STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345419	A. BUILDING _____ B. WING _____	C 10/14/2022

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LEXINGTON HEALTH CARE CENTER	17 CORNELIA DRIVE LEXINGTON, NC 27292

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/10/22 through 10/13/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Y9G811.	E 000		
F 000	INITIAL COMMENTS A recertification, complaint and extended survey was conducted from 10/10/22 through 10/13/22. Event ID#Y9G811. The following intakes were investigated NC00192539, NC00190926, NC00189860, NC00194082, NC00191512, NC00193782, NC00193920, and NC00191145. Past-noncompliance was identified at: CFR 483.10 at tag F580 at a scope and severity (K) CFR 483.45 at tag F760 at a scope and severity (K) The tags F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 4/29/22 and was removed on 6/15/22. This survey was posted one day late due to State IT problems. Deficiencies F684 and F688 were added to the 2567 on 11/8/22 due to State IT problems.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not	F 553		11/9/22

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

Electronically Signed | 11/03/2022

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F 553	Continued From page 1 limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, observations, and record review the facility failed to include residents in the care planning process by not inviting 4 of 10 residents to their care plan meetings (Residents #80, # 59, #34 and #38). Findings included:	F 553	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of	

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F 553	Continued From page 2 1.Resident # 80 was admitted to the facility on 07/26/21. A review of a significant change Minimum Data Set (MDS) dated 09/26/22 revealed thar Resident #80 had no cognitive impairment. Review of a care plan meeting note dated 09/29/22 at 11:10 AM revealed in part that Resident #80 and or her family were invited to the care plan meeting but did not attend. On 10/13/22 at 10:45 AM an interview conducted with Resident #80. She was asked if she had been invited to a care plan meeting or attended a care plan meeting. Resident #80 responded that she had not been invited and did not know what a care plan meeting was. On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed that they believed that the secretary mailed care plan meeting invitations to all resident families but were not certain how residents were invited. An interview conducted with the Administrator on 10/14/22 at 2:17 PM revealed that she was not aware that residents had not been invited to care plan meetings because she attended many of them and residents had been present during those care plan meetings. 2.Resident # 59 was admitted to the facility on 04/29/22. Review of care plan meeting notes for Resident #59 revealed the most recent care plan meeting was conducted on 06/17/22 and neither the resident nor her family attended.	F 553	correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F553 1. Facility allegedly failed to include Residents #80, # 59, #34 and #38 in the care planning process by not inviting them to the care plan meeting scheduled. The residents identified will have rescheduled care plan conferences with invitation to allow for participation in care plan meetings no later than 11-7-22. 2. All current resident□s care plans invitations will be audited to ensure that both Resident and Family are invited to care plan conference. If any residents indicate they were not invited, a new care plan conference will be offered to them in order to participate. Audit will be completed by 11-7-22. 3. MDSC and Care plan team were educated by Region of Director of Clinical Reimbursement or designee regarding facility process of care plan invitations are to be sent to both Resident (delivered in room) and to RP (mailed) with both copies being uploaded into electronic record. Education completed on 11/03/2022 4. Regional Director of Clinical Reimbursement or designee will audit 5 MDS careplan meetings weekly x 4 weeks, then 5 bi weekly x 8 weeks then 5 monthly x 1 month. 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for	

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F 553	Continued From page 3 A review of a quarterly Minimum Data Set (MDS) dated 09/15/22 revealed Resident #59 had no cognitive impairment. An interview with Resident #59 conducted 10/10/22 at 11:47 AM revealed that she had never been invited to a care plan and she revealed that she did not know what a care plan meeting was. On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed that they believed that the secretary mailed care plan meeting invitations to all resident families but were not certain how residents were invited. An interview conducted with the Administrator on 10/14/22 at 2:17 PM revealed that she was not aware that residents had not been invited to care plan meetings because she attended many of them and residents had been present during those care plan meetings. 3.Resident # 34 was readmitted to the facility on 08/09/22. Review of a quarterly Minimum Data Set (MDS) dated 08/22/22 revealed that Resident # 34 had no cognitive impairment. A care plan meeting note dated 08/25/22 revealed in part that Resident # 34 and her family had been invited to attend the care plan meeting but had not attended. An interview with Resident #34 conducted on 10/14/22 at 8:54 AM revealed that Resident #34	F 553	further problem resolution if needed 6. Date of completion: 11/9/2022	

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had never been invited to a care plan meeting.

On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed that they believed that the secretary mailed care plan meeting invitations to all resident families but were not certain how residents were invited.

An interview conducted with the Administrator on 10/14/22 at 2:17 PM revealed that she was not aware that residents had not been invited to care plan meetings because she attended many of them and residents had been present during those care plan meetings.

4.Resident #38 was admitted to the facility on 11/03/21 and readmitted to the facility on 08/16/22.

Review of a quarterly Minimum Data Set (MDS) dated 08/29/22 revealed Resident # 38 had no cognitive impairment.

Resident #38 was interviewed on 10/10/22 at 12:43 PM and revealed that she had never been invited nor attended a care plan meeting.

On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed that they believed that the secretary mailed care plan meeting invitations to all resident families but were not certain how residents were invited.

An interview conducted with the Administrator on 10/14/22 at 2:17 PM revealed that she was not aware that residents had not been invited to care plan meetings because she attended many of them and residents had been present during those care plan meetings.

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F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		

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F 580	Continued From page 6 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff, nurse practitioner (NP), and Physician interviews, the facility failed to notify the physician or the nurse practitioner that an anti-seizure medication (lacosamide) was not available for administration for 1 of 1 resident reviewed for notification of change (Resident #244). The facility failed to notify the NP or the Physician that lacosamide was not available for administration on 4/30/2022, 5/1/2022, 5/4/2022, 5/8/2022, 5/24/2022, and 5/26/2022. Resident #244 was hospitalized with cardiac issues on 5/11/2022 and with seizure activity on 5/27/2022. Findings included: Resident #244 was admitted to the facility 4/27/2022 at 11:45 PM with diagnoses to include stroke, seizures, and diabetes. The admission Minimum Data Set (MDS) assessment dated 5/2/2022 assessed Resident #244 to be severely cognitively impaired. The MDS documented Resident #244 had a percutaneous endoscopic gastrostomy (PEG) tube for feeding and medications. The MDS documented Resident #244 had seizure disorder.	F 580	Past noncompliance: no plan of correction required.	

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The medical record for Resident #244 was reviewed and physician order dated 4/27/2022 ordered lacosamide 10 milligrams per milliliter (mg/ml) give 15 ml (150 mg) by PEG tube every 12 hours for seizures.

The Medication Administration Record (MAR) for April 2022 was reviewed. The documentation for lacosamide were as follows:

" 4/30/2022 9:00 AM dose, "5". Nursing progress notes written by Nurse #13 for 4/30/2022 documented at 10:07 AM "on hold from pharmacy" without specific medication identified. There was no documentation indicating the NP had been notified the medication was not available.
" 5/1/2022 9:00 AM dose, "5". Nursing progress notes written by Nurse #12 for 5/1//2022 documented at 10:32 AM "(lacosamide)10 mg on order from pharmacy, not available." There was no documentation indicating the NP had been notified the medication was not available.
" 5/1/2022 9:00 PM dose, "9" (other, see progress notes). Nursing progress notes dated 5/1/2022 at 10:47 PM documented "medication not available" without specific medication identified. There was no documentation indicating the NP had been notified the medication was not available.
" 5/4/2022 9:00 PM dose "5". Nursing progress notes written by Nurse #13 dated 5/4/2022 at 9:50 PM documented, "(lacosamide)10 mg on order from pharmacy, not available." There was no documentation indicating the NP had been notified the medication was not available.
" 5/8/2022 9:00 PM dose "9". Nursing progress notes dated 5/8/2022 at 11:06 PM documented "medication not available without specific

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medication identified. There was no documentation indicating the NP had been notified the medication was not available.

Documentation from 5/9-5/11/2022 included NP notification.

Resident #244 was readmitted from the hospital 5/23/2022 with a diagnosis of sinus pause (a cardiac arrhythmia when the heartbeat pauses or stops).

A physician order dated 5/23/2022 ordered lacosamide 10 mg/ml administer 15 ml (150 mg) by PEG tube every morning and at bedtime related to seizure activity.

The MAR for May 2022 was reviewed and the documentation for lacosamide were as follows:

" 5/24/2022 9:00 AM dose "9". Nursing progress notes dated 5/24/2022 at 1:45 PM documented "not in stock", without specific medication identified. There was no documentation indicating the NP had been notified the medication was not available.
" 5/26/2022 9:00 PM dose "5". No nursing progress note was documented. Nurse #11 was assigned to Resident #244 on this date. There was no documentation indicating the NP had been notified the medication was not available.

Documentation 5/25/2022 included NP notification.

An interview was conducted with Nurse #10 on 10/12/2022 at 3:51 PM. Nurse #10 reported that he had provided care to Resident #244 and had administered medications to him. Nurse #10

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reported that he did not specifically remember lacosamide for Resident #244 and he could not remember if he talked to the DON or the NP regarding the availability of doses.

An interview was conducted with Nurse #12 on 10/12/2022 at 4:38 PM. Nurse #12 reported she vaguely remembered Resident #244 but did not remember the medication administration. Nurse #12 reported that if her documentation did not say she contacted the NP, she had not called the NP to notify the lacosamide was not available.

Nurse #11 was interviewed on 10/12/2022 at 5:02 PM. Nurse #11 reported that he was an agency nurse and he had provided care to Resident #244. Nurse #11 reported he told the DON Resident #244 did not have lacosamide available for administration but was not certain of the date.

An interview was conducted with Nurse #13 on 10/13/2022 at 9:38 AM. Nurse #13 reported that lacosamide was not available and she notified the NP the medication was not available. Nurse #13 reported she had not reported the medication was not available to the DON. Nurse #13 reported she was unable to remember which NP she had contacted and on what date she had notified the NP the lacosamide was not available. Nurse #13 reported she must have forgotten to document she contacted the NP on 4/30/2022 and 5/4/2022.

Nurse #9 was interviewed on 10/12/2022 at 12:36 PM. Nurse #9 reported she had provided care to Resident #244, and she had not been able to administer lacosamide to Resident #244 because the medication was not in the facility. Nurse #9 reported she had notified a NP, but she was not certain of the date she contacted the NP, or if she

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spoke to the facility NP or the on-call NP. Nurse #9 reported that she had not notified the Director of Nursing (DON) that lacosamide was not available for administration to Resident #244. Nurse #9 initials were on the MAR for Resident #244 on 4/28/2022, 4/29/2022, 5/7/2022, and 5/8/2022.

An interview was conducted with the NP on 10/12/2022 at 1:53 PM. The NP reported that she was not notified by any nursing staff that the facility had not administered lacosamide to Resident #244 until 5/27/2022. The NP explained that lacosamide was a controlled medication and prescription had to be handwritten and submitted to the pharmacy for the medication to be filled. The NP reported on 4/23/2022 she had written a handwritten prescription and it was faxed to the pharmacy and she believed that Resident #244 was receiving the lacosamide for seizures because she was not notified lacosamide had not been delivered by the pharmacy. The NP reported she was notified on 5/27/2022 that Resident #244 had not received lacosamide "for 3 days." The NP reported it was not until later (uncertain of date) she was notified that Resident #244 had not received any lacosamide in the facility from admission until 5/28/2022. The NP stated missing the lacosamide was a significant medication error that could have resulted in brain injury related to uncontrolled seizure activity.

The NP was interviewed again 10/12/2022 at 3:06 PM. the NP reported that abruptly stopping lacosamide could also cause significant cardiac issues. The NP reported if she had been notified of the issues with obtaining the medication, then she could have had discussions with the family, the facility, and the physician about changing or

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modifying medications.

The facility physician (MD) was interviewed on 10/12/2022 at 3:13 PM. The MD reported he was not aware Resident #244 had not received lacosamide as ordered until today (10/12/2022). The MD reported that not administering the lacosamide for Resident #244 was a significant and serious error that could have impacted his cardiac health and his neurological health. The MD explained that after a stroke, some patients have seizure activity, and that was why Resident #244 required the medication lacosamide.

The DON was interviewed on 10/12/2022 at 6:01 PM. The DON explained that when Resident #244 was admitted from the hospital on 4/23/2022 he did not have a handwritten prescription for lacosamide, and the NP wrote a prescription for the medication. The DON reported that the NP had written for tablets to be administered and Resident #244 required the liquid form for administration through the PEG tube. The DON reported there were complications from the pharmacy with the dosage of the medication that required clarification by the NP. The DON reported that she was not aware Resident #244 had not received lacosamide until 5/27/2022, 3 days after Resident #244 was readmitted to the facility from the hospital. The DON reported that Resident #244 was sent to the hospital for seizure activity and sent back to the facility. The DON reported that on 5/27/2022 the NP wrote another handwritten prescription for lacosamide, and it was sent to the pharmacy, and the medication was delivered on 5/28/2022. The DON reported that she notified Resident #244's family member about the medication error on 5/27/2022 and she started a plan of correction for

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the medication error.

The Administrator was notified of the immediate jeopardy on 10/12/22 at 6:30 PM.

The facility provided a plan of correction with a correction date of 6/15/2022. The plan of correction included F580:

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
(Lacosamide) was not available for resident upon admission. The patient missed his medication upon admit 4/27/2022 to 5/11/2022.
The patient discharged to hospital on 5/11/2022 and returned from hospital on 5/23/2022. Patient had a delay in (lacosamide) again from 5/23/2022 until 5/27/2022.
On 5/27/2022, the patient received his medication.
Nursing administration self-identified this ongoing issue of medication availability, and put together a 4-step plan POC for both:
1. Notification to physician and/or nurse practitioner (NP) when medications are unavailable at med pass for follow-up
2. Medication availability in general
The root cause of this issue upon the first admission, was that upon missing medications, the physician and/or NP was not notified of the need for the hard script related to the (lacosamide). The hospital did not send the patient with the hard script upon admit. The information was passed from shift to shift by nurses, and not to nursing administration for intervention and resolution.
Upon readmission on 5/23, the root cause was that the discharging hospital did not send the

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hard script again (for lacosamide). The NP was notified and did provide a script; however, it was for tablets, versus a liquid format given that the patient has a PEG tube for medications.
The NP was notified, then re-wrote the script for liquid dosing; however, pharmacy could not accept this prescription related to the dosage. (The prescription could not be split as it was a scheduled medication)
The NP again was notified and re-wrote the prescription for(lacosamide) with the appropriate dosage which could be filled by the pharmacy.
The pharmacy provided the medication in liquid form and the patient received the medication moving forward.
The patient discharged on 6/5/2022.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All medications were reviewed by the Director of Nursing (DON) for lacosamide. No other residents in the facility were found to be ordered lacosamide.

-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
Education given to all current nurses (fulltime, part time and agency staff) on process of obtaining medication (lacosamide) and/or generic when not available. Moving forward nurses on hire will also receive this education.
This will include notifying the physician and/or non-physician practitioner (PA, NP) with any and each missed dose of (lacosamide), for follow-up.
The protocol is as follows:
1. Notify MD or NP/PA of missed (lacosamide) at time of med pass if unavailable.

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F 580	Continued From page 14 2. Ask for hold order, alternate order and/or determine what next steps are via the MD/NP/etc. 3. If physician and/or NP does not offer a hold/alternate order for (lacosamide), notify DON for further intervention and follow-up, up and including administrator, attending physician, medical director and/or pharmacy consultant until resolution. 4. Notify pharmacy of missed medication to determine root cause and resolution. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. DON will audit all patients who receive (lacosamide) to ensure adequate supply three times weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing. If/when a (lacosamide) medication is missed, audit will be performed to determine if the proper and timely notification was done to MD/NP for hold order, alternate order and/or next steps. Any issues found will be corrected immediately, and any nurse found not to be in compliance with protocol for medication availability and notification will be re-educated and/or disciplined up to and including termination as needed. The results will be reported to the monthly Quality Committee for review and discussion to ensure compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. Date of compliance as of 6/15/22. The plan of correction was reviewed and validated 10/13/2022 and 10/14/2022 by interviews with nursing staff, including Nurse #1,	F 580		

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F 580	Continued From page 15 Nurse #2, Nurse #3, and Nurse #4. Included in the validation was a review of the educational in-services, review of the monitoring and audits, and medication administration observations. F580 was in compliance on 6/15/2022.	F 580		
F 656 SS=B	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.	F 656		11/9/22

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F 656	Continued From page 16 (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 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 record review and staff interviews the facility failed to ensure a comprehensive care plan was accurate for 1 of 32 reviewed for comprehensive care plans. Findings included: Resident # 152 was admitted to the facility on 4/27/22 and readmitted on 5/12/22. Resident #162 discharged on 6/8/22. Resident #152 was admitted with a diagnosis of acute chronic congestive heart failure, displaced fracture of right femur, morbid obesity due to excess calories. Residents comprehensive care plan revised on 5/17/22 included a focus area of Activities of Daily living (ADLs) self-care performance deficit related to activity intolerance. The following interventions were included for transfers: Resident #152 is a one assist. An admission minimum data set (MDS) dated 5/18/22 assessed Resident #152 as having a moderate cognitive impairment. Resident's MDS revealed resident #152 required extensive assistance with the assistance of two plus	F 656	F656 1. Facility allegedly failed to ensure comprehensive care plan accuracy for Resident #152. Resident□s comprehensive care plan has been updated / revised to reflect their current transfer assist status. 2. All current resident□s care plans will be audited for accuracy in relation to ADL transfer care and updated to reflect current status if an error is noted. Audit will be completed and all updates in place by 11-7-22. 3. MDSC and Care plan team were educated by Regional Director of Clinical Reimbursement or designee regarding the need for updating the comprehensive care plan to ensure accuracy if an error is noted in order to reflect the resident□s correct and current transfer status level. 4. Regional Director of Clinical Reimbursement or designee will audit 5 MDS weekly x 4 weeks, then 5 MDS bi weekly x 8 weeks then 5 MDS monthly x 1 month. 5. Results of these audits will be	

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F 656	Continued From page 17 persons for physical assist for bed mobility, transfers, dressing and personal hygiene. An interview was completed with the Rehabilitation Director on 10/12/22 at 10:24 AM who stated that that Resident #152 re-entered physical therapy on 5/13/22 with goals to have Resident #152 stand in therapy and was a maximum of assist of two people. Rehabilitation Director stated that she should not have been a one person assist for transfers. An interview was completed with Nurse Aide #3 on 10/12/22 at 12:08 PM who stated that Resident #152 was a two person transfer and did not recall if she was a lift transfer or not. NA #3 stated that I know for sure she was not a one-person transfer. An interview was conducted with MDS Nurse #1 nurse on 10/13/22 at 5:33 PM who stated that she would finish the care plan. The MDS Nurse #1 stated she would look to see what the NAs had charted regarding transfers and review a resident's physical therapy evaluation. The MDS Nurse #1 reviewed the information and stated that she should have marked that Resident #152 was a two person transfer and must have overlooked this. An interview was completed with the Director of Nursing (DON) 10/13/22 at 6:22 PM who stated that at no time was Resident #152 a two-person transfer, the aides used a lift when she first came in and she was a two-person lift. The DON stated that she did not think that one person could move Resident #152. An interview was completed with the	F 656	reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 11/9/2022	

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F 656	Continued From page 18 Administrator on 10/14/22 at 1:45 PM who stated that she would want the comprehensive care plan to be accurate to ensure the safety of the patient.	F 656		
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (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. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, record review the facility failed to review and revise comprehensive care plans for 3 of 10 residents reviewed for	F 657	F657 1. The facility failed to review and revise care plans for residents #80 #59, #34	11/9/22

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F 657	Continued From page 19 comprehensive care plan review and revision. The resident's care plan must be reviewed after each assessment time frame and revised based on changing goals, preferences and needs of the resident and in response to current interventions for the resident to meet resident care needs (Residents # 80, # 59, and # 34). Findings included: 1.Resident # 80 was admitted to the facility on 07/26/21 with diagnoses that included weakness, hemiplegia (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), cerebral infarction, cervical disc degeneration and fracture of the left tibia (larger of the two bones between the knee and the ankle) and left medial malleolus (the bump that protrudes on the inner side of your ankle it is part of the tibia). Review of a care plan for Resident # 80 revised most recently on 03/17/22 revealed that Resident #80 was at risk for falls due to deconditioning the goal stated that Resident # 80 would not sustain a serious injury through the next review with interventions that included in part to administer medications as ordered, anticipate needs, use assistive devices such as 2 assist bars and a left side half lap tray for support when seated in the wheelchair, assist with care as needed keep call light in reach and educated Resident # 80 and family of safety precautions. Another care plan for Resident # 80 revised recently on 05/12/22 revealed in part that Resident # 80 had a self- care deficit with interventions that Resident # 80 required 1 staff assist with bed mobility, transfers, dressing,	F 657	based on their changing needs. The care plans for identified residents have since been updated / revised to reflect their current status. 2. All current resident□s care plans will be audited for accuracy in relation to care plans that have triggered for falls and subsequent fall interventions, ADL changes (decline or improvement), nutrition needs, new devices, weight loss supplements. Audit will be completed and any revisions in place by 11-7-22. 3. MDSC and Care plan team was educated by Region of Director of Clinical Reimbursement or designee regarding the need for updating and completion of the comprehensive care plan to reflect the resident□s current status, falls and falls interventions, physical and nutritional needs including adaptive equipment. Education completed on 11/03/2022 4. Regional Director of Clinical Reimbursement or Designee will audit 5 MDS weekly for 4 weeks, 5 MDS biweekly for 4 weeks, and then monthly for one month. 5. Results of these audits will be reviewed at Quarterly QA meeting x1 for further problem resolution if needed. 6. Date of completion: 11/9/2022	

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eating, toileting and personal hygiene.

Review of a significant change Minimum Data Set (MDS) dated 09/26/22 revealed in part that Resident # 80 had no cognitive impairment and required extensive assist of at least 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident # 80 had frequent pain that made it hard for her to sleep and limited her daily activities. Resident # 80 sustained 1 fall with a major injury.

On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed the care plans for Resident # 80 had not been revised as required (the care plan must be reviewed and revised periodically to include services, measurable objectives, measurable time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's highest practicable physical, mental, and psychosocial well-being). Resident # 80 sustained an actual fall with fracture, was non weight bearing to the left leg and the left leg was to be maintained elevated on pillows. Resident # 80 also required increased daily care assist of 2 staff for bed mobility, transfers, dressing, toileting, and personal hygiene. Resident # 80 only required set up for meals but was able to feed herself. MDS Nurse #1 and MDS Nurse #2 revealed that they needed to follow care plan revisions as directed by the Resident Assessment Instrument (RAI).

On 10/14/22 at 2:17 PM the facility Administrator

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was interviewed and revealed that all resident care plans be revised as needed to reflect changes and reflect the current status of each resident.

2.Resident #59 was admitted to the facility on 04/29/22 with diagnoses that included sciatica, osteoarthritis, muscle weakness and carpal tunnel syndrome.

Review of a care plan for Resident # 59 dated 05/12/22 revealed that Resident # 59 had a self -care performance deficit and her current level of function would improve through the next review. Interventions included that Resident # 59 was able to feed herself.

Review of a quarterly MDS dated 09/15/22 revealed in part that Resident # 59 had no cognitive impairment required extensive assist of 1 staff for bed mobility, transfers, eating and toileting. Resident #59 did not sustain a fall and she weighed 130 pounds with a significant weight loss not prescribed by the physician (MD).

On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed the care plans for Resident # 59 had not been revised as required to reflect that Resident # 59 sustained an actual fall on 08/05/22 with no injury and MD order dated 05/02/22 for placement of fall mats next to the bed of Resident # 59.The self- care deficit care plan did not include that Resident # 59 required to be fed meals and the nutrition care plan did not include a significant weight loss, the need to be fed meals ,nutritional supplements, use of a double handled covered non spill cup,

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lipped plate or built up red handled spoon. MDS Nurse #1 and MDS Nurse #2 revealed that they needed to follow care plan revisions as directed by the RAI.

On 10/14/22 at 2:17 PM the facility Administrator was interviewed and revealed that all resident care plans be revised as needed to reflect changes and reflect the current status of each resident.

3. Resident # 34 was readmitted to the facility on 9/10/22 with diagnoses that included polyneuropathy, weakness, and end stage renal disease.

A review of care plans for Resident # 34 revised 08/12/22 revealed Resident # 34 had a self-care deficit, and her current level of function would improve through the next review. Interventions included that Resident # 34 required 1 staff assist to eat.

Another care plan revised on 08/12/22revealed Resident # 34 was at risk for falls related to deconditioning and she would not sustain serious injury through the next review. Interventions included to anticipate and meet the needs of Resident # 34, keep call light in reach, maintain bed in low position, ensure she is wearing appropriate non-slip footwear when ambulating or mobilizing in wheelchair or mobilizing in her wheelchair and apply dycem to the seat of the wheelchair seat.

Review of a quarterly MDS dated 08/22/22 for Resident # 35 revealed she had no cognitive impairment, required extensive assist of 1 staff for bed mobility, transfers and toileting. Resident

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F 657	Continued From page 23 # 34 was able to feed herself after tray set up. Resident # 34 had no falls and received as needed (prn) pain medication for frequent pain rated a 7 of 10 on the pain scale. She received dialysis. On 10/14/22 at 1:41 PM MDS Nurse #1 and MDS Nurse #2 were interviewed and revealed the care plans for Resident # 34 had not been revised as required to reflect that Resident # 34 sustained 5 actual falls without injury on 09/11/22,09/14/22, 09/16/22, 09/20/22 and 10/07/22 with interventions put in place after each fall. Resident # 34's care plan also revealed that resident required 1 staff assist with meals. MDS Nurse #1 and MDS Nurse #2 revealed that they needed to follow care plan revisions as directed by the RAI. On 10/14/22 at 2:17 PM the facility Administrator was interviewed and revealed that all resident care plans be revised as needed to reflect changes and reflect the current status of each resident.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff, and Nurse Practitioner interviews the facility failed to follow orders to apply non-medicated cream for dry skin for 1 of 7 residents reviewed for treatment orders. (Resident #71)	F 658	F658 1. Facility allegedly failed to provide Resident # 71 with non-medicated cream for dry skin as ordered by nurse practitioner. Resident #71 has since been	11/9/22

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F 658	Continued From page 24 Findings Included: Resident #71 was admitted to the facility on 9/15/22 with a diagnosis of acute chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease with (acute) exacerbation and venous insufficiency. An admission minimum data set (MDS) dated 9/21/22 assessed Resident #71 as being cognitively intact. A record review of the treatment authorization report (TAR) revealed Resident #71 had an order dated 9/21/22 for a non-medicated cream to both lower and upper extremities every day and evening shift for dry skin. On 10/3/22, 10/4/22, the day shift of 10/5/22 and evening shift on 10/9/22 no treatments were signed off as completed on the TAR. An observation and interview were conducted on 10/10/22 with Resident #71 at 3:24 PM who was sitting in her wheelchair and her legs were exposed. Resident #71 had dry, scaley, red legs. Resident #71 stated that she would have to wait for her granddaughter to put lotion on her legs as the staff do not put lotion on her legs. An observation and interview were conducted on 10/12/22 at 9:30 AM with Resident #71 and her legs were dry and scaly Resident #71 was asked if the nurses had put lotion on her legs and Resident #71 stated the nurses "don't mess with me" and do not put any lotion on her legs. An interview was completed with the Nurse Practitioner #1 (NP) on 10/12/22 at 2:47 PM who	F 658	provided the ordered cream and receiving as directed in order by the nurse practitioner. 2. current residents that have orders for dry skin treatments have the potential to be affected. An audit was completed of all residents to determine if recommended orders for non-medicated cream are in place and being provided. Any issues discovered were corrected and audit completed by 11-7-22. 3. Director of Nursing/Designee provided education on providing treatments as ordered and sign off on treatment record as required. Education with all licensed nurses completed by 11-7-22. Any licensed nurse who is not educated will not be allowed to work until education is received. Any new licensed nurse will be educated by Staff Development Nurse or Director of Nursing or designee will receive education during the orientation process DON/ Designee will audit treatment record for holes and will audit observation of 2 creams 5 x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks 4. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 5. Date of completion: 11/09/2022	

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F 658	Continued From page 25	F 658		

stated when she would see Resident #71 her legs were very dry and had ordered lotion twice as when she would see Resident #71 her legs would be dry, so the NP #1 stated she had then put in an order for it to be scheduled. The NP #1 stated she initiated this on 9/22/22 two times a day and then ordered it again on 10/3/22 as the NP #1 felt that it had not been completed. The NP #1 stated that she had believed the resident when she would say it is not being done.

An interview was completed with Nurse #6 on 10/13/22 at 3:33 PM who stated she could not remember if Resident #71 had an order for lotion. The TAR was shown to nurse #4 who had signed off on the TAR on 10/11/22 for both day and evening treatment. Nurse #4 stated she must had then given it to Resident #71 and stated she did remember giving it to her on Tuesday 10/11/22. At 4:03 PM on 10/13/22 Nurse #4 was asked to show the lotion that was being used on Resident #71's legs. Nurse #4 brought out a bag that had advance foot cream and was labeled for another resident. Nurse #4 stated that the resident who had the lotion was discharged so we would use it for Resident #71. Nurse #4 confirmed that Resident #71 should have had her own lotion.

An interview was completed with the Director of Nursing (DON) on 10/13/22 at 6:38 PM who stated that that Resident #71 should have had her own lotion for her legs.

A phone interview was completed with Nurse #18 On 10/14/22 at 11:26 AM who worked on 10/3/22, and 10/4/22 when Resident #71 did not get her lotion treatments. Nurse #18 was asked what treatments Resident #71 would get on her legs and Nurse #18 stated she did not remember.

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F 658	Continued From page 26 Nurse #18 was asked why she did not give Resident #71 her lotion treatments and stated that she must had given it to Resident #71 but must not have signed off on it. Nurse #18 stated she thought that Resident #71 kept her cream in her room. A phone interview 0n 10/14/22 at 12:50 PM was completed with Nurse #19 who worked on the evening on 10/4/22. Nurse #19 stated that she did not remember Resident #71 and did not remember if she put lotion on her legs. Nurse #19 stated that some nights she would get to her treatments late and the computer screen would change, and she was unable to click off the treatment, the screen was white and would not allow her to click off that the treatment was completed. An interview was completed with the Administrator on 10/14/22 at 1:45 PM who stated that she wants to ensure the best care for her patients, and staff need to follow the orders as written.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to ensure 1 of 6 residents, Resident #88, dependent for activities of daily living was assisted with nail care.	F 677	F677 1. Facility failed to provide appropriate nail care to patient number 88. Patient has since received appropriate nail care and splint ordered by therapy has been	11/9/22

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F 677	Continued From page 27 Findings included: Resident #88 was admitted to the facility on 4/25/2018 with diagnoses of left-hand contracture and hemiplegia. A Therapy Restorative Nursing Referral dated 4/13/2022 at 12:38 pm indicated Resident #88's palm guard splint should be applied to her left hand during daytime and removed at night. The referral also stated Resident #88's hand should be washed and dried and range of motion provided prior to splint application and her nails should be kept short to prevent skin breakdown. A quarterly Minimum Data Set (MDS) assessment dated 9/30/2022 indicated Resident #88 was mildly cognitively impaired and required extensive assistance with bathing and personal hygiene. On 10/10/2022 at 10:12 am an observation of Resident #88 in bed revealed she had a contracture to her left hand and her fingers are curled into her palm. Resident #88 had a dark brown substance under her nails to both hands and her fingernails were jagged. During an observation on 10/12/2022 at 9:57 am of Resident #88 her nails on both hands continued to have a dark brown substance under her fingernails and the nails on both hands were jagged. On 10/12/2022 at 10:07 am Nurse #1 was interviewed and observed Resident #88's hands and stated the fingernails were dirty and jagged and needed to be cleaned and trimmed. Nurse #1 stated the Nurse Aides are responsible for	F 677	put in place. 2. Current residents are at risk within the facility. An audit of all resident□s nail care completed for each resident residing in LHCC. Any resident found to have inappropriate nail care was treated by the assigned nursing assistant. Audit completed by 11-7-22. 3. Current nursing assistants were educated on Activities of Daily living including nail care and application of any ordered splints as directed by therapy. Education completed by 11-7-22. Therapy will communicate the need for splint application to nursing leadership and nursing leadership will place splint application on task list for nursing assistants. Education for splint application will consist of hygiene care of area where splint is applied. Current licensed nurses will be educated on splint application and procedure for documentation of splint application. Education completed by 11-7-22. Any licensed nurses who is not educated will not be allowed to work until education is received. Any nursing assistant who is not educated will not allowed to work until education is received. Any new nursing assistant will be educated by Staff Development or Director Nursing during the orientation process. Any new licensed nurses will be educated by Staff Development or Director of Nursing during the orientation process. 4. DON or designee will audit 5 dependent residents for nail care 5x weekly x 4 weeks then 3x weekly x 4	

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F 677	Continued From page 28 trimming and cleaning the resident's fingernails. Nurse Aide #1 was interviewed on 10/14/2022 at 9:03 am and she stated Resident #88's nails should be cleaned and trimmed by the Nurse Aide whenever needed. Nurse Aide #1 stated Resident #88's nails had been cleaned and trimmed. The Director of Nursing (DON) was interviewed on 10/13/2022 at 5:33 pm and stated nail care is done when needed by the Nurse Aides and the Nurses and Resident #88's nails should have been kept clean and trimmed. During an interview with the Administrator on 10/14/2022 at 9:19 am she stated the Nurse Aides should provide nail care when needed and Resident #88's nails should have been clean and trimmed.	F 677	weeks, then weekly x 4 weeks. DON or designee will audit 3 residents with splint 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of completion: 11/09/2022	
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 record review, observation, and Wound Care Nurse Practitioner and staff interviews the facility failed to provide a surgical dressings for 1 of 1 residents, Resident #149,	F 684	F684 1. The facility failed to ensure that Resident # 149 had her dressing changed	11/18/22

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F 684	Continued From page 29 reviewed for surgical wound care to a right foot amputation and failed to obtain compression wraps to legs and a chest X-ray for 1 of 7 residents, Resident #71, reviewed for the facility following the physician's orders. Findings included: 1. Resident #149 was admitted to the facility on 10/3/2022 with diagnoses of osteomyelitis of right ankle and foot and amputation of right foot. Resident #149's Care Plan dated 10/4/2022 indicated she had a surgical wound to her right foot amputation site that was at risk of infection and complications, and the wound treatment should be provided as ordered. A Physician's Order dated 10/4/2022 at 4:16 pm indicated Resident #149's right foot surgical wound should have a wet to dry dressing daily with antiseptic (betadine) soaked gauze and packing in open incision to the right ankle every evening shift. A review of the Treatment Administration Record for 10/2022 indicated the right foot surgical dressing was not signed as completed on 10/7/2022, 10/9/2022, and 10/10/2022. On 10/11/2022 at 9:58 am an interview was conducted with Resident #149, and she stated the nursing staff had not changed the dressing to her right foot daily as ordered by the physician and she was concerned she would develop an infection to her right foot amputation surgical site. Resident #149 stated the surgeon had attempted to keep as much of her heel as possible and had warned her if she developed an infection she may	F 684	as ordered. Facility also failed to ensure that Resident # 71 had her recommended orders followed as written by her nurse practitioner. Facility corrected these issues upon discovery. Both patients have since been discharged home. 2. All current residents have the potential to be affected. 3. Education provided to current nursing staff by Director of Nursing or designee on following doctor orders for treatments and changing dressings as ordered. Education provided to MD and NPs regarding process of entering orders. Medical providers will enter orders into PCC and nursing staff will confirm orders and continue to process. Any new staff hired after the completion date will be trained during the orientation process. Education to be completed by 11-17-22. 4. Director of Nursing or designee will audit 10 treatment sheets for completion daily x 5 times weekly x 4 then 3 times weekly x 4, then weekly x 4 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of completion: 11-18-22	

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F 684	Continued From page 30	F 684		

lose more of her foot and ankle.

A Minimum Data Set assessment was not completed at the time of the survey.

An observation and interview was conducted 10/12/2022 at 8:26 am with the Wound Care Nurse Practitioner changing Resident #149's surgical wound. The amputation surgical wound had sutures and the Wound Care Nurse Practitioner stated there were no signs of infection to the surgical wound.

During an interview on 10/12/2022 at 8:38 am with the Nurse #4 she stated she the nurses are responsible for changing the dressings on their assignments. Nurse #4 stated she assisted with dressing changes when the Wound Care Nurse Practitioner assessed the wounds each week.

An interview was conducted with Nurse #3 on 10/12/2022 at 4:32 pm and she stated she did not change the dressing to Resident #149's right foot on 10/10/2022 on the 3:00 pm to 11:00 pm shift as it was ordered because she was overwhelmed that evening. Nurse #3 stated she had 4 admissions on 10/10/2022 and no one had helped her. She stated she told the Director of Nursing they needed to have three nurses on the 200 Hall, but they had not given her any assistance.

An interview was conducted with the Director of Nursing on 10/13/2022 at 5:40 pm and she stated the Nurses should have completed the dressing changes as ordered by the physician for Resident #149's right foot surgical wound.

During an interview with the Administrator on

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F 684	Continued From page 31	F 684		

10/14/2022 at 9:31 am she stated the nurses are responsible for doing the wound care on their assignments and should have completed Resident #149's surgical wound dressing change as ordered by the physician.
2. Resident #71 was admitted to the facility on 9/15/22 with a diagnosis of acute chronic diastolic (congestive) heart failure, chronic obstructive pulmonary disease with (acute) exacerbation and venous insufficiency.

A review of a NP #2 visit who saw Resident #71 on 10/12/22 for edema. The note read in part; 'patient was seen today for reports of edema to BLEs. Patient lying in bed with feet elevated on oxygen and in no acute distress. Patient endorses a headache that started 2 days ago, occasional cough, nasal congestion, and runny nose. Lungs, clear to auscultation (the action of listening to sounds from the heart lungs or other organs with a stethoscope), heart rate, regular rate and rhythm. BLEs with dependent edema, dry flaky skin, no erythema, warmth, or open areas. Educated patient on elevating legs while sitting up. Documentation revealed a plan ordered by the NP #2 read in part; Chest X-ray related to congestion, and compression wraps: apply kerlex (gauze) and ace wrap to BLEs apply in morning and remove in the evening. Keep legs elevated while sitting up.

An interview was completed with Nurse #16 on 10/13/22 at 6:46 PM who was asked if he had any treatments to do for Resident #71 and stated he was not aware of anything special he had to do for the resident's edema.

A review of Resident #71's order summary and medication and treatment authorization record

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F 684	Continued From page 32	F 684		

were reviewed on 10/14/22 revealed no orders were in the system from the NP #2 visit on 10/12/22.

An interview was completed with the NP #1 On 10/14/22 at 11:58 AM who stated Resident #71 was seen by NP #2 on 10/12/22 and the NP#2 ordered elevation when out of bed, ordered compression wraps, and a chest X-ray. NP stated once we put in the orders, we write everything on a communication book and the nurses are to check it every shift and it should be present in the resident's orders. NP #1 stated to follow up with the Unit Manager (UM) to see why the orders are not in the system.

An interview was completed on 10/14/22 at 12:15 PM with the UM who reviewed Resident #71 orders. The UM was asked if Resident #71 had gotten her chest X-ray and why weren't the compression wraps in the system. UM reviewed the NP's note from 10/12/22 and stated that what is supposed to happened is the NPs are to put in the order and the nurses are to confirm the order. The UM stated the previous NP #1 Would do the paper or enter it herself. The UM stated normally the nurse is to do their own order they are to check the communication book and check Point Click Care (PCC). The UM confirmed Resident #71 had not gotten the chest X-ray as she did not see the result, nor had she gotten the compression wraps. The UM stated she would look for the orders for October 12, 2022.

On 10/14/22 at 12:23 PM NP #2 was at the nurse's station and was asked how the orders were put in for Resident #71. NP #2 stated orders for consultations, wound care, X-rays etc. are put in the communication book and all medication

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F 684	Continued From page 33 orders are to be entered into the electronic health record. An interview was completed with the Administrator on 10/14/22 at 1:45 PM who stated that she wants to ensure the best care for her patients, and staff need to follow the orders as written. An interview was completed with the Director of Nursing (DON) on 10/14/22 at 3:01 PM who stated that we check the communication book daily and then run an order log. Both the NPs can put in the orders in the electronic health record. The DON stated we have a morning meeting where all entered orders are reviewed and highlighted areas of concerns that are checked daily on each unit. The DON stated that her expectation is that the NP's will enter all orders in PCC moving forward and the communication book is for nurses to communicate with physician concerns and physician will respond by writing/entering the orders in the electronic health record.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to	F 688		11/18/22

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F 688	Continued From page 34 prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews the facility failed to ensure a mobility aide was provided as ordered for 1 of 2 residents, resident #88, who required a left hand splint to prevent further contracture of left hand. Findings included: Resident #88 was admitted to the facility on 4/25/2018 with diagnoses of hemiplegia and left hand contracture. A quarterly Minimum Data Set (MDS) assessment dated 9/30/2022 indicated Resident #88 was mildly cognitively impaired and had impairment of range of motion to extremities on one side of her upper body. An Inservice/Education Record dated 4/12/2022 stated resident #88 should have a palm splint to her left hand during the day and removed at night, and her hand should be washed and dried before the left palm splint is applied. The Inservice/Education Record was signed by Nurse Aides on the 7:00 am to 3:00 pm and 3:00 pm to 11:00 pm shifts. A Therapy Restorative Nursing Referral Note written by Occupational Therapist #1 and dated 4/13/2022 at 12:38 pm indicated Resident #88	F 688	F688 1.Facility failed to ensure that Resident #88 received the recommended left hand splint as determined by Occupational Therapy. Resident now has proper splint in place and being used as ordered. 2. Current residents have the potential to be affected. An audit of all residents was completed to ensure that recommended adaptive equipment was in place for identified residents. Audit completed by 11-17-22. 3. Education provided to all current nursing staff by Director of Nursing or designee regarding following recommendations for hand splints and how to apply splints as ordered. Training will be completed by 11-18-22. Training on hand splints and use of adaptive equipment will also be part of the orientation process for new nursing staff hired after this training date. Task will also be added to the task record for nursing assistants to ensure they are placed each day. 4.Director of Nursing or designee will audit ordered splints to ensure in place 5x weekly x 4 weeks, then 3 x weekly x 4 weeks ,then monthly x 1. Unit managers	

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F 688	Continued From page 35 should have a left hand palm splint placed in her left hand daily to be worn during daytime and removed at night. The Therapy Restorative Nursing Referral Note further indicated Resident #88's left hand should be washed, and range of motion provided before the splint was applied each day. During an observation and interview with Resident #88 on 10/10/2022 at 10:12 am her left hand was contracted with her fingers curled into her palms, and she was not wearing a splint. The skin on Resident #88's left hand was not broken or red. Resident #88 stated she had a splint a long time ago, but she did not know where it was, and the staff had not put it on her left hand in several months. Resident #88 stated she had not refused to wear the left hand splint and does not know why the staff do not apply it. An observation of Resident #88 on 10/12/2022 at 9:57 am revealed she was in bed and her left hand is contracted with no splint in place. On 10/13/2022 at 10:53 am an attempt was made to reach Occupational Therapist #1 who wrote Resident #88's Therapy Restorative Nursing Referral Note and provided the in-service education for her left hand palm splint, but her number was no longer in service. On 10/12/2022 at 10:07 am an interview and observation with Nurse #1 was conducted and she observed Resident #88's left hand. Nurse #1 stated Resident #88's left hand was contracted but she was not aware of her having a splint for her left hand and had never seen her with a left hand splint on since she started working at the facility in 6/2022. During an interview and observation of Resident	F 688	will continue to review the task record completed by nursing assistants after audits are completed to ensure ongoing compliance. 5. Results of audits will be reviewed at Quarterly Quality Assurance Meeting x 1 for further resolution if needed 6. Date of Completion: 11/18/2022	

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#88 on 10/12/2022 at 2:33 pm she has a left hand splint in place and she stated staff placed it on her a little while ago. Resident #88 stated she does not mind wearing the splint and it is not uncomfortable.

The Director of Nursing (DON) was interviewed on 10/13/2022 at 5:33 pm and she stated when a resident has a referral from therapy it should be reported to the Nurse. The DON stated the therapist should do training with the staff on placing the splint correctly and then nursing would create a task in the electronic record for the Nurse Aides to apply the splint. The DON also stated the Therapy Manager should bring information on any new splints to the daily morning meeting. The DON stated the facility does not obtain a physician's order for mobility devices such as hand splints. The DON stated the splint may have been missed because the facility had been using agency staff.

Nurse Aide #1 was interviewed on 10/14/2022 at 9:03 am and she stated she cared for Resident #88 frequently and had worked at the facility since 4/2022 and was not aware of a left hand splint for Resident #88. Nurse Aide #1 stated a splint should be in the nurse aide's electronic tasks and Resident #88 does not have a task for a left hand splint and no one told her Resident #88 should wear a left hand splint.

On 10/14/2022 at 9:19 am the Administrator was interviewed and stated therapy should have notified nursing of the recommendation for a splint to Resident #88's hand and then Nursing should have communicated to the staff and put the left hand splint in place.

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F 690	Continued From page 37	F 690		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §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. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (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; (ii) A resident who enters the facility with an 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 (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. §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. This REQUIREMENT is not met as evidenced by:	F 690		11/9/22

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F 690	Continued From page 38 Based on record review, observation, and staff interviews the facility failed to ensure 1 of 4 residents, Resident #87, reviewed for indwelling catheters had a catheter bag that was secured off the floor. Findings included: A Significant Change Minimum Data Set (MDS) assessment dated 9/29/2022 indicated Resident #87 was moderately cognitively impaired and had an indwelling catheter. Resident #87 re-admitted to the facility on 10/5/2022 with diagnoses of chronic kidney disease and urinary retention. Resident #87's Care Plan dated 10/6/2022 indicated he required a urinary catheter and catheter care should be provided every shift. Resident #87 was interviewed on 10/10/2022 at 3:11 pm and stated he did not want to be interviewed. On 10/10/2022 at 3:20 pm Resident #87's catheter bag was found on the floor. Nurse #4 had entered the room and stated Resident #87's catheter bag should not be on the floor. Nurse #4 secured the catheter bag on the side of the bed, off the floor. During an observation and interview with Nurse Aide #2 on 10/12/2022 at 9:37 am Resident #87 was in bed with the head of the bed elevated. His catheter bag was on the floor under his bed. Nurse Aide #2 stated she had not been in the room yet and was not aware Resident #87's catheter bag was on the floor. Nurse Aide #2	F 690	F690 1. Resident #87 indwelling catheter was not placed in privacy bag and taken off the floor 2. Current residents with indwelling catheters are at risk 3. Education provided to current nursing staff including licensed nurses, nursing assistants and medication aides to ensure that all catheter bags have a privacy cover/fig leaf bag and kept off the floor Any member of nursing staff who is not educated will not be allowed to work until education is received. Any new member of nursing staff will be educated by Staff Development or Director of Nursing During the orientation process. 4. DON or designee will audit 5 patients with indwelling catheter to ensure catheters are secured properly 5x weekly x 4 weeks, then 3x weekly x 4 weeks, then weekly x 4 weeks. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of completion: 11/09/2022	

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F 690	Continued From page 39 stated they had changed her assignment this morning due to another nurse aide calling out and she had not been able to get to the room since the assignment was changed. Nurse #8, who was assigned to Resident #87, was interviewed on 10/12/2022 at 10:54 am and stated she was made aware of Resident #87's catheter bag being on the floor under his bed on 10/10/2022 by Nurse #9. She stated she would not have been in the room because a Medication Aide was assigned to give Resident #87 his medications. Nurse #8 stated she thought the Nurse Aide #2 should have made sure the catheter bag was secured to the side of his bed, off the floor. On 10/13/2022 at 5:26 pm an interview was conducted with the Director of Nursing, and she stated the nurse and nurse aide assigned to the resident should have made sure Resident #87's catheter bag was secured to the side of the bed and off the floor. On 10/14/2022 at 9:09 am an observation of Resident #87 revealed he was in bed with his eyes closed. His catheter bag was on the floor between his bed and the room door. The catheter bag was visible from the door.	F 690		
F 760 SS=K	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff, Nurse Practitioner	F 760	Past noncompliance: no plan of	

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(NP), and Physician interviews, the facility failed to administer an anti-seizure medication (lacosamide) as ordered by the physician for 1 of 1 resident reviewed for significant medication errors (Resident #244). Resident #244 missed 34 doses of lacosamide. The facility failed to administer lacosamide on 4/28/2022 to 4/30/2022, 5/1 to 5/11/2022; 5/23 to 5/27/2022. Resident #244 was sent to the emergency room from a physician appointment on 5//11/2022 with cardiac issues (and admitted for treatment) and was sent to the emergency room for evaluation after seizure activity on 5/27/2022.

Findings included:

Resident #244 was admitted to the facility 4/27/2022 at 11:45 PM with diagnoses to include stroke, seizures, and diabetes.

The admission Minimum Data Set (MDS) assessment dated 5/2/2022 assessed Resident #244 to be severely cognitively impaired. The MDS documented Resident #244 had a percutaneous endoscopic gastrostomy (PEG) tube for feeding and medications. The MDS documented Resident #244 had seizure disorder.

The medical record for Resident #244 was reviewed and physician order dated 4/27/2022 ordered lacosamide 10 milligrams per milliliter (mg/ml) give 15 ml (150 mg) by PEG tube every 12 hours for seizures.

The Medication Administration Record (MAR) for April and May 2022 were reviewed. The documentation for lacosamide was as follows:

" 4/28/2022 9:00 AM dose, "5" (hold/see

correction required.

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progress note). Progress notes for 4/28/2022 revealed that all morning medications were on hold and the NP was aware. This note was written by Nurse #9.
" 4/28/2022 9:00 PM dose was documented as administered.
" 4/29/2022 9:00 AM dose, "6" (hospitalized). Nursing progress notes written by Nurse #9 dated 4/29/2022 documented that Resident #244 was sent to the hospital because he pulled out his PEG tube. The note documented Resident #244 returned to the facility at 11:00 AM, the morning medications were not administered at that time, and the provider (NP) was notified.
" 4/29/2022 9:00 PM dose was documented as administered by Nurse #11.
" 4/30/2022 9:00 AM dose, "5". Nursing progress notes written by Nurse #13 dated 4/30/2022 documented at 10:07 AM "on hold from pharmacy" without specific medication identified.
" 4/30/2022 9:00 PM dose was documented as administered.
" 5/1/2022 9:00 AM dose, "5". Nursing progress notes written by Nurse #12 dated 5/1//2022 documented at 10:32 AM "(lacosamide)10 mg on order from pharmacy, not available."
" 5/1/2022 9:00 PM dose, "9" (other, see progress notes). Nursing progress notes dated 5/1/2022 at 10:47 PM documented "medication not available" without specific medication identified.
" 5/2/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/2/2022 at 12:59 PM documented "hold, NP aware," without specific medication identified.
" 5/2/2022 9:00 PM dose "5". Nursing progress notes dated 5/2/2022 at 10:17 PM documented "hold, NP aware," without specific medication identified.

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" 5/3/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/3/2022 at 10:23 AM documented "hold, NP aware," without specific medication identified.
" 5/3/2022 9:00 PM dose "5". Nursing progress notes dated 5/3/2022 at 9:46 PM documented "hold, NP aware," without specific medication identified.
" 5/4/2022 9:00 AM dose was documented as administered by Nurse #13.
" 5/4/2022 9:00 PM dose "5". Nursing progress notes dated 5/4/2022 at 9:50 PM documented, "(lacosamide)10 mg on order from pharmacy, not available."
" 5/5/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/5/2022 at 10:31 AM documented "hold, NP aware," without specific medication identified.
" 5/5/2022 9:00 PM dose "5". Nursing progress notes dated 5/5/2022 at 9:16 PM documented "hold, NP aware," without specific medication identified.
" 5/6/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/6/2022 at 1:18 PM documented "hold, NP aware," without specific medication identified.
" 5/6/2022 9:00 PM dose "5". Nursing progress notes dated 5/6/2022 at 6:57 PM documented "hold, NP aware," without specific medication identified.
" 5/7/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #4 dated 5/7/2022 at 1:25 PM documented "hold, NP aware," without specific medication identified.
" 5/7/2022 9:00 PM dose was documented as administered.
" 5/8/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/8/2022 at 12:56 PM documented "hold, NP aware," without

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specific medication identified.
" 5/8/2022 9:00 PM dose "9". Nursing progress notes dated 5/8/2022 at 11:06 PM documented "medication not available without specific medication identified.
" 5/9/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/9/2022 at 10:01 AM documented "hold, NP aware," without specific medication identified.
" 5/9/2022 9:00 AM dose "5". Nursing progress notes dated 5/9/2022 at 9:13 PM documented "Med held, NP notified," without specific medication identified.
" 5/10/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/10/2022 at 1:42 PM documented "hold, NP aware," without specific medication identified.
" 5/10/2022 9:00 PM dose "5". Nursing progress notes dated 5/10/2022 at 9:48 PM documented "NP aware, hold," without specific medication identified.
" 5/11/2022 9:00 AM dose "5". Nursing progress notes written by Nurse #13 dated 5/11/2022 at 10:37 AM documented "on hold, NP aware," without specific medication identified.

Nursing progress notes dated 5/12/2022 at 1:49 AM documented Resident #244 had been admitted to the hospital.

The hospital discharge summary dated 5/23/2022 documented Resident #244 had a history of cryptogenic stroke (a stroke with an unknown cause) and was hospitalized after a loop recorder (heart rhythm monitor) detected 5-17 second pause during the night on 4/2/2022. Resident #244 was seen in the cardiologist office on 5/11/2022 and referred to the hospital emergency department after that appointment. During

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transport to the hospital, it was noted Resident #244 had apnea (stopped breathing for several seconds). During the hospital stay, it was noted Resident #244 had second-degree heart block (electrical signals in the heart are disrupted, which can cause cardiac arrhythmias). The discharge note documented Resident #244 would continue to follow up with cardiology after discharge.

Resident #244 was readmitted to the facility from the hospital 5/23/2022 with a diagnosis of sinus pause (a cardiac arrhythmia when the heartbeat pauses or stops). A physician order dated 5/23/2022 ordered lacosamide 10 mg/ml administer 15 ml (150 mg) by PEG tube every morning and at bedtime related to seizures.

New orders for Resident #244 were entered into the electronic documentation system at 2:38 PM. A nursing progress note dated 5/23/2022 at 10:00 PM documented the NP was aware of Resident #244 readmission to the facility.

The May 2022 MAR was reviewed and documentation for lacosamide was as follows:

" 5/24/2022 9:00 AM dose "9". Nursing progress notes dated 5/24/2022 at 1:45 PM documented "not in stock", without specific medication identified.
" 5/24/2022 9:00 PM "5". A nursing note dated 5/25/2022 at 12:16 AM documented "(lacosamide) 15 ml np aware, hold."
" 5/25/2022 9:00 AM dose "5". A nursing note written by dated 5/25/2022 written by Nurse #13 at 10:47 AM documented "on hold NP aware" without specific medication identified.
" 5/25/2022 9:00 PM dose was documented as

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administered by Nurse #10.
" 5/26/2022 9:00 AM dose "5". Nursing progress note dated 5/26/2022 at 1:25 PM written by Nurse #13 documented "on hold, NP aware" without specific medication identified.
" 5/26/2022 9:00 PM dose "5". Nurse progress note written by Nurse #11, dated 5/26/2022 at 11:27 PM documented "med on hold np aware" without specific medication identified.
" 5/27/2022 9:00 AM no documentation for missed dose of medication.
"

A Nursing progress note dated 5/27/2022 at 4:37 PM documented Resident #244 was having a seizure during physical therapy, and he was sent to the hospital.

An emergency department discharge note dated 5/27/2022 documented Resident #244 had been sent to the hospital for evaluation after an apparent seizure. The note documented when the medics arrived at the facility, Resident #244 was no longer having seizure activity. The note documented that Resident #244 had not received lacosamide for 3 days.

Lacosamide was documented as administered on 4/28/2022 9:00 PM, 4/29/2022 9:00 PM by Nurse #11, 4/30/2022 at 9:00 PM, 5/4/2022 at 9:00 AM by Nurse #13, 5/7/2022 at 9:00 PM, and 5/25/2022 at 9:00 PM by Nurse #10.

An interview was conducted with Nurse #10 on 10/12/2022 at 3:51 PM. Nurse #10 reported that he had provided care to Resident #244 and had administered medications to him. Nurse #10 was asked about dose of lacosamide that were documented as given on 5/25/2022 at 9:00 PM. Nurse #10 reported he did not specifically

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remember 5/25/2022, and he said that if the medication was not in the building, he may have mistakenly clicked that he gave the medication. Nurse #10 reported that he did not specifically remember lacosamide for Resident #244 and he could not remember if he talked to the DON or the NP regarding the availability of doses.

Nurse #11 was interviewed on 10/12/2022 at 5:02 PM. Nurse #11 reported that he was an agency nurse and he had provided care to Resident #244. Nurse #11 reported when he attempted to administer the lacosamide to Resident #244, he discovered there was no lacosamide in the facility. Nurse #11 reported he did not know why he documented administering lacosamide to Resident #244 on 4/29/2022 because the medication was not in the building. Nurse #11 reported he told the DON Resident #244 did not have lacosamide available for administration, but he was not certain of the date he made the report.

An interview was conducted with Nurse #13 on 10/13/2022 at 9:38 AM. Nurse #13 reported that she had provided care to Resident #244. Nurse #13 reported that lacosamide was not available and she notified the NP the medication was not available. Nurse #13 reported she had not reported the medication was not available to the DON. Nurse #13 reported she was unable to remember which NP she had contacted and on what date she had notified the NP the lacosamide was not available. Nurse #13 reported she was not certain why she documented she administered lacosamide on 5/4/2022 and reported she may have clicked off the medication on accident.

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Nurse #9 was interviewed on 10/12/2022 at 12:36 PM and she reported she had provided care to Resident #244, and she had not been able to administer lacosamide to Resident #244 because the medication was not in the facility. Nurse #9 reported she had notified a NP, but she was not certain of the date she contacted the NP, or if she spoke to the facility NP or the on-call NP. Nurse #9 reported that she had not notified the Director of Nursing (DON) that lacosamide was not available for administration to Resident #244.

An interview was conducted with the NP on 10/12/2022 at 1:53 PM. The NP reported that she was not notified that the facility had not administered lacosamide to Resident #244 until 5/27/2022. The NP explained that lacosamide was a controlled medication and prescription had to be handwritten and submitted to the pharmacy for the medication to be filled. The NP reported on 4/23/2022 she had written a handwritten prescription and it was faxed to the pharmacy and she believed that Resident #244 was receiving the lacosamide for seizures because she was not notified lacosamide had not been delivered by the pharmacy. The NP reported she was notified on 5/27/2022 that Resident #244 had not received lacosamide "for 3 days." The NP reported it was not until later (uncertain of date) she was notified that Resident #244 had not received any lacosamide in the facility from admission until 5/28/2022. The NP stated missing the lacosamide was a significant medication error that could have resulted in brain injury related to uncontrolled seizure activity.

The NP was interviewed again 10/12/2022 at 3:06 PM. the NP reported that abruptly stopping lacosamide could also cause significant cardiac

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issues. The NP reported if she had been notified of the issues with obtaining the medication, then she could have had discussions with the family, the facility, and the physician about changing or modifying medications.

The facility physician (MD) was interviewed on 10/12/2022 at 3:13 PM. The MD reported he was not aware Resident #244 had not received lacosamide as ordered until today (10/12/2022). The MD reported that not administering the lacosamide for Resident #244 was a significant and serious error that could have impacted his cardiac health and his neurological health. The MD explained that after a stroke, some patients have seizure activity, and that was why Resident #244 required the medication lacosamide.
The DON was interviewed on 10/12/2022 at 6:01 PM. The DON explained that when Resident #244 was admitted from the hospital on 4/23/2022 he did not have a handwritten prescription for lacosamide, and the NP wrote a prescription for the medication. The DON reported that the NP had written for tablets to be administered and Resident #244 required the liquid form for administration through the PEG tube. The DON reported there were complications from the pharmacy with the dosage of the medication that required clarification by the NP. The DON reported that she was not aware Resident #244 had not received lacosamide until 5/27/2022, 3 days after Resident #244 was readmitted to the facility from the hospital. The DON reported that Resident #244 was sent to the hospital for seizure activity and sent back to the facility. The DON reported that on 5/27/2022 the NP wrote another handwritten prescription for lacosamide, and it was sent to the pharmacy, and the medication was delivered on 5/28/2022. The

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DON reported she started a plan of correction for the medication error.

The Administrator was notified of the immediate jeopardy on 10/12/22 at 6:30 PM.

The facility provided a plan of correction with a correction date of 6/15/2022. The plan of correction included F760:

1 - Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.
(Lacosamide) was not available for resident upon admission. The patient missed his medication upon admit 4/27/2022 to 5/11/2022.
The patient discharged to hospital on 5/11/2022 and returned from hospital on 5/23/2022. Patient had a delay in (lacosamide) again from 5/23/2022 until 5/27/2022.
On 5/27/2022, the patient received his medication.
Nursing administration self-identified this ongoing issue of medication availability, and put together a 4-step plan POC for both:
1. Notification to physician and/or nurse practitioner (NP) when medications are unavailable at med pass for follow-up
2. Medication availability in general
The root cause of this issue upon the first admission, was that upon missing medications, the physician and/or NP was not notified of the need for the hard script related to the (lacosamide). The hospital did not send the patient with the hard script upon admit. The information was passed from shift to shift by nurses, and not to nursing administration for intervention and resolution.
Upon readmission on 5/23, the root cause was

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that the discharging hospital did not send the hard script again (for lacosamide). The NP was notified and did provide a script; however, it was for tablets, versus a liquid format given that the patient has a PEG tube for medications.
The NP was notified, then re-wrote the script for liquid dosing; however, pharmacy could not accept this prescription related to the dosage. (The prescription could not be split as it was a scheduled medication)
The NP again was notified and re-wrote the prescription for(lacosamide) with the appropriate dosage which could be filled by the pharmacy.
The pharmacy provided the medication in liquid form and the patient received the medication moving forward.
The patient discharged on 6/5/2022.

- 2 Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
All medications were reviewed by the Director of Nursing (DON) for lacosamide. No other residents in the facility were found to be ordered lacosamide.
-3 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
Education given to all current nurses (fulltime, part time and agency staff) on process of obtaining medication (lacosamide) and/or generic when not available. Moving forward nurses on hire will also receive this education.
This will include notifying the physician and/or non-physician practitioner (PA, NP) with any and each missed dose of (lacosamide), for follow-up.
The protocol is as follows:
1. Notify MD or NP/PA of missed (lacosamide) at time of med pass if unavailable.

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F 760	Continued From page 51 2. Ask for hold order, alternate order and/or determine what next steps are via the MD/NP/etc. 3. If physician and/or NP does not offer a hold/alternate order for (lacosamide), notify DON for further intervention and follow-up, up and including administrator, attending physician, medical director and/or pharmacy consultant until resolution. 4. Notify pharmacy of missed medication to determine root cause and resolution. # - 4 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed. DON will audit all patients who receive (lacosamide) to ensure adequate supply three times weekly x 4 weeks, then weekly x 4 weeks and monthly ongoing. If/when a (lacosamide) medication is missed, audit will be performed to determine if the proper and timely notification was done to MD/NP for hold order, alternate order and/or next steps. Any issues found will be corrected immediately, and any nurse found not to be in compliance with protocol for medication availability and notification will be re-educated and/or disciplined up to and including termination as needed. The results will be reported to the monthly Quality Committee for review and discussion to ensure compliance. Once the QA Committee determines the problem no longer exits, then review will be completed on a random basis. Date of compliance as of 6/15/22. The plan of correction was reviewed and validated 10/13/2022 and 10/14/2022 by interviews with nursing staff, review of the	F 760		

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F 760	Continued From page 52 educational in-services, review of the monitoring and audits, and medication administration observations. F760 was in compliance on 6/15/2022.	F 760		
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 observations, record review and staff interviews the facility failed to remove expired medications in one of two medication storage rooms and on one of three medication carts. The	F 761	F761 1. No residents were affected by the alleged deficient practice. 2. Current residents have the potential to	11/9/22

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F 761	Continued From page 53 facility also failed to label an opened insulin vial with an expiration date located in the refrigerator in one of two medication rooms. (Medication storage room B Hall and Medication cart A hall - North side). Findings included: 1. A review of the medication storage room on the B hall was conducted on 10/13/22 at 11:27 AM. The Staff Development Coordinator (SDC) opened the medication storage room and stated the normal procedure was for the Unit Manager (UM) to check the expiration dates for medications. SDC explained that B hall does not have a UM, so the Director of Nursing (DON) was reviewing the B hall storage room. An observation of a box was on the counter and partially open. Inside the box was a package of Sodium Chloride 0.45%. The package had been out of the shrink wrap and had a written expiration date of 7/24/22 and the ports were exposed. A review of the medication refrigerator revealed a vial of an open multi dose Humulin Insulin 100 unit per milliliter (ml). There was no expiration date written on the side of the bottle to alert staff that per manufactures recommendations it was good for 28 days after opening. In a storage drawer of the refrigerator was 1 bag of Intravenous Vancomycin 750 milligram/250 ml Normal saline 0.9% sodium chloride which read; use by August 10, 2022. On 10/13/22 at 12:05 PM the DON reviewed the findings in the medication storage room on the B hall and stated the box with the sodium chloride was in our overstock box and it belongs in our	F 761	be affected by the alleged deficient practice. 3. Unit managers and Director of Nursing conducted audits of current medication storage rooms, medication rooms, and med carts to ensure expired medications were discarded. The DON or designee to provided facility licensed nurses with education on the labeling and storage of drugs. On designated area to place vials or medications with questionable expiration dates. Undated and expired medications are to be discarded immediately. Any licensed nurses who is not educated will not be allowed to work until education received. Any new licensed nurse will receive education during the orientation process. 4. DON, Nursing ,administration will conduct reviews of medications in the facility storage rooms, medication rooms, and medication carts for expired medications 3 times a week for 4 weeks, 1 time a week x 8 weeks, and then monthly x 1 months. The facility pharmacist will also review medications carts monthly and report any concerns with labeling and storage of drugs to the Administrator and Director of Nursing. 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of compliance: 11/09/2022	

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Omnicell. The DON stated that she thought a nurse may have noticed it was expired as it was considered open once removed from the shrink wrap. The DON stated regarding the Humulin Insulin she had just checked the refrigerator on Monday 10/10/22 and it had not been there. The resident who was prescribed the vancomycin had switched to hospice and does not get this medication and was not on the unit at that time in August 2022. The DON explained the UM will review and pick one medication room and one cart per week however the B side does not currently have a UM so the SDC and the DON had been reviewing the B side medication room.

2. A review was completed on the A side of the North medication cart on 10/13/22 at 2:45 PM with nurse #8 in attendance. The observation revealed the following expired medications:

- Novolog 100 unit per ml opened on 9/11/22. Per the manufactures recommendations it was good for 28 days after opening.
- Humalog 100 units per ml opened on 9/6/22. Per the manufactures recommendations it was good for 28 days after opening.
- Lantus 100 units per ml opened on 9/14/22. Per the manufactures recommendations it was good for 28 days after opening.

Nurse #8 stated the nurses are required to check the date of expiration, but she inquired how long an opened insulin vials would last.

An interview was completed with the DON on 10/13/22 at 6:28 PM who stated that it was her expectation to review medications in the refrigerator daily and medication carts weekly and a monthly review of the medication room.

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F 761	Continued From page 55 Medications should be labeled once opened with an expiration date. An interview was completed with the Administrator on 10/14/22 at 1:45 PM who stated that following recommendations regarding medicine and appropriate storage should be completed.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label opened beverages, failed to clean fluids off the bottoms of coolers, failed to label and close frozen foods, failed to air-dry steamer pans, and failed to label and date resident food in 1 of 2 nutritional rooms observed	F 812	F812 1. The facility failed to properly label beverages and opened frozen foods, along with resident food stored in nourishment room refrigerator. Facility failed to clean spilt fluids from the bottoms	11/9/22

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F 812	Continued From page 56 (200 hall). This had the potential to affect 86 of 87 residents in the facility. Findings included: A tour of the kitchen was conducted on 10/10/2022 at 10:16 AM with the Dietary Manager (DM). Cooler #1 was observed with purple and orange colored liquid spilled on the bottom of the cooler. The DM reported he thought that juice was spilled this morning during the breakfast service. The DM reported the bottom of the cooler should be cleaned. Cooler #3 was observed with thawing ground beef in a metal steamer pan. The packages of meat were wrapped in plastic and the metal bins were sitting on the bottom of the cooler. On the shelf above the ground beef was a metal steamer pan with pork loins wrapped in plastic. Red colored liquid was dripping from the packages of pork loins in the metal steamer pan. The drippage was noted to be pooled on and around the packages of ground beef and under the ground beef metal pan. The DM reported he thought the spilled liquid was drainage from the thawing meat and the cooler should be cleaned. The walk-in freezer was observed with the following frozen foods open to air and unlabeled: breaded chicken strips, cookie dough, and garlic bread. The DM reported any food that was opened needed to be closed and labeled with the date it was opened. The DM reported he did not know why the items were not closed and labeled. The pan storage area was observed, and the DM separated two metal steamer pans that were stacked together on a shelf and stored ready for	F 812	of the coolers. Facility also failed to air-dry steamer pans. Current residents have the potential to be affected by the alleged deficient practice. All non-labeled food in the freezer and nourishments room was immediately thrown out. The spilt fluids in cooler were cleaned up immediately. Steamer pans were re-washed and properly dried as required. 2. Current Residents are at risk. 3. Current Dietary employees educated on proper labeling techniques within the kitchen area and the unit nourishment rooms. Also educated on proper cleaning schedule and expectations for air drying items completely before storing. Education will be completed by Dietary Manager or designee. Any dietary employee not completing required education by 11-9-22 will not be allowed to work until education completed. will not be allowed to work until education is received All new dietary employees will be educated by Dietary Manager or designee during the orientation process. 4. Dietary manager/designee to audit all food storage and proper cleaning techniques in the kitchen and unit nourishment rooms 5 x weekly x 4 weeks then 3 times weekly x 4 weeks, then monthly x1 5. Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 1 for further resolution if needed 6. Date of compliance: 11/09/2022	

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use. When separated, the preparation pans were observed to have water dripping off them. The DM was unable to explain why the pans were stacked together and stored wet and reported that all pans and other items were to be air dried before storage.

The DM was interviewed 10/14/2022 at 9:12 AM. The DM reported that he provided education to the kitchen staff about placing their food and drinks into the coolers used for resident foods. The DM reported that he had started to organize the walk-in freezer on 10/10/2022 and had noticed the bags of opened foods in the freezer, but he did not have a chance to discard the food before the tour. The DM reported he had been at the facility for 2 months and had in-services planned for education related to kitchen regulations.

The Administrator was interviewed on 10/14/2022 at 1:47 PM. The Administrator reported the DM had been in his role for only 2 months and was trying to get the kitchen organized. The Administrator reported she expected the kitchen to be maintained appropriately, and that the DM and kitchen staff followed all policies and procedures for the health and safety of the residents.