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ACCORDIUS HEALTH AT ASHEVILLE	500 BEAVERDAM ROAD ASHEVILLE, NC 28804

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F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 10/27/22 through 11/1/22. Event ID# GJ3B11. The following intakes were investigated NC00193841, NC00193766, NC00193394, NC00191456 and NC00190029. One of the sixteen complaint allegations was substantiated and cited. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J). Tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/25/22 and was removed on 10/30/22. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff, resident, and Nurse Practitioner (NP) interviews, the facility failed to provide supervision and a safe smoking environment 1 of 3 residents reviewed for smoking (Resident #1). Resident #1 was admitted to the facility on 7/27/22 with a documented history of smoking with oxygen in	F 689	Tag # F689 Free of Accident Hazards/Supervision/Devices 1. The facility was cited for F689 (Free of Accident Hazards/Supervision/Devices). Based on the findings, it was alleged that the facility	11/1/22

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

Electronically Signed | 11/21/2022

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F 689	Continued From page 1 use at another facility and was assessed as being safe to smoke unsupervised. On 10/25/22 the Director of Nursing intervened twice and removed the oxygen tank off the back of Resident #1's wheelchair as he was going out to smoke and provided education both times. No other interventions were initiated, and Resident #1 continued to smoke without supervision. On 10/27/22 Resident #1 was observed smoking unsupervised with oxygen in use via nasal cannula putting himself and other residents at risk for serious adverse outcome. Immediate jeopardy began on 10/25/22 when the Director of Nursing witnessed Resident #1 attempting to go out to smoke with an oxygen tank on the back of his wheelchair and oxygen in use via nasal cannula and no interventions were put in place. The immediate jeopardy was removed on 10/30/22 when the facility implemented an acceptable credible allegation for immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Review of admission correspondence from previous facility received by the Admission Coordinator dated 07/07/22 revealed Resident #1 diagnosis of dependence of supplemental oxygen and nicotine dependence. The admission correspondence also revealed Resident #1 had received a 30-day discharge notice due to breaking smoking policy multiple times, having	F 689	failed to prevent Resident #1 from smoking with oxygen on. Resident #1 was admitted to the facility on 7/27/22 with a primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD) and use of supplemental oxygen ordered as needed via nasal canula at 2 liters/minute. Director of Nursing verbally educated Resident #1 on admission to remove oxygen, leave it on the wheelchair, and walk as he is able into the smoking area to sit in straight chair without oxygen to smoke, resident verbalized understanding. On 7/27/22, the licensed nurse completed the Safe Smoking Screening and determined that resident is a current smoker with assessment and care plan to smoke independently without staff supervision. The Director of Nursing (DON) stopped Resident #1 twice on Tuesday (10/25/22) as he was going out to smoke with oxygen on and did verbal education with him on both occasions about the importance of removing his oxygen before going outside to smoke. The Director of Nursing did not report what occurred on 10/25/22 and Resident #1 continued to smoke without supervision. On 10/27/22, resident was observed in designated smoking area smoking independently with oxygen cylinder attached to back of wheelchair, by the state surveyor. He took a couple of puffs, put out his cigarette, and then re-entered the facility. The Administrator was informed by the surveyor. The DON did not report what occurred on 10/25/22 and Resident #1 continued to smoke without supervision.	

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F 689	Continued From page 2 smoking materials on his person, and smoking in his room with supplemental oxygen which could cause death and or harm to other residents. Admission Coordinator was unavailable for interview. Resident #1 was admitted to the facility on 07/27/22 with diagnoses to include chronic obstructive pulmonary disease and supplemental oxygen dependence. Review of revised facility smoking policy dated July 2017 revealed upon admission residents shall be informed of facility smoking policy to include: oxygen use is prohibited in smoking areas, staff shall consult the Attending Physician and Director of Nursing to determine if safety restrictions need to be placed on a resident's smoking privileges, resident's ability to smoke will be re-evaluated quarterly, upon significant change, and as determined by staff, any smoking-related privileges, restrictions, and concerns shall be noted on care plan and all personnel caring for residents shall be alerted to these issues, and facility may impose smoking restrictions on a resident at any time, if it is determined the resident cannot smoke safely with the available levels of support and supervision. Review of admission smoking assessment dated 07/27/22 revealed Resident #1 required no supervision and may smoke independently due to no history of smoking-related incidents, safely be without supplemental oxygen during smoking times, and was able to acknowledge understanding of facility smoking policy. The assessment was completed by Nurse #1.	F 689	2. " On 10/27/22, the licensed nurses completed updated Safe Smoking Screening Assessments for all current facility smokers to reflect supervised or unsupervised. Care plans were audited for accurate reflection. O2 orders updated to reflect accurate flow rate, and additional directions were added per Medical Director approval with may remove oxygen while smoking. " On 10/27/22, Care Plans of all residents who smoke were reviewed and revised to reflect supervised or unsupervised smoking. Those with oxygen dependence care plans were revised to reflect oxygen prohibited during smoking for safety. Completed by Regional Director of Clinical Services and Director of Nursing. " On 10/27/22, an updated list of supervised and unsupervised smokers was added to each nurse□s station by the Regional Director of Nursing. This list will be updated with each admission and in daily morning clinical meeting as needed for residents who smoke. " An Ad HOC QAPI meeting was held by the Administrator on 10/27/22 to notify the IDT team and the Medical Director of the concerns, solutions and ask for any suggestions. The team agreed with the plan. " A meeting was held with all smokers on 10/28/22 to inform the residents of the	

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A telephone interview was conducted with Nurse #1 on 11/03/22 at 1:35 PM revealed she was familiar with Resident #1 and had completed his admission smoking assessment. She stated Resident #1 had been admitted with oxygen and educated on not smoking while wearing oxygen and to leave oxygen inside when smoking. She revealed she completed the smoking assessment for Resident #1 by observing his abilities to smoke safely and had deemed him a safe smoker. Nurse #1 stated she had no knowledge of Resident #1 previous placement or history of smoking while wearing oxygen and had she known she would have included in smoking assessment, and he would have possibly been deemed a supervised smoker so he could have been monitored more closely.

Review of admission Minimum Data Set (MDS) dated 08/02/22 revealed Resident #1 was cognitively intact and was coded as supplemental oxygen dependent and current tobacco use.

Review of physician progress note dated 08/03/22 revealed Resident #1 had informed the physician he had a lit a cigarette in his room at his previous facility and had his smoking privileges revoked and had requested a transfer to current facility.

Review of admission care plan dated 09/25/22 revealed focus area for smoking for Resident #1. Interventions included instruct Resident #1 about smoking risks and hazards, instruct Resident #1 about facility policy on smoking to include locations, times, and safety concerns, notifying charge nurse immediately if it is suspected Resident #1 had violated facility smoking policy, and observe clothing and skin for signs of

changes to the smoking policy and the removal of 1 smoking location.
3.
" A smoking assessment will be completed for all new admissions prior the resident being able to smoke or a new assessment completed for any resident who has a violation of the smoking policy or who are placed on oxygen immediately.
" The smoking list will be updated by the Director of Nursing with any change and placed at each nursing station and in the designated smoking area for staff to reference.
" Education on the smoking policy was provided to all staff on 10/27/22 and was completed on 10/31/22. All newly hired staff and contract staff will be educated prior to their 1st shift. This education was added to the orientation packet as well as the new hire packet to be provided to staff by the Human Resources Director or the Director of Nursing.
4.
" The Administrator, Maintenance Director or Director of Nursing will perform audits 5x/week for 6weeks to the exit doors of the current smoking area and the previous smoking area to ensure staff are monitoring for residents to go into areas inappropriately.
" The Administrator or Business office Manager will audit the smoking area 5x/weekly for 6 weeks during supervised smoking times for any concerns and report and correct any issues immediately.
" The Director of Nursing or Unit Managers will audit 3 residents weekly for

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F 689	Continued From page 4 cigarette burns. The admission care plan also revealed focus area for respiratory for Resident #1. Interventions included oxygen via nasal cannula as per MD order. Review of current physician order dated 10/27/22 revealed Resident #1 to receive supplemental oxygen via nose cannula at 2 liters per minute as needed. There were no prior orders for supplemental oxygen available in Resident #1 electronic medical chart. An interview was conducted with Director of Nursing (DON) on 10/27/22 at 5:59 PM revealed earlier this week (10/25/22) she had witnessed Resident #1 twice on the same day, attempting to go outside and smoke with supplemental oxygen attached to his wheelchair while wearing nasal cannula. She stated both times she had stopped Resident #1 and removed the supplemental oxygen tank from the wheelchair and educated on why it was not safe to smoke with oxygen. She revealed she had not documented incidents, nor had she completed a new smoking assessment and had not notified the Administrator of incidents. Resident #1 was observed on 10/27/22 at 10:20 AM smoking while sitting outside in the designated area with oxygen tank attached to his wheelchair and nasal cannula in place. Resident #1 was receiving supplemental oxygen via nasal cannula tubing at 2 liters. Upon observation, Resident #1 placed cigarette in ash tray and came back into building with oxygen in place. Resident #1 observation and interview conducted on 10/27/22 at 11:26 AM revealed him sitting on his bed receiving supplemental oxygen through	F 689	6weeks from the list of current smokers to check their smoking assessment and Care Plan for being current and up to date. " All audits and concerns will be taken to the QAPI committee after time frame above and reviewed with the IDT to determine if there is a need to continue or changes should be made. 5. Completion Date: 11/01/22	

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room concentrator set at 3 liters via nasal cannula. Resident #1's wheelchair was observed in room with supplemental oxygen tank attached to back of wheelchair. Resident #1 stated he was currently on 3 liters of continuous oxygen and was only able to go without using supplemental oxygen for no more than 45 minutes at a time. He admitted to being outside smoking earlier that morning while wearing his oxygen and stated he did so because he believed the oxygen tank attached to his wheelchair to be almost empty and he had hoped no one would notice. Resident #1 stated he had been at the facility for 2 ½ months and had been made aware of smoking policy during admission to include not wearing oxygen while smoking. He revealed he had been discharged from his previous facility for smoking in his room while wearing his oxygen and was aware of the danger smoking around oxygen could have caused for himself or others.

An interview was conducted with the Nurse Practitioner (NP) on 10/27/22 at 12:09 PM revealed she had previously witnessed residents at the facility outside smoking with supplemental oxygen tanks attached to their wheelchairs and nose cannula in place. She stated she had spoken with the facility administration about residents being outside smoking with supplemental oxygen in place and they were supposed to have educated the residents about the dangers of smoking while using supplemental oxygen and placed no oxygen use signs on the doors leading out to the smoking areas. The NP revealed she had also educated residents about the dangers of smoking while using supplemental oxygen such as the building could blow up or they could catch themselves or other residents on fire. She stated she had assumed residents were

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continuing to go outside and smoke while using supplemental oxygen due to the different types of residents being admitted to the facility. The NP revealed she had been told Resident #1 had been transferred to the facility because his previous facility was no smoking and he wanted to be at facility where he could smoke. The NP was not aware of Resident #1 being discharged from his previous facility due to smoking in his room while wearing supplemental oxygen and this information should have been used to determine if Resident #1 should be a supervised or unsupervised smoker.

An interview was conducted with Administrator on 10/27/22 at 3:36 PM revealed he had not been made aware of Resident #1being observed earlier this morning outside smoking while wearing his supplemental oxygen. The Administrator revealed upon admission, Resident #1 had been assessed for smoking and deemed to be a safe smoker with no supervision and the facility smoking policy had been discussed with Resident #1 and included not wearing oxygen while smoking. He stated he had no knowledge of Resident #1 being discharged from previous facility due to breaking smoking rules and smoking in room with oxygen. The Administrator further stated had this information been available it would have been used as part of Resident #1's smoking assessment and may or may not have determined him to be a supervised smoker. The Administrator revealed no resident should be outside smoking while wearing supplemental oxygen due to causing possible harm to themselves or others and staff should stop any resident immediately if they are witnessed trying to go outside to smoke while wearing oxygen or are outside smoking while wearing oxygen and

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F 689	Continued From page 7 report to administration. An interview was conducted with Administrator and Regional Director of Operations on 10/27/22 at 6:50 PM revealed they had not been made aware that earlier in the week the Director of Nursing had stopped Resident #1 twice in one day from attempting to go outside and smoke with supplemental oxygen attached to wheelchair with his nasal cannula in place. They stated the Director of Nursing should have notified the Administrator immediately and the incident should have been documented and new smoking assessment completed, and Resident #1 monitored more closely. The Regional Director of Operations revealed she had no knowledge of Resident #1 being discharged from his previous facility due to breaking smoking policy multiple times and smoking in his room while wearing his oxygen. She stated if the facility had known this information, it would have been used during Resident #1 smoking assessment and he would have been closely monitored and deemed a supervised smoker. The facility was notified of immediate jeopardy on 10/28/22 at 11:16 AM. The facility provided the following plan for IJ removal. Identify those residents who have suffered, or likely to suffer, a serious adverse outcome as a result of the noncompliance: The facility failed to prevent a Resident from smoking with oxygen on. Resident #1 was admitted to the facility on 7/27/22 with a primary diagnosis of Chronic	F 689		

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Obstructive Pulmonary Disease (COPD) and use of supplemental oxygen ordered as needed via nasal canula at 2 liters/minute. Director of Nursing verbally educated Resident #1 on admission to remove oxygen, leave it on the wheelchair, and walk as he is able into the smoking area to sit in straight chair without oxygen to smoke, resident verbalized understanding. On 7/27/22, the licensed nurse completed the Safe Smoking Screening and determined that resident is a current smoker with assessment and care plan to smoke independently without staff supervision. The Director of Nursing (DON) stopped Resident #1 twice on Tuesday (10/25/22) as he was going out to smoke with oxygen on and did verbal education with him on both occasions about the importance of removing his oxygen before going outside to smoke. The Director of Nursing did not report what occurred on 10/25/22 and Resident #1 continued to smoke without supervision. On 10/27/22, resident was observed in designated smoking area smoking independently with oxygen cylinder attached to back of wheelchair, by the state surveyor. He took a couple of puffs, put out his cigarette, and then re-entered the facility. The Administrator was informed by the surveyor. The DON did not report what occurred on 10/25/22 and Resident #1 continued to smoke without supervision.

On 10/27/22, the licensed nurse completed an updated Safe Smoking Screening and determined that Resident #1 was no longer safe to smoke independently without supervision. Care plan was updated to reflect this change and resident was reeducated on the smoking policy and safety concerns of smoking with oxygen and verbalized understanding and acknowledged via

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written signature. Effective 10/27/22, Resident #1 will be supervised by staff when smoking during designated smoking times and will not have oxygen in smoking area.

Residents who smoke are at risk. All staff, including agency, were questioned to determine if anyone else had observed Resident #1 or any other resident requiring oxygen in the smoking area with oxygen in use or with oxygen equipment on their wheelchair, by 10/29/22. Any resident who has been observed by staff in the past to have been in the smoking area with oxygen on will have updated smoking assessment, signed education, care plan, and be placed on the supervised smoking list. The Director of Nursing will update the list of supervised and unsupervised smokers daily and prn with any new admission or in morning clinical meeting with any resident who has had a change in condition following a safe moving assessment. The updated list will be posted at each nursing station prn with any change.
Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

On 10/27/2022, the Administrator, Director of Nursing, Regional Director of Operations, Regional Director of Clinical Services, VP of Risk Management, Social Worker, Maintenance Director, Activities Director and Medical Director conducted an Ad Hoc QAPI meeting to discuss root cause analysis of the facilities failure to prevent a resident from smoking with oxygen. The facility determined that Resident #1 did not have adequate understanding of the dangers of smoking with oxygen and staff did not

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immediately implement appropriate interventions when observing a resident's attempts at smoking with oxygen in use.

On 10/27/22, the licensed nurses completed updated Safe Smoking Screening Assessments for all current facility smokers to reflect supervised or unsupervised. Care plans were audited for accurate reflection. O2 orders updated to reflect accurate flow rate, and additional directions were added per Medical Director approval with "may remove oxygen while smoking".

On 10/27/22, Care Plans of all residents who smoke were reviewed and revised to reflect supervised or unsupervised smoking. Those with oxygen dependence care plans were revised to reflect oxygen prohibited during smoking for safety. Completed by Regional Director of Clinical Services and Director of Nursing.

On 10/27/22, an updated list of supervised and unsupervised smokers was added to each nurse's station by the Regional Director of Nursing. This list will be updated with each admission and in daily morning clinical meeting for residents who smoke. The Director of Nursing was notified on 10/27/22 of this responsibility and will oversee the process.

Effective 10/28/22, the facility provided education to all smokers. Unsupervised smokers were instructed verbally by the Administrator on the danger of oxygen in the smoking area and how to report any observation of oxygen in the smoking area. They were also educated on smoking being restricted to one designated area, not sharing cigarettes or lighters with supervised smokers

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and keeping all smoking materials in their assigned lock boxes. Any violations of this could result in becoming a supervised smoker or 30-day discharge from facility. The unsupervised smokers signed this education in acknowledgement of understanding. The supervised smokers were educated verbally by the Administrator on the danger of oxygen in the smoking area and how to report any witnessed violations of this and that any unsupervised smokers smoking materials are to be kept by staff and provided during supervised smoking times. All supervised smokers signed this education in acknowledgement of understanding.

On 10/28/22, alarms were added to both exit doors by the Maintenance Director to alert staff if a resident attempts to go out to the smoking area unattended. These alarms do not stop unsupervised smokers from exiting out the door independently, it only alerts staff to visualize the resident, when alarm sounds, to see if it is a supervised or unsupervised smoker. On 10/28/22, education was provided to all staff, including agency/contract staff, in person that were working at the time and the on-coming shift and by phone if not working that day. This education was provided by the Administrator, Director of Nursing and the Regional Team on the purpose of the alarms and how to respond. The Administrator and Director of Nursing will ensure that all staff to include contract staff are educated going forward prior to the start of their shift. On 10/29/22 the Regional Team performed an audit to ensure that all were educated to include agency/contract staff.

On 10/28/22, the Director of Nursing (DON) was

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educated by the Administrator on the smoking policy and need for immediate interventions if a resident is witnessed as unsafe such as an incident report, reporting to MD and Administrator, updating Safe Smoking Screening and care plan to reflect supervised smoking status and reeducation to resident on the Smoking policy and smoking safety. Director of Nursing (DON) was educated by the administrator on the requirement of reporting smoking incidents to the Administrator immediately.

On 10/28/22, All staff in all departments, including agency/contract staff, were educated by Administrator or Director of Nursing (DON) either in writing or verbally over the phone, of the dangers of oxygen or oxygen equipment in the smoking area, and requirements of supervision for all supervised smokers. Understanding of education provided by phone was validated by asking staff to restate materials taught and also asking questions throughout. Education also includes the smoking policy, removal of oxygen prior to going into the smoking area, the dangers of smoking with O2 in use and what actions to take, such as immediate removal of oxygen from smoking area, ensuring all residents are safe and then immediately notifying the Director of Nursing (DON) and Administrator of the smoking incident for further intervention. One designated smoking area, response to alarms, supervised and unsupervised smoking lists and where they are located, was also included. Newly hired employees will be educated on the above topics by the Director of Nursing (DON) or Unit Manager upon hire. The Director of Nursing and Human Resources Director will ensure that all staff will be educated via their agency/contract staff

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orientation packet and understand its contents prior to their first assignment at the facility. An audit of the orientation packet was completed on 10/28/22 and a copy of the updated smoking policy was added. The agency/contract staff orientation packet includes the smoking policy and the proper notifications that should be made per the policy if a smoking incident occurs. The education also reviews the items that should be available to ensure safe smoking is able to occur and alerts staff that a list of supervised smokers is located at each nursing station. And finally, the education explains that you should follow the policy and procedure in the event of an emergency staff present in facility during educational session on 10/28/22 attended an in-service however the remainder of staff received in-service by phone. A questionnaire was given by the Administrator and Director of Nursing to ensure staff who were educated via phone call on 10/28/2022 to ensure understanding of the smoking policy, how to report a breach of policy or an incident and safety of residents while in the smoking area. The Director of Nursing and Administrator will ensure that all new staff to include agency/contract staff have completed their new hire packet prior to working a shift. The Director of Nursing and Unit Managers were also educated on 10/28/22 and informed of this responsibility by the Regional Director of Clinical Services and the Administrator.

On 10/28/22, All lock box keys were gathered by Maintenance Director, Administrator or Director of Nursing, from supervised smoking residents and assigned to staff for safe keeping. Unsupervised smokers lock boxes will remain outside in the designated cubby, and they are allowed to keep

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their keys unless they are observed to not follow rules.

Effective 10/28/22, All residents will be assessed by a licensed nurse for smoking upon admission, quarterly and with any changes. Any new admission or change in assessment will also require re-education to the smoking policy and smoking contract that will be reviewed with the resident by the Social Worker and signed by the resident. During clinical meetings, all new admissions referrals will be thoroughly examined for previous smoking incidents and risks by the Director of Nursing (DON) or Unit Manager. Education to the Director of Nursing (DON) and Unit Manger was given on 10/28/22 to include this new responsibility.

Effective 10/28/2022, the Administrator and Director of Nursing will be ultimately responsible to ensure implementation of this immediate jeopardy removal for this alleged noncompliance.

Alleged Date of IJ Removal: 10/30/22

On 11/03/22 the credible allegation for the immediate jeopardy removal was validated and the removal date of 10/30/22 was confirmed.

The audit tools completed by the facility on 10/27/22 were reviewed. The physician and nurse practitioner were notified of results from the audits and all smoking assessments and care plans had been updated to reflect any changes to include residents assessed for smoking and receiving supplemental oxygen would become supervised smokers.

On 10/28/22, the Regional Clinical Manager and

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Administrator provided education with the Director of Nursing regarding the revised smoking policy and procedures. Observations, record review and interviews completed on 11/03/22 revealed Observed updated smoking assessments and care plans for each smoker, copies of updated lists of smokers and revised smoking policy available at each nurse's station and signage on door leading out to smoking area stated no oxygen use and supervised smokers must always be accompanied by staff. Interviews with nursing staff revealed the Director of Nursing continued to review list of smokers, revised smoking policy, and any smoking concerns or violations during nurse's morning meeting.

On 10/28/22, the Regional Clinical Director, Administrator, and Director of Nursing provided education to all smoking residents regarding the revised smoking policy and procedures. Further review of facility documents and interviews completed on 11/03/22 revealed Observed all smoking residents had signed and dated they had been educated on the revised smoking policy, including immediate need for safe interventions and verbalized understanding by written signature for acknowledgement and understand consequences of failure to follow updated smoking policy and received copies of revised smoking policy and oxygen usage safety sheet. Observations of Also observed supervised smokers confirmed they were outside smoking supervised by staff, oxygen tanks were left inside, and smoking materials were distributed by staff from lockbox. The door alarm to smoking area had been installed and could be heard throughout building to alert staff when residents were going in and out of door. Interviews with staff revealed supervised smokers had set smoking times

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F 689	Continued From page 16 accompanied by staff, smoking materials were distributed by staff from a lockbox held at the nursing station and oxygen tanks were left inside the hallway or in the resident's room for safety. Interviews with nurses, nurse aides, housekeeping staff, business office manager, activities director, nurse practitioner revealed they received education on revised smoking policy and procedures including smoking area was moved to East Hall only and an all-day alarm was placed on door to alert staff to observe residents coming in and out of door, all oxygen dependent residents are now placed on supervised smoking list and oxygen tanks and tubing must be left in hallways or rooms and cannot be outside, supervised smokers have designated times to smoke and must be supervised by staff at all times and smoking materials contained in lock box and distributed by staff, updated smoking list kept at both nursing stations for review, and report any smoking violations immediately to supervisor, Director of Nursing and Administrator. Staff stated the revised smoking policy including the updated list of smokers allowed them to know who should be supervised and unsupervised and staff rotated accompanying supervised smokers. The staff also stated the door alarm had been helpful by allowing them to be more alert as to who was going in and out to smoke and they believed the overall revisions to the smoking policy was for the better of the residents and staff.	F 689		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 755		11/19/22

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F 755	Continued From page 17 them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Pharmacist, and Nurse Practitioner interviews, the facility failed to obtain methadone (a schedule II narcotic medication used to treat moderate to severe pain) as ordered by the physician for a resident with chronic pain (Resident #2) resulting in three missed doses of the medication. Resident #2 was not administered methadone for three days on 9/15/22, 9/16/22 and 9/17/22 resulting in	F 755	Tag # F755 Pharmacy Srvcs/Procedures/Pharmacist/Records 1. The facility was cited for Tag # F755 (Pharmacy Srvcs/Procedures/Pharmacist/Records). Based on the findings, it was alleged that resident #2 was ordered Methadone and was not given her routine dose for 3	

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F 755	Continued From page 18 symptoms of nausea and dizziness. Resident #2 called emergency medical services and was transported to the hospital on 09/18/22 where she was administered her medication. This occurred for 1 of 3 residents reviewed for pharmacy services. The findings included: A hospital discharge summary dated 09/13/22 revealed Resident #2 had a history of chronic pain syndrome maintained with the medication Methadone (narcotic medication used to treat moderate to severe pain). The summary read to continue administering Methadone 15 milligrams (mg) daily. The summary stated the Physician had verified the order with the resident's methadone provider. Resident #2 was admitted into the facility on 09/14/22 with diagnosis which included chronic pain. Resident #2's Medication Administration Record (MAR) dated September 2022 revealed an order initiated on 09/15/22 for Methadone Hydrochloride (HCL) tablet 10 mg give 1.5 tablet orally one time a day for pain. The medication was documented as a (9) not given based on the coding chart located on the back of the MAR on 09/15/22 and 09/16/22. The order was discontinued on 09/16/22. The review of Resident #2's MAR revealed a second order was initiated on 09/17/22 for Methadone HCL tablet 10 mg by mouth in the morning for pain. The medication was documented as a (9) not given based on the coding chart located on the back of the MAR	F 755	consecutive days to include 9/15/22, 9/16/22 and 9/17/22 resulting in nausea and dizziness. The resident called 911 on 9/18/22 and was taken to the ER where she was administered her routine dose of Methadone at that time prior to returning back to the facility. The resident has a dx of chronic pain syndrome. Staff reported that the medication had not been delivered from the pharmacy during the 3 dates the medication was missed. The medication was indeed delivered to the facility on the pharmacy night run on 9/17/22. 2. " The Director of Nursing and Unit Managers completed MAR/TAR/CART checks on 11/11/22. Any missing medications were ordered from the pharmacy and follow-up was completed by the Director of Nursing to ensure that all medications did indeed arrive from the pharmacy and were placed on the med-carts. 3. " The Director of Nursing Unit Manager will review all new admissions and verify that medications were received and are on the med/treatment cart daily. " The Director of Nursing will run the missing orders report Mon-Fri in morning clinical meeting to ensure medications are being given as ordered. If medications are missed, the Director of Nursing will investigate and notify MD, RP, ADM, and RDCS as appropriate for orders and further direction and education up to disciplinary action as appropriate. " Education was provided by the	

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F 755	Continued From page 19 given on 09/17/22 and 09/18/22. The order was discontinued on 09/18/22. On 10/27/22 at 10:20 AM an interview was conducted with Resident #2. During the interview Resident #2 stated she had come from the hospital to the facility on 09/14/22 and the facility withheld her medication Methadone on 09/15/22, 09/16/22 and 09/17/22. She stated she started having withdrawal symptoms of nausea, dizziness and felt like she couldn't move in the bed. The interview revealed she had called for an ambulance on 09/18/22 and was at the hospital from 10:00 AM until 2:00 PM getting the medication Methadone that the facility could not provide. On 10/27/22 at 11:37 AM an interview was conducted with MA #1. During the interview she stated she had worked during the days of 09/15/22 through 09/18/22. MA #1 stated Resident #2 had to wait 3 days because pharmacy had not delivered the medication Methadone to the facility. The interview revealed if the medication was not in the facility to ensure it was on order through pharmacy. She stated the Director of Nursing was aware the medication was not in the facility. Review of the hospital records dated 09/18/22 at 10:03 AM revealed emergency medical services reported they did not think the facility was prepared for Resident #2 because she had not received her medication. Resident #2 stated at the hospital she had not had any methadone since 09/14/22. The hospital administered Resident #2 Methadone and discharged her back	F 755	Director of Nursing and the Regional Director of Clinical Services to all nurses and Medication Aides to ensure medications are given per physician orders. This education started on 11/15/22 and was completed by 11/19/22. " Education was also added to the orientation packet by the Director of Human Resources for new contract staff and the on-boarding packet for all new hires. All newly hired staff to include contract staff will be receive education through orientation prior to their first day of work in the facility. 4. " Director of Nursing or Unit Manager will perform MAR/TAR/CART audit on all new admissions and 3 current residents per unit each week for 6 weeks to ensure the medications are received and have been documented on the MAR/TAR. " The Director of Nursing or Unit Manager will audit the MAR/TAR for 3 residents per unit 3x/weekly for 6 weeks. " All audits and concerns will be taken to the QAPI committee by the Administrator after time frame above and reviewed with the IDT to determine if there is a need to continue or changes should be made. 5. Completion Date: 11/19/22	

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to the facility.

On 10/27/22 at 12:25 PM an interview was conducted with the Nurse Practitioner (NP). During the interview she stated she could not prescribe the medication Methadone. She stated it was only prescribed by the Medical Director (MD) and she knew Resident #2 had experienced a delay in receiving the medication due to the MD not being in the area at the time of Resident #2's admission and the pharmacy needed a written prescription to fill the medication. The interview revealed Resident #2 was not sent to the facility with a written prescription for the medication. The interview revealed the facility normally did not admit residents who were prescribed Methadone. She stated they did not call the methadone clinic because the MD came into the building on 9/16/22 to write the order for the medication.

On 10/27/22 at 5:58 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she knew Resident #2 had not received Methadone after she was admitted in September due to the hospital not sending the facility a written prescription. She stated she did not call the hospital or any outside resource to obtain a written prescription. She stated the NP did not have access to get her a prescription, the on-call physician wouldn't prescribe it and the MD was out of town. The interview revealed the MD finally wrote the prescription on 09/16/22, but pharmacy did not fill the prescription until 09/18/22 after the resident had left the facility to go to the hospital. The interview revealed the facility knew Resident #2 was receiving the medication based on her transfer form that was sent to the facility prior to her arrival.

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F 755	Continued From page 21 On 10/18/22 at 10:35 AM an interview was conducted with Pharmacist #1. During the interview she stated the pharmacy had received the written prescription for Methadone 15 mg for Resident #2 on 09/17/22 at 2:33 PM. She stated the medication was filled and delivered to the facility on 09/17/22 during the night delivery per their records.	F 755		
F 760 SS=G	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 and resident, staff,. Nurse Practitioner and Pharmacist interviews the facility failed to administer methadone (a schedule II narcotic medication used to treat moderate to severe pain) to 1 of 3 residents reviewed for pharmacy services (Resident #2). Resident #2 was not administered methadone for three days on 9/15/22, 9/16/22 and 9/17/22 resulting in symptoms of nausea and dizziness. Resident #2 called emergency medical services and was transported to the hospital on 09/18/22 where she was administered her medication. The findings included: A hospital discharge summary dated 09/13/22 revealed Resident #2 had a history of chronic pain syndrome maintained with the medication Methadone (narcotic medication used to treat moderate to severe pain). The summary read to continue administering Methadone 15 milligrams	F 760	Tag # F760 Residents Free of Significant Med Errors 1. The facility was cited for Tag # F760 (Residents Free of Significant Med Errors). Based on the findings, it was alleged that resident #2 was ordered Methadone and was not given her routine dose for 3 consecutive days to include 9/15/22, 9/16/22 and 9/17/22 resulting in nausea and dizziness. The resident called 911 on 9/18/22 and was taken to the ER where she was administered her routine dose of Methadone at that time before returning back to the facility. The resident has a dx of chronic pain syndrome. Staff reported that the medication had not been delivered from the pharmacy during the 3 dates the medication was missed. The medication was indeed delivered to the facility on the pharmacy night run on 9/17/22.	11/19/22

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F 760	Continued From page 22 (mg) daily. The summary stated the Physician had verified the order with the resident's methadone provider. Resident #2 was admitted into the facility on 09/14/22 with diagnosis which included chronic pain. Resident #2's admission Minimum Data Set (MDS) dated 09/21/22 revealed she had intact cognition. Resident #2 was coded for having occasional pain during the MDS assessment with a numeric rating of 3 on a 0-10 scale. Resident #2 was coded for receiving opioids on 3 days during the lookback period. Resident #2's care plan dated 10/01/22 revealed a focus area for risk for altered comfort status related to chronic pain. The goal was for Resident #2 to display a decrease in behaviors of inadequate pain control through the next review date. Interventions included the administration of medication as per orders and observe for effectiveness. Resident #2's Medication Administration Record (MAR) dated September 2022 revealed an order initiated on 09/15/22 for Methadone Hydrochloride (HCL) tablet 10 mg give 1.5 tablet orally one time a day for pain. The medication was documented as not given on 09/15/22 and 09/16/22. The order was discontinued on 09/16/22. A nursing progress note dated 09/15/22 at 3:25 AM revealed Resident #2 had a couple of episodes of verbal aggression related to not getting her medication. The note revealed the medications had not been delivered by pharmacy.	F 760	2. " The Director of Nursing and Unit Managers completed MAR/TAR/CART checks on 11/11/22. Any missing medications were ordered from the pharmacy and follow-up was completed by the DON to ensure that all medications did indeed arrive from the pharmacy and were placed on the med-carts. 3. " The Director of Nursing or Unit Manager will review all new admissions and verify that medications were received and are on the med/treatment cart daily. " The Director of Nursing will run the missing orders report Monday-Friday in morning clinical meeting to ensure medications are being given as ordered. If medications are missed, the Director of Nursing will investigate and notify MD, RP, ADM, and RDCS as appropriate for orders and further direction and education up to disciplinary action as appropriate. " Education was provided by the Director of Nursing and the Regional Director of Clinical Services to all nurses and Medication Aides to ensure medications are given per physician orders. This education started on 11/15/22 and was completed by 11/19/22. " Education was also added to the orientation packet by the Director of Human Resources for new contract staff and the on-boarding packet for all new hires. All newly hired staff to include contract staff will be receive education through orientation prior to their first day of work in the facility. 4.	

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F 760	Continued From page 23 The review of Resident #2's MAR revealed a second order was initiated on 09/17/22 for Methadone HCL tablet 10 mg by mouth in the morning for pain. The medication was documented as not given on 09/17/22 and 09/18/22. The order was discontinued on 09/18/22. A nursing progress note dated 09/18/22 at 7:10 PM written by Medication Aide (MA) #1 revealed Resident #2 had called 911 multiple times during the morning and wanted to be sent to the hospital due to not receiving the medication Methadone while in the facility. Resident #2 was sent to the hospital per request to receive Methadone. The note revealed the medication had just arrived in the facility from pharmacy after the resident had already left to go to the hospital. Resident #2 was transported back to the facility during the evening of 09/18/22 in a pleasant mood with no behaviors after receiving Methadone at the hospital. On 10/27/22 at 11:37 AM an interview was conducted with MA #1. During the interview she stated she had worked during the days of 09/15/22 through 09/18/22. MA #1 stated Resident #2 had to wait 3 days because pharmacy had not delivered the medication Methadone to the facility. She stated the resident was verbally aggressive to staff due to not receiving the medication and stated to her that she was sick feeling nauseated and dizzy. The interview revealed she did not recall the resident showing any physical symptoms such as vomiting from not having the medication. The interview revealed once the resident came back from the hospital she was in a much better mood and had no other complaints. She stated they normally	F 760	" Director of Nursing or Unit Manager will perform MAR/TAR/CART audit on all new admissions and 3 current residents per unit each week for 6 weeks to ensure the medications are received and have been documented on the MAR/TAR. " The Director of Nursing or Unit Manager will audit the MAR/TAR for 3 residents per unit 3x/weekly for 6 weeks. " All audits and concerns will be taken to the QAPI committee by the Administrator after time frame above and reviewed with the IDT to determine if there is a need to continue or changes should be made. 5. Completion Date: 11/19/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. BUILDING _____ B. WING _____	C 11/01/2022

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didn't accept residents who were on the medication methadone, so she had never dealt with that situation before.

Review of the hospital records dated 09/18/22 at 10:03 AM revealed emergency medical services reported they did not think the facility was prepared for Resident #2 because she had not received her medication. Resident #2 stated at the hospital she had not had any methadone since 09/14/22. The record revealed Resident #2 was experiencing mild withdrawal symptoms stating she felt uncomfortable all over. The hospital administered Resident #2 methadone and discharged her back to the facility.

On 10/27/22 at 10:20 AM an interview was conducted with Resident #2. During the interview Resident #2 stated she had come from the hospital to the facility on 09/14/22 and the facility withheld her medication Methadone on 09/15/22, 09/16/22 and 09/17/22. She stated she started having withdrawal symptoms of nausea, dizziness and felt like she couldn't move in the bed. The interview revealed she had called for an ambulance on 09/18/22 and was at the hospital from 10:00 AM until 2:00 PM getting the medication Methadone that the facility could not provide. Resident #2 stated she had told nursing staff and the doctor, but nobody would listen to her.

The review of Resident #2's MAR revealed a third order was initiated on 09/19/22 for Methadone HCL tablet 10 mg given by mouth in the morning for pain until 09/26/22. The medication was documented as administered on 09/19/22 through 09/26/22.

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A Medical Director (MD) progress note dated 09/21/22 revealed Resident #2 told the MD she was experiencing withdrawal symptoms and having trouble with her Methadone. The note revealed Methadone was being prescribed by another Physician and was being tapered off.

On 10/27/22 at 12:25 PM an interview was conducted with the Nurse Practitioner (NP). During the interview she stated she could not prescribe the medication Methadone. She stated it was only prescribed by the MD and she knew Resident #2 had experienced a delay in receiving the medication due to the MD not being in the area at the time of Resident #2's admission and the pharmacy needed a written prescription to fill the medication. The interview revealed Resident #2 was not sent to the facility with a written prescription for the medication. The NP stated the medication Methadone was a significant medication that needed to be taken as ordered. She stated if a resident stopped taking the medication abruptly, they could go into withdrawal symptoms including nausea, vomiting, or dizziness. The interview revealed the facility normally did not admit residents who were prescibed methadone. She stated they did not call the methadone clinic because the MD came into the building on 9/16/22 to write the order for the medication.

On 10/27/22 at 5:58 PM an interview was conducted with the Director of Nursing (DON). During the interview she stated she knew Resident #2 had not received Methadone after she was admitted in September due to the hospital not sending the facility a written prescription. She stated she did not call the hospital or any outside resource to obtain a

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written prescription. She stated the NP did not have access to get her a prescription, the on-call physician wouldn't prescribe it and the MD was out of town. The interview revealed the MD finally wrote the prescription on 09/16/22, but pharmacy did not fill the prescription until 09/18/22 after the resident had left the facility to go to the hospital. The DON stated Resident #2 had expressed no issues of nausea or dizziness to her. The interview revealed the facility knew Resident #2 was receiving the medication based on her transfer form that was sent to the facility prior to her arrival.

On 10/18/22 at 10:35 AM an interview was conducted with Pharmacist #1. During the interview she stated the pharmacy had received the written prescription for Methadone 15 mg for Resident #2 on 09/17/22 at 2:33 PM. She stated the medication was filled and delivered to the facility on 09/17/22 during the night delivery per their records. Pharmacist #1 stated Methadone should not be stopped abruptly and if was stopped it could send someone into withdrawal symptoms within 2-3 days. She stated withdrawal symptoms could include nausea, vomiting, tiredness, or headache. She stated the symptoms would not be life threatening.