 3 nurses a week administer at least 6 medications each for 12 weeks to ensure medications are being administered according to the physician's order. Audits will be reviewed weekly in resident review and monthly in QAPI for the duration of the monitoring. The plan of correction may be changed to extended to ensure ongoing compliance. | |

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| F 759 | Continued From page 34<br>Multivitamin. She indicated that it was an error on her part and she had notified the Nurse Practitioner of the medication error.<br><br>The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that she expected the nurses to follow the doctor's order on medication administration. | F 759 | | |
| F 761 SS=D | Label/Store Drugs and Biologicals<br>CFR(s): 483.45(g)(h)(1)(2)<br><br>§483.45(g) Labeling of Drugs and Biologicals<br>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.<br><br>§483.45(h) Storage of Drugs and Biologicals<br><br>§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.<br><br>§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.<br>This REQUIREMENT is not met as evidenced | F 761 | | 11/15/22 |

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| F 761 | Continued From page 35<br>by:<br>Based on record review, observation and staff interview, the facility failed to discard expired muti-dose inhaler and to date multi-dose inhalers and protein supplements for 2 of 2 medication carts observed (500 & 100 medication carts).<br><br>Findings included:<br><br>1.The 500-hall medication cart was observed with Nurse #1 on 10/20/22 at 1:40 PM. The following were observed:<br><br>a. Used Advair diskus (use to treat Asthma and Chronic Obstructive Pulmonary Disease (COPD) 250/50 micrograms (mcg) inhaler dated 9/10/22. The instruction on the box of the inhaler read "discard 1 month after opening the foil pouch".<br><br>b. Used Trelegy Ellipta (use to treat Asthma and COPD) 100/62.5 mcg. inhaler that was undated. The instruction on the box of the inhaler read "discard 6 weeks after opening the foil tray".<br><br>c. Opened bottle of Prostat (protein supplement) liquid, ½ full, that was undated. The instruction on the bottle of the Prostat read "discard 3 months after opening. Record date opened on bottom of the container".<br><br>Nurse #1 was interviewed on 10/20/22 at 1:45 PM. He observed and verified that the used Advair inhaler was already expired, and he was observed to discard the inhaler. He also observed and verified the used Trelegy Ellipta inhaler and the opened bottle of Prostat to have no "date opened" and stated that the nurse who opened the Trelegy inhaler and the Prostat should have written the date they were opened on the | F 761 | Expired medication and undated multi-dose medications were removed from the medication cart by the DON on 10/20/2022.<br>DON or designee will check expiration dates and open dates of each medication on each medication cart by 11/11/2022. Any expired medication or undated multi-dose items will be removed from the cart and reordered.<br>The DON or designee will re-educate each nurse using the Omnicare Medication storage education by 11/13/2022. All nurses not educated by 11/13/2022 will not be permitted to work until education is provided. A copy of the Omnicare Medication storage will be placed on each medication cart for reference.<br>DON or designee will audit each medication cart weekly for 8 weeks to ensure ongoing compliance. The audits will be reviewed in the weekly resident review meeting for 8 weeks and the monthly QAPI meeting for 3 months. The plan may be modified or extended to ensure ongoing compliance. | |

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| F 761 | Continued From page 36 | F 761 | | |

inhaler/bottle.

The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that the Nurse Unit Manager was responsible for checking the medication carts for expired/undated medications. She reported that currently, the facility did not have a Unit Manager, she was on medical leave.

2.The 100-hall medication cart was observed with Nurse #3 on 10/20/22 at 1:50 PM. The following were observed:

a. Used Advair diskus 250/50 mcg. Inhaler that was undated. The instruction on the box of the inhaler read "discard 1 month after opening the foil pouch".

b. Opened bottle of Prostat liquid, 1/3 full, that was undated. The instruction on the bottle of the Prostat read "discard 3 months after opening. Record date opened on bottom of the container".

Nurse #3 was interviewed on 10/20/22 at 1:53 PM. The Nurse observed and verified the used Advair inhaler and the opened bottle of Prostat to have no "date opened" and stated that the nurse who opened them should have written the date on the inhaler/bottle.

The Administrator was interviewed, in the absence of the Director of Nursing (DON), on 10/21/22 at 9:55 AM. The Administrator stated that the Nurse Unit Manager was responsible for checking the medication carts for expired/undated medications. She reported that currently, the facility did not have a Unit Manager,

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| F 761 | Continued From page 37<br>she was on medical leave. | F 761 | | |