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F 000	INITIAL COMMENTS A complaint investigation was conducted 2/2/2023 to 2/8/2023. Five of the sixteen allegations resulted in deficiencies. Intakes # NC00197207, NC00197313, NC00197554, NC00197932, NC00197936, and NC00197948	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to prevent misappropriation of a controlled medication for one (Resident #2) of 4 residents reviewed for accountability of controlled substance medication. Findings included: Resident #2 had a physician order initiated on 12/23/2022 for Hydrocodone-Acetaminophen (Norco) 7.5-325 mg (milligrams) to be administered as one tablet by mouth three times a day for pain management. This order was put on hold from 1/9/2023 to 1/11/2023. Documentation in the nursing notes dated 1/8/2022 revealed Resident #2 was sent to the emergency room at the request of her responsible party. Documentation on hospital emergency room	F 602		

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

Electronically Signed

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notes revealed Resident #2 arrived in the emergency department at 6:28 PM on 1/8/2023.

Documentation on the Controlled Medication Utilization Record (CMUR) dated 1/8/2022 revealed one dose of Norco was removed from the narcotic card for Resident #2 on 1/8/2022 at 9:00 PM.

Documentation on the Medication Administration Record (MAR) revealed Resident #2 was not documented as receiving the dose of Norco on 1/8/2022 at 9:00 PM but was documented as in the hospital by Nurse #5.

Nurse #5 was interviewed on 2/4/2023 at 3:29 PM. Nurse #5 stated she did not remove the Norco dose from the medication cart on 1/8/2023 at 9:00 PM because Resident #2 was in the hospital at that time. Nurse #5 stated it was not her signature on the CMUR on 1/8/2023 at 9:00 PM. Nurse #5 stated she documented on the MAR the medications to be administered to Resident #2 on 1/8/2023 at 9:00 PM with the initials "HO" indicating the resident was in the hospital. Nurse #5 stated when she went over the counting of the narcotic medications for accountability at the end of her shift with another nurse on 1/8/2023 at 11:15 PM, she was certain the signature for the Norco on the CMUR dated 1/8/2023 at 9:00 PM was not there.

Documentation on the nursing daily staffing sheet dated 1/8/2023 revealed Nurse #2 was working on the same hallway as Nurse #5 for the 6:45 PM to 7:15 AM shift. Nurse #2 was interviewed on 2/5/2023 at 3:54 PM. Nurse #2 stated she was sharing a medication cart with Nurse #5 on 1/8/2023 but that she never had the keys to the

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front medication cart where the medications for Resident #2 were kept. Nurse #2 also stated Nurse #5 always wanted to have the keys for the narcotic box for the front cart on the hallway and the shared medication cart on the same hallway on 1/8/2023.

Documentation on the nursing daily staffing sheet dated 1/8/2023 revealed Nurse #4 was assigned from 6:45 AM to 3:15 PM for the medication cart and hallway where Resident #2 resided prior to her discharge to the hospital. Nurse #4 was interviewed on 2/6/2023 at 11:53 AM. Nurse #4 stated she was not in the building at 9:00 PM on 1/8/2023 and she did not sign out a Norco for Resident #2 at that time.

Nurse # 6 was interviewed on 2/6/2023 at 12:57 PM. Nurse #6 confirmed she went over the controlled medication count with Nurse #5 on 1/9/2023 at the start of her shift at 7:15 AM. Nurse #6 stated there was an accurate accounting of the medications on the morning of 1/9/2023 when she received the keys to the medication cart for the hallway for which Resident #2 had resided so she would not have noticed any discrepancies. Nurse #6 stated she did not sign out a Norco for Resident #2 on 1/8/2023 at 9:00 PM because Resident #2 was in the hospital at the start of her shift on 1/9/2023 at 7:15 AM. An interview was conducted with the Interim Director of Nursing (IDON) on 2/4/2023 at 3:50 PM. The IDON stated that she reported the missing Norco to the authorities and the state after it was brought to her attention. The IDON stated it was the policy of the facility to return narcotic medication to the pharmacy after a resident was gone for 24 hours but this was not done for Resident #2, whose narcotic

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F 602	Continued From page 3 medications stayed on the cart until her return to the facility on 1/12/2023. The IDON stated she was in the process of investigating the missing Norco for Resident #2.	F 602		
F 684 SS=G	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 and staff interview the facility failed to communicate, follow care planned interventions, and physician orders regarding bowel movements (Resident #5) and failed to provide wound care as ordered (Resident #7) for 2 of 4 residents reviewed for receiving care according to professional standards, care plans and residents' choice. Findings included: 1. Resident #5 had multiple diagnoses some of which included dementia, diabetes mellitus, intellectual disability and a motor disability. Documentation in annual wellness visit note written by Nurse Practitioner #1 dated 12/27/2022 revealed Resident #5 was seen in the emergency department of the hospital on 11/18/2022 for abdominal pain and treated for constipation. The note also revealed Resident #5 was seen in the emergency department of the hospital on	F 684		

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12/8/2022 for abdominal pain and treated for fecal impaction.

Resident #5 had the following physician orders for treatment of constipation. Initiated on 5/7/2022 Glycolax powder to be administered by mouth as 17 grams mixed with 4 to 8 ounces of liquid one time a day. Initiated on 5/7/2022 Linzess to be administered as one 290 microgram capsule in the morning by mouth one time a day. Initiated 5/7/2022 Senna-Docusate Sodium to be administered as two tablets of 8.6-50 micrograms each by mouth on time a day. Initiated 6/20/2022 Milk of Magnesia suspension to be administered as 30 milliliters of 400 milligram/5 milliliters by mouth on an as needed basis at bedtime if no bowel movement in three days. Initiated 6/20/2022 A Dulcolax suppository to be administered as 10 milligrams inserted rectally as needed for constipation if no result from the milk of magnesia by the next shift. Initiated 6/20/2022 Fleet Enema to be administered as one dose of 7-19 grams/milliliters inserted rectally as needed if no result from the Dulcolax within 2 hours. If no result from the Fleet enema, call the medical doctor/advanced practice provider for further orders.

Documentation on the annual Minimum Data Set assessment dated 12/10/2022 revealed Resident #5 had moderately impaired cognition, was dependent for all activities of daily living (ADL) and had range of motion impairment on both sides of her upper and lower extremities.

Documentation in the care plan for Resident #5, dated as last reviewed on 1/3/2023, revealed a focus area for a risk for gastrointestinal symptoms or complications related to

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constipation and gastroesophageal reflux disease. Some of the interventions included observation for complaints of abdominal pain and distention, administration of medications as ordered and observation for effectiveness and side effects, monitoring and recording bowel movements, assessment of symptoms of constipation, and documentation of frequency and consistency of stools.

Documentation on the same care plan dated 1/3/2023 for Resident #5 revealed additional focus areas for exhibiting verbal behaviors related to uncontrollable crying that different family members are dead, symptoms of deficits in cognitive function, and potential for alteration in communication.

Review of the documentation on the Medication Administration Record (MAR) for January 2023 revealed Resident #5 received the Glyolax powder, Linzess, and Senna-Docusate Sodium as ordered for that month. The MAR documentation for January 2023 also revealed Resident #5 did not receive any doses of Milk of Magnesia, Dulcolax suppository, or Fleet Enema.

Documentation in a nursing alert note dated 1/26/2023 at 10:52 AM Resident #5 had a large bowel movement.

Documentation in the electronic medical record under the nurse aide tasks revealed Resident #5 had a small soft/loose stool on 1/26/2023 at 7:36 PM.

Documentation on a handwritten ADL (activity of daily living) record revealed Resident #5 was incontinent of bowel on 1/27/2023 with no

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notation of size, consistency, or number.

There was no documentation on the paper ADL record or the electronic medical record of any bowel movements for Resident #5 on 1/28/2023, 1/29/2023, or 1/30/2023.

Documentation in the electronic medical record under the nurse aide tasks revealed Resident #5 had a small soft/loose stool on 1/31/2023 at 2:56 AM.

Documentation in a general nursing note dated 2/1/2023 at 6:25 PM written by Nurse #7 stated, "Resident sent to [emergency room] per in-house PA (physician assistant) [due to] [altered mental status] and uncontrollable crying. [Responsible party] made aware. Will follow up with the hospital for update.

An interview was conducted with Nurse #7 on 2/6/2023 at 1:40 PM. Nurse #7 revealed the following information. Nurse #7 stated NA # 1 came to her at approximately 8:00 AM on 2/1/2023 and stated Resident #5 did not look like her normal self. Nurse #7 stopped what she was doing and went to assess Resident #5 and take her vital signs. Nurse #7 indicated she went to get the unit supervisor to assess Resident #5. Nurse #7 revealed Resident #5 was "yelling and crying a lot." Nurse #7 revealed Resident #5 had periods where she would calm down, but she continued to cry and yell all morning. Nurse #7 stated, "When the PA came in he sent her out. He said he didn't know what was going on so ordered us to send her out." Nurse #7 stated she asked the unit supervisor to look to see when the last time Resident #5 had a bowel movement but the nursing system is different then where the nurse

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aides chart bowel movements. Nurse #7 indicated the unit supervisor might have forgotten because the unit supervisor never got back to her about when Resident #5 had her last bowel movement.

NA #1 was interviewed on 1/6/2023 at 2:08 PM. NA #1 indicated she was usually assigned to care for Resident #5 and was very familiar with her care needs. NA #1 stated she was not working at the facility on 1/31/2023 so she did not know how Resident #5 was the day prior to Resident #5 going to the emergency room. NA #1 stated on the morning of 2/1/2023 Resident #5 did not want to eat her breakfast and she kept on crying. NA #1 said she couldn't get Resident #5 to tell her what was wrong, so she went to get help from the nurse. NA #1 stated she knew that Resident #5 was not having an issue with her bowel movements because on 1/30/2023 Resident #5 had a solid bowel movement and it had not been three days. NA #1 said the documentation of the bowel movements of the residents was on paper and then it switched to the electronic medical record recently. NA #1 stated, "She would have told me if her stomach was bothering her."

The unit supervisor, Nurse #10, was interviewed on 2/6/2023 at 2:15 PM. The unit supervisor acknowledged Nurse #7 came to her on the morning of 2/1/2023 and told her Resident #5 "was not acting right." Nurse #10 stated Resident #5 usually gave correct feedback when she was asked questions. Nurse #10 said Resident #5 had a runny nose and her eyes were crusty, so she thought maybe she had a cold. Nurse #10 stated Resident #5 denied being in pain. Nurse #10 stated she called the doctor and was told the PA would be into the facility that day and would

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assess Resident #5 when he arrived. Nurse #10 revealed when the PA came in to assess her, he wanted her to be sent to the hospital because he didn't know what else to do. Nurse #10 denied being asked by Nurse #7 to look when Resident #5 last had a bowel movement.

An interview was conducted with Nurse Practitioner #1 on 2/4/2023 at 10:15 AM. Nurse Practitioner #1 stated Resident #5 was not a patient of the doctor she worked for, and she would only see this resident if nursing needed support.

The Physician Assistant (PA #1) was interviewed on 2/6/2023 at 11:31 AM. PA #1 revealed he came to the building and was asked to assess Resident #5 on 2/1/2023. PA #1 stated he sent Resident #5 out to the hospital for crying and altered mental status. PA #1 indicated that altered mental status could mean anything from a stroke or a cardiac event so, he felt the best course of action was to send her to the emergency room because someone who was crying uncontrollably needed to be evaluated immediately. PA #1 stated that x-rays in the facility are not obtained quickly and if Resident #5 needed an x-ray the results would be obtained faster in the emergency room. PA #1 revealed he was not aware of her last bowel movement at the time of his assessment of Resident #5 on 2/1/2023.

Review of the hospital emergency room provider notes for Resident #5 dated 2/1/2023 at 3:56 PM revealed the following information. "Staff from the nursing home had contacted [emergency medical services] stating that the patient seemed more fatigued, had been crying excessively, and had possible abdominal distention. She does have a

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long history of constipation issues due to being bedbound, her contractures, and [motor disability]. Patient has been evaluated in the emergency department several times for fecal impaction. ... ...According to the patients MAR it does appear that she received Linzess, Docusate, and Dulcolax today. She also has several other constipation relief type medications that can be provided as needed. It is unknown when the patient last had a bowel movement."

Review of the hospital discharge summary for Resident #5 dated 2/3/2023 revealed an x-ray in the emergency room revealed a stool impaction. Resident #5 received a milk of molasses enema and received the medication Lactulose with multiple bowel movements. A repeat x-ray suggested Resident #5 had an ileus (painful obstruction) but then tolerated a diet, denied any abdominal pain, and had present bowel sounds.

An interview with the Interim Director of Nursing (IDON) was conducted on 2/4/2023 at 3:50 PM. The IDON stated the facility was working on a bowel protocol so that residents who are not having bowel movements can be recognized and treated prior to being sent to the emergency room. The IDON stated the facility NA's were using paper ADL sheets for documentation and she was teaching them to use the electronic system for recording ADLs to include documentation of bowel movement so it can be tracked easier.

2. Record review revealed Resident # 7 was admitted on 10/4/22. His diagnoses in part included lymphedema, venous insufficiency, and a history of cellulitis.

Resident # 7's quarterly Minimum Data Set

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assessment, dated 1/5/23, coded Resident # 7 as being cognitively intact.

Resident # 7's care plan, updated 1/18/23, noted Resident # 7 had an abrasion to his right thigh. Staff were directed on the care plan to provide treatment as ordered.

A nursing note, dated 11/28/22, noted Resident # 7 had psoriasis to both lower extremities and he had developed abrasions to the back of his legs.

Review of Resident # 7's orders revealed an order, dated 11/29/22, to daily cleanse the right lower posterior thigh with normal saline and apply calcium alginate silver. The wound was then to be covered with a dry dressing.

Resident #7's January and February 2023 TARs (Treatment Administration Records) revealed the order to cleanse the right lower posterior thigh with normal saline and apply calcium Alginate with silver had not been signed as completed on the following dates: 1/6/23; 1/8/23; 1/9/23; 1/10/23; 1/16/23 and 1/23/22. On 2/2/23, Nurse # 6 signed she had completed the dressing change.

On 2/3/23 at 1:25 PM Resident # 7 was interviewed and reported no one had changed his dressing the previous day (2/2/23) and that had not been the first time he had missed dressing changes.

On 2/6/23 the facility provided a list of nurses who had been responsible for the dressing changes that had not been signed as completed. The list was as follows:

1/6/23-Nurse # 6

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F 684	Continued From page 11 1/8/23-Nurse # 4 1/9/23 Nurse # 6 1/10/23 Nurse # 6 1/16/23 Nurse # 4 1/23/23 Nurse # 6 Nurse # 6 was interviewed on 2/6/23 at 4:05 PM via phone and reported the following. On 2/2/23 she had not done Resident # 7's dressing change although she had signed that she had. She had inadvertently signed for Resident # 7's dressing change when she had been doing Resident # 7's roommate's dressing change. At the end of her shift, she usually checked everything to make sure there were no flags of tasks she had not done. Resident # 7's dressing change had not flagged on the TAR as something that still needed to be done since she had signed for it. Therefore, she had not caught that she had not done it. She could not recall the specific details of the January dressing changes that were not signed as done by her. She typically documented if she did do a dressing change or reported to another nurse it had not been done. Given Nurse # 6 had signed for something she had not done without recognizing it, she was interviewed further about her workload. She reported that things were very busy on 2/2/23. She had 28 to 30 residents to medicate, was responsible for a tracheostomy resident, and another resident who needed help with his ostomy multiple times per day. According to the nurse she was rushed and had not recognized the error of the missed dressing change she had signed for. Nurse # 4 was interviewed on 2/6/23 at 4:30 PM via phone and reported the following. If she had	F 684		

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F 684	Continued From page 12 done a treatment for Resident # 7, she would have signed for it, but she had not known that it was her responsibility to have done the dressing changes. She thought the facility usually had a treatment nurse. The ADON (Assistant Director of Nursing) was interviewed on 2/4/23 at 11:20 AM and reported the following. Resident # 7's wound area was a result of developing a small area of skin breakdown where he formally had psoriasis. Treatments were typically the responsibility of the treatment nurse and if the treatment nurse was not present, then they were the responsibility of the floor nurses. There had been changes in who was responsible for treatments in recent months. She (the ADON) had been doing treatments in December 2022 and then had transitioned into the role of the ADON. The facility had hired a treatment nurse, but the new treatment nurse was not present on the date of 2/2/23 when Resident # 7's dressing change was missed. The new treatment nurse had been in training at another facility on 2/2/23. A review of Resident # 7's most recent assessments by the facility wound NP (Nurse Practitioner) revealed a notation on 1/24/23 that the wound was "stable and improving." The NP again noted on 1/31/23 that the wound was stable.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		

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Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and
(ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, record review, and staff interview the facility failed to assess a pressure sore for a resident who preferred to have his dressing changes done at night rather than the day when facility assessments were routinely done. This was for one (Resident # 11) of two sampled residents reviewed for pressure sores. The findings included:

Record review revealed Resident # 11 was most recently admitted to the facility on 9/7/22. The resident's diagnoses in part included a stroke, peripheral vascular disease, diabetes, and chronic kidney disease.

Resident # 11's quarterly Minimum Data Set assessment, dated 1/16/23 revealed Resident # 11 was cognitively intact and needed extensive assistance with his bed mobility and hygiene needs. He was also coded on this Minimum Data Set assessment as having a Stage II pressure sore.

Resident # 11's care plan, dated 1/27/23, noted Resident # 11 refused care and treatments at

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times. The care plan also noted he had a sacral pressure sore and there were instructions to perform weekly assessments if the resident would allow.

Resident # 11's last Sacral pressure sore order was dated 12/19/22. The order included instructions to clean the pressure sore and apply medihoney and a foam dressing daily.

Review of Resident # 11's January and February TARs (treatment administration records) revealed the treatment was transcribed to be done by the night shift nurses. A review of these TARS on 2/4/23 revealed the nurses had documented they had performed the pressure sore wound care 24 times in January, 2023 and 2 times in February as of the record review date of 2/4/23.

A review of Resident # 11's record revealed no measurements or assessments of the pressure sore since the last order of 12/19/22. There was no documentation that the pressure sore had been resolved.

The Assistant Director of Nursing (ADON) was interviewed on 2/4/23 at 1:45 PM and reported the following. Resident # 11 was an early riser and stayed up during the day. Resident # 11 refused care during the day of the pressure sore and his dressing changes were being done by the night nurses. According to the ADON, day shift was the typical time assessments of wounds were done.
The ADON stated she could not find measurements of the pressure sore or assessments. She was unsure of the current stage of the pressure sore. According to the ADON, the assessments of the pressure sore

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should be being done.

Resident # 11 was interviewed on 2/4/23 at 3:15 PM and reported the staff changed his Sacral pressure sore dressing every other day. He reported that the facility staff told him it was getting better.

During a follow up interview with the ADON on 2/7/23 at 11:12 AM the ADON reported that since the date of 2/4/23 she had talked to several night shift nurses who dressed Resident # 11's pressure sore and they had reported to her that the area had closed and it was scar tissue. She also reported that Resident # 11 had agreed to go back to bed during the current day (2/7/23) so that the Nurse Practitioner could assess his pressure sore.

Nurse # 8 was one of the night shift nurses who had signed on Resident # 11's TAR that she had administered wound care to the pressure sore in January and February, 2023. Nurse # 8 was interviewed on 2/7/23 at 4:45 PM and reported the following. At times Resident # 11 would let the nurses change his pressure sore dressing and other times he would not. The last time she had looked at the pressure sore it was scar tissue and not open.

During a follow up interview with the ADON on 2/7/23 at 3:42 PM, the ADON reported the following. The pressure sore had been evaluated that day (2/7/23) and was open. There was a small fingernail tip sized area that had not closed. The skin tissue was scarred and fragile. Prior to her role as the ADON, she had been responsible for treatments in December, 2022 and had not been aware he had a pressure sore. Then she

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F 686	Continued From page 16 saw a report by the dietician that included the names of residents with pressure sores and Resident # 11's name was on the list. That was approximately a week and a half ago, and that was when she became aware he had a pressure sore that was not being assessed. She had tried again to find assessments of the pressure sore but had just found that the nurses were documenting he had a pressure sore with a treatment in place. The ADON felt the pressure sore might be healing and reopening but there was no assessment to reflect this.	F 686		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and a responsible party interview the facility failed to administer and communicate missed doses of scheduled pain medication giving the potential for break through pain for 1 (Resident #2) of 3 residents reviewed for pain management. Findings included: Resident #2 was readmitted to the facility on 1/12/2023 with the multiple diagnoses some of which included arthritis, dementia, and osteoarthritis. Documentation on an annual Minimum Data Set assessment dated 1/2/2023 coded Resident #2	F 697		

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as having severely impaired cognition, moderately impaired vision, and moderately impaired hearing. Resident #2 was not coded as having any moods or behaviors. The documentation also revealed Resident #2 was receiving scheduled pain medication and as needed pain medication.

Documentation on the care plan dated 1/4/2023 revealed a focus area for Resident #2's risk for alteration in comfort related to chronic pain syndrome and generalized discomfort relative to osteoarthritis. One of the interventions was to medicate Resident #2 as ordered for pain, monitor for effectiveness, monitor for side effects, and report to the physician as indicated.

Resident #2 had a physician's order initiated on 1/12/2023 for Hydrocodone-Acetaminophen (Norco) 7.5-325 mg (milligrams) to be administered as one tablet by mouth three times a day for pain management.

Resident #2 also had a physician's order initiated on 1/13/2023 for Acetaminophen to be administered by mouth as 2 tablets of 325 mg each every 4 hours as needed for general discomfort. The physician/midlevel provider was to be notified if the discomfort persisted.

Documentation on a Nurse Practitioner (NP #1) progress note dated 1/13/2023 for Resident #2 under the history of the present illness stated in part, "She gets scheduled Norco three times a day, but I discussed with nursing that she needs a [as needed] dose of Acetaminophen now to see if it will help alleviate her discomfort. She says she has pain "all over, I have arthritis" and can not give me a specific area that hurts her more."

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Documentation on the Medication Administration Record for 1/13/2023 at 5:37 PM revealed Resident #2 was administered as needed Acetaminophen as ordered for pain and it was noted to be effective.

Documentation on the Medication Administration Record (MAR) revealed the dose of Norco to be administered on 1/21/2023 at 9:00 PM to Resident #2 was left blank. There was no documentation on the Controlled Medication Utilization Record (CMUR) to indicate Norco was removed from the medication cart to administer to Resident #2 on 1/21/2023 at 9:00 PM. There was no documentation of notification of the physician or an order to hold the medication.

Documentation on the MAR revealed no doses of as needed Acetaminophen were administered on 1/21/2022.

Documentation on the MAR revealed a dose of Norco to be administered on 1/22/2023 at 6:00 AM was administered by Nurse #11 to Resident #2. Documentation on the CMUR revealed Norco was not removed from the medication cart for Resident #2 on 1/22/2023 at 6:00 AM.

Documentation on the MAR revealed a dose of Acetaminophen was administered on 1/22/2023 at 1:48 PM and was unknown if it was effective.

Documentation on the MAR revealed a dose of Norco to be administered on 1/23/2022 at 6:00 AM was not administered by Nurse #11 because Resident #2 was sleeping. There was no documentation of notification of the physician or an order to hold the medication.

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Nurse # 11 was interviewed on 2/7/2023 at 10:55 AM. Nurse #11 confirmed she was assigned to care for Resident #2 on 1/21/2023 from 6:45 PM to 1/22/2022 at 7:15 AM. Nurse #11 did not have an explanation and did not recall why she did not administer the pain medication to Resident #2 on 1/21/2022 at 9:00 PM. Nurse #11 did not know why she documented on 1/22/2023 at 6:00 AM that the Norco was administered to Resident #2 when there was no documentation on the CMUR of her removing the Norco from the medication cart. Nurse #11 explained that it was likely Resident #2 was asleep on those occasions just as she had documented on 1/23/2022 at 6:00 AM. Nurse #11 stated she did not notify the physician on any of those occasions when Resident #2 did not receive the ordered doses of Norco but did pass on the information to the next nurse in report about the resident sleeping.

Documentation on the MAR revealed no other doses of as needed Acetaminophen were administered in the month of January 2023 except for on 1/27/2023 at 4:32 PM with effective results.

An observation of Resident #2 was made on 2/2/2023 at 2:03 PM. Resident #2 was rolling around from her doorway to her room, into the hallway and then back again. Resident #2 was repetitively saying, "Pain, Pain, Pain."

Documentation on the MAR revealed no doses of as needed Acetaminophen were administered on 2/2/2023.

An interview was conducted with the responsible party for Resident #2 on 2/2/2023 at 3:15 PM.

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F 697	Continued From page 20 The responsible party stated that when ever he visits, Resident #2 was complaining of pain despite the fact she was supposed to get pain medication on a scheduled basis and as needed basis. The responsible party was concerned Resident #2 was not getting her pain medication every time she was ordered to do so. An interview was conducted with Nurse #4 on 2/4/2023 at 1:54 PM. Nurse #4 stated she was very familiar with Resident #2. Nurse #4 stated Resident #2 complains about pain "all day every day" and that was her normal routine. Nurse #4 stated Resident #2 received Norco around the clock. An interview was conducted with NP #1 on 2/6/2023 at 10:15 AM. NP #1 confirmed Resident #2 was constantly complaining of pain and confirmed her responsible party was concerned Resident #2 was not getting her pain medication. NP #1 stated that if the nurses are holding her pain medication or not giving her the pain medication NP #1 should be notified by the nursing staff. NP #1 confirmed she was not notified of any doses of Norco that were missed for Resident #2. NP #1 stated Resident #2 needed her pain medication on a scheduled basis and if she was not receiving her pain medication as scheduled it could likely be the cause of break through pain for her.	F 697		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in	F 755		

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§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 interviews the facility failed to consistently follow established procedures for the accounting of controlled substance medication and administration (Resident, #2, #4, and #9), provide pain assessment prior to administration for an as needed controlled substance medication (Resident #4), and administer controlled substance medication with a physician's order to do so (Resident #4) for 3 of 4 residents reviewed

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for pharmaceutical services for controlled substance medications. The findings included:

1. Resident #4 was admitted to the facility on 1/26/2023 and had multiple diagnoses some of which included chronic respiratory failure with hypoxia, sleep apnea, congestive heart failure, neuropathy, and left knee pain.

Documentation on a nurse practitioner (NP) progress note dated 1/27/2023 written by NP #1 indicated Resident #4 was being seen for the first time after admission for a review of her chronic medical problems. The documentation explained Resident #4 had severe pain with and without touching her left knee. In the plan portion of the note NP #1 documented, "[Left] knee pain with osteoarthritis - chronic with worsening, attempting to be controlled with Acetaminophen, Gabapentin, and Tizanidine. Her opioids were held during her hospitalization due to respiratory suppression. Order placed for Aspercreme patch daily."

Documentation in a nursing note dated 1/28/2023 at 3:18 PM stated, "Resident verbalized pain to unit nurse on this AM. Resident stated that [as needed] Tylenol was not resolving pain. Resident stated, "I take Oxy (Oxycodone) at home." Resident [history and physical] stated to continue Oxycodone as needed for diabetic peripheral neuropathy. Resident was not sent with a hard script for Oxycodone. Third eye called, physician ordered/e-scribed 7.5/325 mg (milligrams) Oxy [every] 6 [as needed] pain x 3 days until attending physician reevaluates. Medications called in; medications arrived. Medication administered per MD order. Resident verbalized relief from pain medication. Will continue with current plan of care."

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Documentation in the electronic medical record of Resident #4 revealed a physician's order was placed with the pharmacy on 1/28/2023 at 9:56 AM for Hydrocodone-Acetaminophen 7.5 -325 mg (Norco), a narcotic, to be administered as one tablet by mouth every 6 hours on an as needed basis for pain.

Documentation on a Controlled Medication Utilization Record (CMUR) revealed Nurse #1 removed one dose of Hydrocodone-Acetaminophen 7.5 - 325 mg (Norco) at 1:00 PM on 1/28/2023 from the medication cart for Resident #4.

Documentation on the Medication Administration Record (MAR) for Resident #4 revealed the Norco order was not started until 1/29/2023 at 9:30 AM. There was no documentation of the Norco being administered to Resident #4 on the MAR on 1/28/2023 at 1:00 PM.

Documentation on the CMUR and the MAR revealed Nurse #1 administered a dose of Norco to Resident #4 on 1/29/2023 at 10:13 AM.

Documentation on the CMUR revealed Nurse #1 removed 1 dose of Norco for Resident #4 on 1/29/2023 at 5:26 PM. There was no documentation on the MAR to indicate the dose of Norco was administered to Resident #4 on 1/29/2023 at 5:26 PM.

An interview was conducted with Nurse #1 on 2/4/2023 at 12:42 PM. Nurse #1 explained she was the nurse working at the medication cart on 1/28/2023 when Resident #4 requested narcotic pain medication for her knee pain. Nurse #1

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further explained she called the nurse practitioner (NP #1) who instructed her to call Third Eye. Nurse #1 stated she was not familiar with the on-call service the facility used called Third Eye because she was a travel nurse from another state and new to the facility. Nurse #1 stated she asked for help from the unit supervisor who was working at the desk and who obtained the order for Norco from the physician from Third Eye. Nurse #1 explained the narcotic medication came to the facility from the pharmacy within 45 minutes and she administered it to Resident #4 because she was in pain. Nurse # 1 explained there was no order on the MAR yet so she did not document the Norco as administered on 1/28/2023. Nurse #1 stated she did administer a second dose of the narcotic to Resident #4 on 1/29/2023 but did not document it on the MAR. Nurse #1 explained she was later educated she was supposed to have an order on the electronic MAR before she administered the narcotic to the resident so that it can be documented as administered. Nurse #1 stated she was educated that all narcotic medications must be documented on the MAR and the CMUR at the time of the administration.

Documentation on the CMUR and the MAR revealed a Medication Aide (Med Aide #1) administered a dose of Norco to Resident #4 on 1/30/2023 at 9:48 AM.

Documentation on the CMUR revealed Nurse #4 removed a dose of Norco from the narcotic storage on 1/31/2023 at 5:42 PM for Resident #4. There was no documentation on the MAR to indicate Norco was administered to Resident #4 on 1/31/2023 at 5:42 PM.

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Nurse #4 was interviewed on 11:17 AM on 2/4/2023. Nurse #4 stated that it was her first-time hearing there was no documentation on the MAR for Resident #4's Norco on 1/31/2023 at 5:42 PM. Nurse #4 stated she was usually very careful about the accurate documentation of narcotics. Nurse #4 stated she did administer the Norco to Resident #4 on 1/31/2023 but might have failed to put it on the MAR.

Documentation on the CMUR revealed Nurse #3 removed a dose of Norco from the narcotic storage on 1/31/2023 at 11:15 PM. The order for Norco was discontinued on the MAR on 1/31/2023 at 9:33 PM and there was no documentation of Norco being administered on the MAR on 1/31/2023.

Nurse #3 was interviewed on 2/4/2023 at 3:37 PM. Nurse #3 explained that around 9:00 PM or 9:30 PM on 1/31/2023 Resident #4 was complaining of pain and requested pain medication. Nurse #3 stated she removed a dose of Norco for Resident #4 from the narcotic storage on the medication cart and looked at the CMUR realizing it was too soon to give the Norco to Resident #4 as ordered. Nurse #3 explained that at the time she removed the Norco from the medication cart, Resident #4 had an active order for the pain medication. Nurse #3 stated she stored the Norco until she administered it to Resident #4 at 11:15 PM but then realized the Norco had been discontinued at that point so she could not document on the MAR that she gave the medication to Resident #4. Nurse #3 stated she did receive education that she was to look at the medication order first before removing the medication from the medication cart and sign after administration of the medication.

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Documentation on the CMUR revealed Med Aide #1 removed a dose of Norco for Resident #4 from the narcotic storage on 2/1/2023 at 9:34 AM. There was no order on the MAR and no documentation on the MAR for Norco for Resident #4 on 2/1/2023.

Med Aide #1 was interviewed on 2/4/2023 at 1:41 PM. Med Aide #1 stated on 2/1/2023 she was administering medications to residents in the morning and Resident #4 requested a pain pill. Med Aide #1 stated she removed the Norco from the medication cart and documented she did so. She revealed that she then put the Norco in with the other medications to be administered to Resident #4 that morning and administered medications to Resident #4. Med Aide #1 stated she then went to document on the MAR that she administered the Norco, but she discovered there was no longer an order for the medication. Med Aide #1 revealed she notified the Interim Director of Nursing (IDON). Med Aide #1 confirmed she did receive education on how it is out of her scope of practice to assess residents for pain and that she must check the orders before administering a narcotic to a resident.

Documentation in the nursing notes dated 2/1/2023 at 11:24 PM revealed the following information. Resident #4 was complaining of knee pain. She was notified by the nursing staff the order for Norco was discontinued. Resident #4 did not think the Tylenol she had ordered would be strong enough for her pain and requested to go to the hospital. Within 30 minutes of her request for pain medication she left the facility with paramedics at 9:00 PM.

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An interview was conducted with the NP #1 on 2/6/2023 at 10:15 AM. NP #1 stated it was brought to her attention that some of the travel nurses are not familiar with Third Eye and how and when to contact her versus Third Eye. NP #1 explained that Third Eye was used as an on-call service for the facility. NP #1 explained Resident #4 did not come from the hospital with orders for Norco because it stated in the hospital record there was a concern it would suppress her already compromised respiratory ability. NP #1 confirmed there was no history and physical from the hospital recommending narcotic pain medication for the relief of diabetic neuropathy for Resident #4. NP #1 further explained an order was obtained through Third Eye for a 3-day supply of Norco to be given on an as needed basis to Resident #4. NP #1 explained when she looked at the MAR for Resident #4, she noted that only two doses of Norco had been administered so, on the third day, 1/31/2023, she discontinued the Norco in the evening. NP #1 stated she did not look at the CMUR and did not realize Resident #4 was being administered Norco more frequently. NP #1 figured the nurses would call if Resident #4 needed more Norco, but Resident #4 requested to go to the hospital before an order for more Norco could be obtained by the nursing staff.

An interview was conducted with the IDON on 2/3/2023 at 4:02 PM. The IDON revealed it was brought to her attention on 2/1/2023 that the CMUR did not match the MAR for Resident #4. The IDON stated Nurse #1 received education while Nurse #3 and Med Aide #1 were educated and disciplined about always checking the MAR before administering medication so there can be an accurate administration and accounting of the

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narcotic medication. The IDON also explained Med Aide #1 was reeducated on having a licensed nurse perform a pain assessment prior to administration for a resident requesting narcotic pain medication administered on an as needed basis. The IDON revealed the facility was in the process of seeing if any other residents were affected by a similar situation and providing education to the rest of the nursing staff.

2. Resident # 2 had multiple diagnoses some of which included arthritis, dementia, and osteoarthritis.

Resident #2 had a physician order initiated on 12/23/2022 for Hydrocodone-Acetaminophen (Norco) 7.5-325 mg (milligrams) to be administered as one tablet by mouth three times a day for pain management. This order was put on hold on 1/9/2023 to 1/11/2023.

Documentation in the nursing notes dated 1/8/2022 revealed Resident #2 was sent to the emergency room at the request of her responsible party.

Documentation on hospital emergency room notes revealed Resident #2 arrived in the emergency department at 6:28 PM on 1/8/2023.

Documentation on the Controlled Medication Utilization Record (CMUR) dated 1/8/2022 revealed one dose of Norco was removed from the narcotic card for Resident #2 on 1/8/2022 at 9:00 PM.

Documentation on the Medication Administration Record (MAR) revealed Resident #2 was not documented as receiving the dose of Norco on

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1/8/2022 at 9:00 PM but was documented as in the hospital by Nurse #5.

Nurse #5 was interviewed on 2/4/2023 at 3:29 PM. Nurse #5 stated she did not remove the Norco dose from the medication cart on 1/8/2023 at 9:00 PM because Resident #2 was in the hospital at that time. Nurse #5 stated it was not her signature on the CMUR on 1/8/2023 at 9:00 PM. Nurse #5 stated she documented on the MAR the medications to be administered to Resident #2 on 1/8/2023 at 9:00 PM with the initials "HO" indicating the resident was in the hospital. Nurse #5 stated when she went over the counting of the narcotic medications for accountability at the end of her shift with another nurse on 1/8/2023 at 11:15 PM, she was certain the signature for the Norco on the CMUR dated 1/8/2023 at 9:00 PM was not there.

An interview was conducted 2/3/2023 at 4:02 PM with the Interim Director of Nursing (IDON). The IDON revealed the facility did not realize one of the Norco doses for Resident #2 was not accounted for because the count was correct, meaning when the amount of medication left on the medication card matched the documented amount signed for by the nurses. The IDON did not know who signed for the Norco on the CMUR for Resident #2. The IDON stated that the only way to know if the accurate number of narcotics were on the cart was to audit every CMUR for the residents versus the MAR of each resident with narcotics.

3. A record review of Resident #9's Medication Administration Records (MARs) and Control Medication Declining Count Sheets (CMDCS) found discrepancies in recording of doses given

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to the resident. There were numerous incidences of medications being recorded as given on the CMDCS but not documented on the MAR, and medications being documented as given on the MAR but not recorded on the CMDCS.

The following are examples of the MAR and CMDCS not matching an order for Resident # 9 for Morphine Sulfate (Concentrate) Oral Solution 100 mg/5 mls (milliliters), to give 0.5ml by mouth every 4 hours for pain or can be given via Gtube (gastrostomy tube).

This medication was recorded as being administered on December 24, 2022 @ 8:00pm on the MAR but not recorded on the CMDCS.

The medication was recorded as being administered on December 26, 2022 @ 12:00pm but not recorded on the CMDCS.

The medication was not recorded being administered on December 30, 2022 @ 12:00 pm on the MAR but was recorded as given on the CMDCS.

The medication was recorded as being administered on January 2, 2023 @ 8:00 am but not recorded on the CMDCS.

The medication was recorded as being administered on January 19, 2023 @ 4:00 pm but not recorded on the CMDCS.

The medication was recorded as being administered on January 22, 2023 @ 4:00 am but was not recorded as being administered on the CMDCS.

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The medication was recorded as being administered on January 27, 2023 @ 12 am, 4 am, 8 am, 12 pm, 4 pm, 8 pm, but were not recorded on the CMDCS for 12 am, 4 am, and twice recorded for 7:23 pm & 8:00 pm.

The medication was recorded as being administered on January 28, 2023 @ 12:00 am but was not recorded on the CMDCS.

The medication was recorded on CMDCS as being given on January 30, 2023 @ 11:15 am but was not documented on the MAR as being given.

Example #2 of the MAR and CMDCS not matching include an order for Resident #9 of Diazepam 5 mg, to take one table via tube twice a day.

The medication was documented as being given on January 1, 2023 @ 10:00 am on the January MAR but was not recorded on the CMDCS.

The medication was documented as being given on January 4, 2023 @ 10:00 pm on the January MAR but was not recorded on the CMDCS.

An interview with the Interim Director of Nursing (IDON) was held on February 7, 2023 @ 1:51 pm. She stated that documentation for the Control Medication Declining Count Sheets (CMDCS) and Medication Administration Records were "all over the place". She stated that education has been given to staff, but they "needed to be more diligent" in how they did things. She stated that this especially pertained to the wing where Resident #9 was living.

An interview with the Assistant Director of Nursing

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F 755	Continued From page 32 (ADON) was conducted on February 7, 2023 @ 2:10 pm. She spoke to the state of the CMDCS and how the milliliters left in the bottle did not correspond to the countdown amount on the sheet for the Morphine Sulfate (Concentrate) for Resident #9. She attributed that to staff had not measured properly, poor math skills, or had not read the syringe correctly. She also stated that two bottles of the same medication had both been open, which could have caused the discrepancy.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview the facility failed to assure their medication error rate was less than five percent. Two nurses were observed administering medications. Two errors were detected out of twenty- six opportunities for error. This resulted in a medication error rate of 7.69 percent. The findings included: Record review revealed Resident # 13 had an order, dated 7/22/22, to apply Aspercream 10 % from a jar to his feet twice per day for pain. Nurse # 10 was observed on 2/3/23 at 8:55 AM as she prepared and administered medications to Resident # 13. Nurse # 10 was observed to apply Aspercreme Lidocaine 4% patches to the bottom of both of Resident # 13's feet. On 2/3/23 at 1:15	F 759		

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F 759	Continued From page 33 PM Nurse # 10 was interviewed about the discrepancy of the percentage of Aspercreme she had applied versus what was ordered. Nurse # 10 reported that was all the Aspercreme Lidocaine that they had. Nurse # 10 looked through her medication cart at the time and showed the surveyor that the 4% Aspercreme Lidocaine patches were the only thing available on her cart. This constituted the first error. Record review revealed Resident # 14 had an order, dated 1/15/23, for Acetaminophen extra strength 500 mg (milligrams) 2 every eight hours as needed for pain. Nurse # 10 was observed on 2/3/23 at 9:30 AM as she prepared and administered medications for Resident # 14. Nurse # 10 reported Resident # 14 had complained of pain a short time before and she was going to administer her Acetaminophen with her other scheduled morning medications. Nurse # 10 was observed to administer two pills of Acetaminophen 325 mg (regular strength) from stock medication. Nurse # 10 signed she administered by Resident # 14's extra strength Acetaminophen order. Nurse # 10 was interviewed on 2/3/23 at 1:15 PM about the discrepancy in using regular strength versus extra strength Acetaminophen and acknowledged she had signed by the extra strength Acetaminophen order but given the regular strength Acetaminophen. Nurse # 10 stated that there was a standing order that could be initiated for all residents to have regular strength Acetaminophen if needed. According to Nurse #10 she had not realized Resident #14 had an order for the extra strength Acetaminophen.	F 759		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

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by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to accurately document wound treatments (Resident #1), and accurately document controlled substance medication on the Medication Administration Record (Resident #2) for 2 of 4 residents reviewed for accurate documentation in the medical record. Findings included:

1. Resident #1 had a physician's treatment order initiated on 12/26/2022 for the left hallux to be

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cleansed with normal saline, calcium alginate applied, and covered with a dry dressing every day shift for wound care.

Documentation on the Treatment Administration Record (TAR) revealed there were blank spaces where the completion of the treatment would have been documented for Resident #1 on 12/21/2022, 12/22/2022, and 12/26/2022.

An interview with the Interim Director of Nursing on 2/3/2023 at 9:40 AM revealed Nurse #2 was assigned the responsibility of performing the treatments for Resident #1 on 12/21/2022, 12/22/2022, and 12/26/2022.

An interview was conducted with Nurse #2 on 2/3/2022 at 9:44 AM. Nurse #2 stated she recalled 12/21/2022 and 12/22/2022 detailing her responsibilities on both those days. Nurse #2 confirmed she did complete the treatments for Resident #1 but did not document on the TAR. Nurse #2 did not recall 12/26/2022 but stated she completed the treatment as ordered but did not document she did so.

2. Resident #2 had an order initiated on 1/12/2023 for Hydrocodone-Acetaminophen (Norco) 7.5-325 milligrams to be administered as one tablet by mouth three times a day for pain management.

Documentation on the Medication Administration Record (MAR) revealed Nurse #11 administered a dose of Norco to Resident #2 on 1/22/2023 at 6:00 AM.

Documentation on the Controlled Medication Utilization Record (CMUR) revealed Nurse #11

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F 842	Continued From page 37 did not remove a Norco dose from the medication cart on 1/22/2023 at 6:00 AM. Nurse #11 was interviewed on 2/7/2023 at 10:55 AM. Nurse #11 stated she made a documentation error on 1/22/2023 on the MAR because she would have documented on the CMUR if she had administered the Norco to Resident #2 at 6:00 AM.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring,	F 867		

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and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on

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high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:

(ii) Develop and implement appropriate plans of

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action to correct identified quality deficiencies;
(iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, family, resident, and staff interview the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put in place following the recertification survey 3/18/2022, complaint investigation completed 10/27/2022, and the complaint investigation 12/1/2022. This was one repeated deficiency in the areas of professional standards, pressure sore care, pharmacy services, and medication error rate originally cited during a recertification survey and complaint investigations. The continued failure of the facility during a recertification survey and 3 complaint surveys showed a pattern of the facilities inability to sustain an effective QAA program.

The findings included:

This citation is cross referenced to:

F684: During the complaint investigation completed 2/8/2023 the facility failed to communicate, follow care planned interventions, and physician orders regarding bowel movements (Resident #5) and failed to provide wound care as ordered (Resident #7) for 2 of 4 residents reviewed for receiving care according to professional standards, care plans and residents' choice.

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During the recertification survey completed 3/18/2022 the facility failed to complete non-pressure wound dressing changes as ordered by the physician for 1 of 2 residents reviewed for wound care.

F686: During the complaint investigation completed 2/8/2023 the facility failed to assess a pressure sore for a resident who preferred to have his dressing change done at night rather than the day when the facility assessments were routinely done. This was for one (Resident #11) of two sampled residents reviewed for pressure sores.

During the recertification survey completed 3/18/2022 the facility failed to complete dressing changes for 1 of 2 residents reviewed for pressure ulcers.

F755: During the complaint investigation completed 2/8/2023 the facility failed to consistently follow established procedures for the accounting of controlled substance medication and administration (Resident, #2, #4, and #9), provide pain assessment prior to administration for an as needed controlled substance medication (Resident #4), and administer controlled substance medication with a physician's order to do so (Resident #4) for 3 of 4 residents reviewed for pharmaceutical services for controlled substance medications.

During a complaint investigation facility completed 10/27/2022 the facility failed to assure 2 of 2 sampled residents received their medications. The facility failed to consistently follow established procedures for the accounting of controlled substance medications administered

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to 2 of 2 residents reviewed who received a controlled substance medication on an as needed (PRN) basis.

F759: During the complaint investigation completed 2/8/2023 the facility failed to assure their medication error rate was less than five percent. Two nurses were observed administering medications. Two errors were detected out of twenty- six opportunities for error. This resulted in a medication error rate of 7.69 percent.

During a complaint investigation completed at the facility on 12/1/2022 the facility failed to assure their medication error rate was less than 5 percent. Four nurses were observed administering medications. Two errors were detected out of twenty-six opportunities for error. This resulted in a medication error rate of 7.69 percent.

An interview was conducted with the facility Administrator and the Interim Director of Nursing (IDON) on 2/8/2023 at 9:23 AM. The IDON indicated the facility was continuing to audit and provide training on many concerns to include areas that were previously cited on previous surveys to include pharmacy services, medication pass error rate, wound care, and professional standards. The IDON stated that the facility pharmacist was involved in the QA process and that ongoing audits were being completed for both F755 and F759. The IDON stated that medication pass observations were performed by the facility pharmacy. The IDON revealed the QA process did not reveal any ongoing issues or concerns with pharmacy services or the medication pass observations. The IDON stated that the high turn over rate of the agency nursing

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F 867	Continued From page 43 staff created an issue of continued training required for pharmacy issues. The facility Administrator added that having a state surveyor watching the medication pass made the nursing staff nervous and it was up to the individual nurse being observed at the time. The Administrator stated the facility would be looking at the recited concerns from a different angle in the QA process of the facility so that more consistent improvement can be made.	F 867		