STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING ______ B. WING ______	C 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT WILMINGTON	820 WELLINGTON AVENUE WILMINGTON, NC 28401

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E 000	Initial Comments An unannounced recertification survey was conducted from 01/09/2023 through 01/20/2023. The facility was found in compliance with the requirement of CFR. 483.73 Emergency Preparedness. Event ID #7KD011.	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation was conducted from 01/09/23 through 01/20/23. Event ID #7KD011. The following intakes were investigated: NC00196297, NC00195892, and NC00194297. 3 of the 8 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 580 SS=E	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		2/20/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 02/14/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, staff interviews, and Physician interviews, the facility failed to notify the Physician of an allegation of resident abuse (Resident #44) and failed to notify the Physician for missed doses of medications (Resident #22 and Resident #14) for 3 of 3 residents observed for notification of change.

Findings included:

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F580 POC
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

A) The attending physician is currently aware of the abuse allegation involving Resident #44.
B) The attending physician is currently

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1. Resident #44 was admitted to the facility on 09/17/22 with diagnoses that included bipolar disorder, anxiety, and dysphagia.

The quarterly Minimum Data Set (MDS) assessment dated 12/17/22 revealed Resident #44 was cognitively intact with verbal and physical behaviors. The MDS also indicated the resident was ambulatory.

The initial 24-hour report alleged resident to staff altercation was faxed to the Health Care Personnel Registry the facility indicating resident abuse between Resident #44 and Nurse Aide (NA) #5 on 11/24/22 at approximately 9:15 PM.

The 5-day investigation report by the previous Administrator revealed this investigation did not include any mention on-call Physician or Physician Assistant (PA-C) were notified of Resident #44's alleged abuse allegation event the evening of 11/24/22.

A Psychotherapy Progress Note dated 11/28/22 for Resident #44 revealed Social Worker reported that on 11/25/22, Resident #44 was assaulted by Nursing Aide (NA#5). The Social Worker (SW) reported that this incident was witnessed, and reported, with police called in to speak with resident. Patient denied any nightmares, flashbacks, exaggerated startle response, or change in moods.

An interview on 01/10/23 at 12:13 PM with the Psychiatrist (PhD) revealed the SW told him that the first time she heard about Resident #44's 11/24/22 abuse allegation incident was from Resident #44 on (Friday) 11/25/22. He said the SW contacted him the same day, and he

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aware that Resident #22 and Resident #14 did not receive their medication as prescribed and Medication Variance Reports have been completed.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents who reside in the facility have been identified as having the potential to be affected.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

A) The Regional Vice President of Operations will educate the Nursing Home Administrator and the Director of Nursing on notifying the Medical Doctor of any allegation of abuse post assessment of the resident(s) involved. The Regional Vice President of Operations will educate the Nursing Home Administrator on completion of the Facility Reportable Incident Completion Checklist. This Checklist indicates the time the alleged abuse occurred and the time the attending physician was notified.
B) The Staff Development Coordinator, Assistant Director of Nursing, Director of Nursing or Nurse Supervisor will educate the Certified Medication Aides (CMA) on their scope of practice and will educate the Certified Medication Aides to notify the Licensed Nurse if medication is not readily available. The Staff Development Coordinator, Assistant Director of Nursing, Director of Nursing or Nurse Supervisor

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immediately set up a trauma assessment for Monday (11/28/22) with Resident #44. The Ph-D said when he was in the facility on 11/28/22, he brought up Resident #44's 11/24/22 abuse allegation event, and the PA-C told him that this was the first time she heard of the 11/24/22 abuse event. PhD said it was his expectation that both the on-call Physician and/or PA-C should have been immediately notified that same evening of Resident #44's alleged abuse and wasn't.

An interview on 01/11/23 at 1:35 PM with Nurse #4, Night Charge Nurse at time of 11/24/22 evening abuse event between Resident #44 and NA #5. The Night Charge Nurse said he assessed the resident immediately after they were separated and Resident #44 was taken to her room and after he escorted NA #5 to her car. Nurse said that night he had a three-way phone call with the Administrator and the Director of Nursing (DON), but did not remember if he called the on-call Physician or not.

An interview on 01/12/23 at 1:00 PM with Resident #44's Physician #1 revealed he was Resident #44's Physician and was also the Physician on-call the evening of 11/24/22. Physician stated it was his expectation that he or his PA-C should have been notified of Resident #44's abuse incident on 11/24/22. He said the first time he was notified of Resident #44's abuse was four days later on 11/28/22. He said he was on-call the night of 11/24/22, and the nurse should have called him, but didn't.

An interview on 01/12/23 at 1:05 PM with Physician Assistant (PA-C) revealed it was her expectation that she or the MD should have been

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will educate the Licensed Nurses to notify the attending physician to obtain further orders if medication is missed, not readily available or if medication is not administered due to medication parameters and when to complete a Medication Variance Report. During their classroom orientation period the Staff Development Coordinator will educate newly hired Certified Medication Aides on their scope of practice and will educate the Certified Medication Aides to notify the Licensed Nurse if medication is not readily available. During their classroom orientation period the Staff Development Coordinator will educate newly hired Licensed Nurses to notify the attending physician to obtain further orders if medication is missed, not readily available or if medication is not administered due to medication parameters and when to complete a Medication Variance Report.
After 2/20/23 no CMA or Licensed Nurse will be permitted to work without receiving the aforementioned education by the Staff Development Coordinator or Nursing Supervisor.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

A) The Nursing Home Administrator will complete the Facility Reportable Incident Completion Checklist for any allegation of abuse. Upon completion, the Facility Reportable Incident Completion Checklist will be scanned to the Regional Vice President of Operations or Regional Vice President of Clinical for review and

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notified of Resident #44's abuse on 11/24/22 and wasn't. She said she first became aware of the abuse allegation was on 11/28/22 from the PhD.

An interview on 01/13/23 at 4:53 PM with the Regional Clinical Vice President (RCVP) revealed she expected nursing staff to follow their facility's notification policy to notify the on-call Physician for any incidents of abuse which was not done for Resident #44 on 11/24/22.

2. Resident #22 was admitted to the facility on 08/29/16.

A review of the physician orders revealed on 08/22/18 an order for Prilosec (Omeprazole) 20 milligrams (mg) one capsule by mouth one time a day for GERD, an order written on 06/11/20 for Valproic Acid Solution 250 mg per 5 milliliters (ml) give 625 mg by mouth two times daily for schizoaffective disorder, and an order written on 06/22/21 for Cetirizine 10 mg by mouth one time daily for allergies.

The Medication Administration Record (MAR) review for Resident #22 revealed on 01/02/23, 01/03/23, 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23 the Valproic Acid Solution order for 625 mg had the #9 recorded for the 9:00 AM dose on 01/02/23, and 01/03/23 and the #9 recorded for both doses (9:00 AM and 9:00 PM on 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23 and 01/10/23. The MAR revealed on

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recommendation. Monthly for any allegation of abuse, the completed Facility Reportable Incident Completion Checklist will be presented by the Nursing Home Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review the Checklist and make recommendations to assure compliance is sustained ongoing.
B) Five times a week for twelve weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager or Nursing Supervisor will perform medication administration pass observation audits for ten residents daily to include documentation of medication administration pass and to validate medication is administered per physician order as well as observation for notification of attending physician for any missed medication. Results of the audits will be presented by the Director of Nursing (DON) in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.

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01/08/23 and 01/11/23 the order for Cetirizine 10 mg had the #9 recorded and on 01/08/23, 01/09/23 and 01/11/23 the MAR revealed the order for Prilosec 20 mg had the #9 recorded. A review of the key coding on the MAR revealed the #9 meant to "see nurse's notes."

A review of the electronic medication administration notes for Resident #22 on 01/02/23 revealed the Valproic Acid Solution note indicated "waiting on pharmacy," On 01/03/23 and 01/04/23 the note indicated the Valproic Acid Solution was "on order," and on 01/08/23 the note indicated the Valproic Acid Solution was "reordered." There were no medication notes for 01/05/23, 01/06/23, 01/09/23, or 01/10/23 indicating why the Valproic Acid Solution was not given. On 01/08/23, the medication note indicated the Cetirizine 10 mg was "out of stock," and on 01/11/23 the note indicated "contacting pharmacy." On 01/08/23 the medication note indicated the Prilosec 20 mg order was "out of stock," and on 01/11/23 the note indicated "contacting pharmacy." There was no medication note indicating why the Prilosec was not given on 01/09/23.

Review of the Physicians' communication book for the month of January 2023 located at the Nurse's station for halls 500/600 revealed there was no documentation to indicate notification that Resident #22 had not received her Valproic Acid, Cetirizine, or Prilosec.

An interview was conducted with Medication Aide (MA) #2 on 01/11/23 at 8:40 AM. She stated on 01/02/23 she documented the #9 which meant see nurses' notes for the Valproic Acid Solution for Resident #22 because it was not available.

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She stated she believed she told Nurse #10 it was not available on 01/02/23. MA #2 stated the Cetirizine, and the Prilosec were not available on the medication cart or in the medication storage room on 01/11/23 and she told Nurse #10 the medications were not available.

An interview with Nurse #10 on 01/11/23 at 3:30 PM revealed she could not recall if she was made aware by MA #2 on 01/02/23 that the Valproic Acid Solution was not available for Resident #22, and she further stated MA #2 did not inform her the Cetirizine or the Prilosec medications were not available and were not given to Resident #22 on 01/11/23. Nurse #10 stated she would notify the physician.

An interview was conducted with the Unit Manager (UM) on 01/11/23 at 3:10 PM. The UM stated the Medication Aides were trained to communicate with their nurses if a medication was unavailable and the nurses were trained to notify the physician if a medication was not available to be given.

An interview was conducted with MA #5 on 01/13/23 at 12:14 PM. MA #5 reported when she worked on the medication cart, she would report to the Charge Nurse assigned to that hall. She stated on 01/03/23, 01/09/23, and 01/10/23 she recorded the #9 for the Valproic Acid Solution for Resident #22 on the MAR because she did not see the medication in the drawer. She stated she could not remember if she asked the nurse if it had been reordered.

An interview was conducted with Nurse #11 on 01/13/23 at 12:47 PM. Nurse #11 confirmed she worked on 01/06/23 and 01/10/23. Nurse #11

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stated she believed she noted in the Physician's communication book which was kept at the nursing station that the medications were not available, and that Resident #22 did not receive them on 01/06/23 and 01/10/23.

An interview was conducted with the Nurse Practitioner (NP) on 01/13/22 at 1:10 PM. The NP stated Resident #22 was getting Valproic Acid Solution to treat schizoaffective disorder. She stated she was not aware the resident was not receiving the medication as ordered and that not receiving the medication could cause Resident #22 to have breakthrough symptoms with the potential for negative side effects. The NP also stated she was not aware Resident #22 had not received her Cetirizine or Prilosec. During this interview, the physician communication book was reviewed for January 2023 and there was no documentation to indicate Resident #22 had not received any of these medications.

A phone interview with the Physician Assistant (PA) on 01/13/23 at 3:50 PM revealed this was the first time she was hearing about Resident #22 not receiving her Valproic Acid, Prilosec, or Cetirizine. She stated she would have expected to be notified after missing 1 and no more than 2 doses of the Prilosec and Cetirizine, but she would have wanted to have been notified if she was missing any doses of the Valproic Acid. She stated the resident has a history of schizoaffective disorder and missing those doses could have caused her to become unbalanced. She stated if nurses and medication aides were documenting medication "not available," she would expect them to be following up on the medication to make sure it was available and to notify her for additional orders if needed.

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An interview with the Regional Clinical Vice President on 01/13/23 at 4:55 PM revealed her expectation of the Medication Aides was to make sure the Charge Nurses were being notified when a medication was not available, and the Charge Nurse should be notifying the Physician anytime a resident did not receive their medications as ordered.

3. Resident #14 was admitted to the facility on 09/03/13.

Review of the physician's order revealed an order was written on 05/12/22 for Atorvastatin Calcium 10 mg; one tablet daily for high cholesterol and on 05/13/22 an order for Lisinopril tablet 2.5 mg; give one tablet daily for high blood pressure.

Review of the Medication Administration Record (MAR) for January 2023 revealed on 01/03/23 the #9 was documented by Nurse #12 for the Atorvastatin. The Lisinopril order was noted to have the letter "X" recorded on 01/06/23 by MA #4, and on 01/07/23 and 01/08/23 by MA #6 under the blood pressure with the #9 and #5 recorded which meant to see nurses' notes.

Review of the electronic medication nursing notes by Nurse #12 on 01/03/23, the note stated Atorvastatin was "not available," and on 01/06/23 by MA #4, 01/07/23 and 01/08/23 by MA #6 the note stated Lisinopril "not available."

Review of the Physicians' communication book for the month of January 2023 located at the Nurse's station for halls 500/600 revealed there was no documentation to indicate notification Resident #14 had not received her Lisinopril or

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Atorvastatin medications.

An interview with Medication Aide (MA) #4 on 01/11/23 revealed the Lisinopril was not available so she documented the #9 on the MAR "not available." She stated she could not remember if she told the nurse or not on 01/06/23.

Medication Aide #6 who recorded the #5 and #9 on the MAR on 01/07/23 and 01/08/23 was not available for an interview.

Nurse #12 who recorded the #9 for the Atorvastatin on 01/03/23 was not available for an interview.

An interview with Nurse #11 on 01/13/23 at 12:47 PM revealed the Atorvastatin and the Lisinopril were both available in the medication dispensing unit and if the Medication Aide came to her to let her know there was none available on the cart, she would have removed them from the medication dispensing unit. She stated neither MA #4 nor MA #6 ever came to her regarding needing those medications not being available for Resident #14.

A phone interview was conducted with the Physician Assistant (PA) on 01/13/23 at 3:50 PM. The PA stated she was not made aware Resident #14 had not received these medications. She stated if nurses and medication aides were documenting medication "not available," she would expect them to be following up on the medication to make sure it was available and to notify her for additional orders if needed.

An interview with the Regional Clinical Vice President on 01/13/23 at 4:55 PM revealed her

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F 580	Continued From page 10 expectation of the Medication Aides was to make sure the Charge Nurses were being notified when a medication was not available, and the Charge Nurse should be notifying the Physician anytime a resident did not receive their medications as ordered.	F 580		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		2/20/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 11 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to: 1a) failed to repair torn floor linoleum in 3 of 13 resident rooms (508, 600, and 603), 1b) failed to remove the black greenish substance from the commode base caulking in 4 of 13 resident rooms (506, 508, 510, and 615), 1c) failed to ensure the ceilings were free from damaged drywall in 2 of 4 shower rooms (500 and 600 halls), 1d) failed to repair a broken wall cabinet door in 1 of 13 resident rooms (502), 1e) failed to replace rough, worn, splintered hand-rails on the 500 and 600 halls, 1f) failed to repair leaking commode bases in 4 of 13 resident rooms (506, 508, 510, and 612). 1g) failed to repair drywall wall damage in 3 of 13 resident rooms (501, 508, and 615), 1h) failed to replace broken or missing floor tile in 8 of 13 resident rooms (502, 508, 600, 609, 610, 612, 614, and 615), and 1i) failed to replace broken window blinds in 2 of 13 resident rooms (600 and 613). Findings included: 1a. An observation on 01/10/23 at 2:20 PM revealed torn floor linoleum in 3 of 13 resident rooms (508, 600, and 603). 1b. An observation on 01/10/23 at 2:20 PM revealed 4 of 13 resident	F 584	F584 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The torn floor linoleum in resident rooms 508, 600, and 603 has been repaired. The black greenish substance from the commode base caulking in resident rooms 506, 508, 510 and 615 has been cleaned or replaced. The ceilings that had damaged drywall in the shower rooms in 500/600 shower rooms have been repaired. The broken wall cabinet in resident room 502 has been repaired. The rough, worn, splintered handrails on the 500 and 600 halls have been repaired. The leaking commode bases in resident rooms 506, 508, 510, and 612 have been repaired. The drywall damage in resident rooms 501, 508 and 615 has been repaired. The floor tile has been replaced in resident rooms 502, 508, 600, 609, 610, 612, 614 and 615. The window blinds have been replaced in resident	

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F 584	Continued From page 12 commodes (506, 508, 510, and 615), were noted to have black greenish substance located around the base of the commodes. 1c. An observation on 01/10/23 at 2:20 PM revealed 2 of 4 facility shower rooms (400 and 500 halls) were noted to have damaged ceiling drywall. 1d. An observation on 01/10/23 at 2:20 PM revealed 1 of 13 broken clothes wall cabinet door broken, hanging diagonally on one hinge in 1 of 13 resident rooms (502). 1e. An observation on 01/10/23 at 2:20 PM revealed 500 and 600 halls wooden handrails were rough, worn, with multiple splintered areas on the 500 and 600 halls. 1f. An observation on 01/10/23 at 2:20 PM revealed 4 of 13 resident room commodes were leaking at their bases with strong sewage smell eminating from the leaking toilets in rooms (506, 508, 510, and 612). 1g. An observation on 01/10/23 at 2:20 PM revealed 3 of 13 resident rooms repair were noted to have drywall wall damage (501, 508, and 615). 1h. An observation on 01/10/23 at 2:20 PM revealed 8 of 13 resident rooms with broken or missing floor tile (502, 508, 600, 609, 610, 612, 614, and 615). 1i. An observation on 01/10/23 at 2:20 PM revealed 2 of 13 resident rooms with broken window blinds (600 and 613). An interview and facilty tour of the 500 and 600 halls was conducted with the Maintenance Director (MD) on 01/10/23 at 2:20 PM. The MD stated there were multiple areas on the 500 and 600 halls that still needed to be addressed, repaired, or replaced. He stated he had had no assistant, but was still able to keep up with faclity repairs. He said he did not know what the black greenis substance actually was around some of the commodes on the 500 and 600 halls, and did not know about the leaking commodes. MD said housekeeping was responsible to cleaning the	F 584	rooms 600 and 613. All repairs were completed by 2/19/23. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Observational audits have been conducted by the Administrator and Maintenance Director to identify areas of concerns to include torn floor linoleum, black greenish substance from the commode base caulking, shower room ceilings with drywall damage, broken wall cabinets, rough, worn, splintered handrails, leaking commode bases, drywall damage, floor tile and broken window blinds. On 2/13/23 a Quality Assurance Performance Improvement Plan was developed to address the identified areas prioritizing any risk areas. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Administrator and Regional Vice President of Operations educated the Maintenance Director on the process for attaining/maintaining a homelike environment. In addition, the facility staff have been educated by the Staff Development Coordinator or a member of the Administrative Team on the process for completing maintenance requests for areas that are not homelike including torn floor linoleum, black greenish substance from the commode base caulking, shower room ceilings with drywall damage, broken wall cabinets, rough, worn,	

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base of the commodes, and that maintenance was responsible for repairing or replacing items in the facility. He said the broken or missing floor tiles were not replaced, because he ordered replacement tiles on 12/19/22, and were still on back order.

An interview and facility tour was conducted with the Regional Vice President of Operations (RVPO) on 01/11/23 at 11:30 AM. She identified additional areas of concern, she observed during the tour of the facility, shower rooms, and resident rooms on the 500 and 600 halls. She said their current Quality Assurance and Performance Improvement Action (QAPI) Plan was not working, and was not specific enough to address all of the residents physical environment needs on the 500 and 600 halls. She stated, the 500 and 600 halls were currently, not home-like. She said her additional concerns included: outstanding maintenance work orders, repair and paint needed in resident rooms/bathrooms, repair or replace of commodes, repair or replace of broken drawers or cabinets, and repair or replace of any other identified physical physical plant concerns that needed to be addressed. The RVPO stated it was her expectation for all the residents to have a safe and homelike environment that was clean and in good repair.

A follow-up observation and facility tour of the 500 and 600 halls on 01/12/23 at 1:30 PM was conducted with the MD. The tour revealed: 2 of 2 shower rooms (500 and 600 halls) ceilings had damaged ceiling drywall, there were black greenish substance around the base of 4 resident commodes (506, 508, 510, and 615), leaking or broken commodes (506, 508, 510, and 612), wooden hall railings, worn, rough, with splintering

F 584

splintered handrails, leaking commode bases, drywall damage, floor tile and broken window blinds. After 2/20/23 staff will not be permitted to work without receiving the aforementioned education by the Staff Development Coordinator, a member of the Administrative Team, or Nursing Supervisor.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Five times a week for twelve weeks the Administrator, Maintenance Director, Director of Nursing, Staff Development Coordinator and select department heads will conduct observational audits of resident rooms to include torn floor linoleum, black greenish substance from the commode base caulking, shower room ceilings with drywall damage, broken wall cabinets, rough, worn, splintered handrails, leaking commode bases, drywall damage, floor tile and window blinds. Results of the observational audits will be presented by the Administrator or Maintenance Director in the monthly Quality Assurance Performance Improvement (QAPI) meeting monthly for three months. The QAPI Committee will review the audits and make recommendations based on their findings to assure compliance is sustained ongoing.

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areas (500 and 600 halls), and multiple residents rooms with torn lonellium and missing or broken tiles. The Maintenance Director (MD) indicated the facility did not utilize fully their electronic work order system (TELS), which was a building management platform disigned for senior living with integrated asset management, life safety, and maintenance solutions. He stated he checked the paper work order binders located at the nursing stations every morning, and added that most of the facility's repair needs were communicated by the staff through verbal communication and not by paper or electronically. He stated he did not routinely complete routine walk-throughs of the facility to address any additional maintenance needs that were not addressed in work order binders. He stated he priortized work order requests based on resident safety concerns. MD stated he did not have a system in place to track regular scheduled facility maintenance, and also could not provide documentation of completed or pending work orders that still needed to be addressed.

A follow-up interview was conducted with the Regional Vice President of Operations (RVPO) on 01/12/23 at 2:00 PM. She stated the additional maintenance personnel she pulled from other sister facilities to address the additional facility concerns she identified, found in facility's storage boxes of floor tiles, and have replaced the missing and broken tile in Resident #44 room on 01/11/23, and were in the process of repairing the torn lenolium and broken window blind.

A follow-up interview was conducted with the Regional Clinical Vice President (RVP) on 01/13/23 at 4:53 PM. She said their current Quality Assurance and Performance

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F 584	Continued From page 15 Improvement Action (QAPI) Plan that addressed the residents physical environment on the 500 and 600 halls did not idenify all the facility's physical plant concerns, problem, or issues.	F 584		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, and police detective interview, the facility failed to protect a Resident's right to be free from physical abuse for 1 of 2 residents reviewed for abuse (Resident #44). Findings included: Resident #44 was admitted to the facility on 09/17/22 with diagnoses that included bipolar disorder, anxiety, dysphagia, gastrostomy, vocal cord cancer with old trach site. The quarterly Minimum Data Set (MDS)	F 600	F600 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: The facility is not able to correct the actions of NA #5 and how she responded to Resident #44 on 11/24/22. NA #5 was suspended per facility policy on 11/24/22. NA #5's employment with the facility was terminated as a result of her interactions with Resident #44. Resident #44 did not show any signs of injury as a result of NA	2/20/23

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F 600	Continued From page 16 assessment dated 12/17/22 revealed Resident #44 was cognitively intact with verbal and physical behaviors. The MDS also indicated the resident was ambulatory, required enteral tube feeding due to dysphagia and eating nothing by mouth (NPO). Resident #44 's care plan dated 11/14/22 revealed resident had an Activities for Daily Living (ADL) self-care performance deficit relate to dementia. Resident had a behavior problem related to going into resident's rooms and taking things that did not belong to her from other rooms/nursing stations. Resident was resistive to tube feeding related to anorexia and was not compliant with nothing by mouth (NPO) order related to dysphagia. Resident had potential nutritional problem related to tube feedings due to supraglottic squamous cell carcinoma, non-compliance with diet order, and would eat and drink from vending machines and other sources. Per care plan initiated 11/16/22-12/20/22, Staff were instructed, when the resident becomes agitated: Intervene before agitation escalates; guide away from source of distress; engage calmly in conversation; if response is aggressive, staff to walk calmly away, and approach later. The initial 24-hour report alleged resident to staff altercation was faxed to the Health Care Personnel Registry the facility indicating resident abuse between Resident #44 and Nurse Aide (NA) #5 on 11/24/22 at approximately 9:15 PM. The 5-day investigation report by the previous Administrator was faxed to the Health Care Personnel Registry on 12/01/22 and indicated Resident #44 had a history of not being truthful	F 600	#5's actions. A Facility Reported Incident and 5-day report were submitted per regulation regarding the allegation of abuse. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who reside in the facility have been identified as having the potential to be affected. NA #5 was suspended on 11/24/22. Abuse education was initiated on 11/25/22 as a result of the actions of NA #5. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On January 2, 2023, the Regional Vice President of Clinical Services educated the Director of Nursing the facility abuse policy. On January 2, 2023, the Regional Vice President of Clinical Services educated the Interim Nursing Home Administrator the facility abuse policy. On 1/23/23 the Regional Vice President of Clinical Services educated the Nursing Home Administrator and the Director of Nursing on notifying the Medical Doctor of any allegation of abuse post assessment of the resident(s) involved. On 1/23/23 the Regional Vice President of Clinical Services educated the Nursing Home Administrator on completion of the Facility Reportable Incident Completion Checklist. This Checklist indicates the time the alleged abuse occurred and the time the	

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F 600	Continued From page 17 regarding her behavior and would deny or attempt to create a reason to justify her action(s) when behavior was stopped and questioned by staff. Statements taken from staff members who were present during Resident #44 and NA #5's interaction were reviewed. The Administrator's investigation report summary revealed "From statements received, it has been determined that NA #5 had attempted to stop Resident #44 from taking candy and cookies which had been left at the nursing station by a family as a holiday treat for the staff but were not safe for Resident #44 to consume. When NA #5 attempted to remove candy and cookies from resident's possession, Resident #44 became aggressive punching NA #5 in the face and pushing her. Skin checks were performed with no alteration to skin integrity were observed. Residents capable to interview on 600-hall were questioned regarding staff interactions without any concerns noted. A traumatic/stressful event screening was performed. A psychiatric evaluation on 11/14/22 indicated Resident #44 had delusional (religious), depression, anxiety, and irritability. A Psychiatric follow-up visit was conducted on 11/28/22 when the allegation of abuse between Resident #44 and Nurse Aide (NA) #5 on 11/24/22 was first alleged. The report indicated that the allegation was resident to staff altercation, and NA #5 was terminated due to failure to redirect resident appropriately. Staff in-services on abuse were provided to staff and an in-service was conducted regarding ways to re-direct residents during episodes of aggression. A review of a written statement by NA #5 revealed, "On the night of 11/24/22, Resident #44 was behind the nursing station going through snacks on the desk. I told her she couldn't be	F 600	attending physician was notified. The Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nurse Supervisor will educate staff, including agency staff, on the facility's abuse policy, what to do if they witness or suspect abuse and how to respond to a behavioral resident. After 2/20/23 no staff will be permitted to work without receiving the aforementioned education from the Nursing Home Administrator, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nursing Supervisor. The Nursing Home Administrator, Staff Development Coordinator, Nurse Supervisor, or a member of the Administrative Team will educate newly hired staff during their orientation period on the facility's abuse policy, what to do if they witness or suspect abuse and how to respond to a behavioral resident. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly for twelve weeks, the Nursing Home Administrator, Social Services Director, Social Worker, Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nurse Supervisor will randomly interview ten staff members to validate their knowledge of abuse, what to do if they witness or suspect abuse and how to respond to a behavioral resident. Anyone who is unable	

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behind the nursing station. Resident #44 was going through the cookies and candy. I was moving the cans and cookies when Resident #44 hit me in the face and was trying to hit me again, calling me a n_____, and pushing and punching me. I pushed her away from me. She punched me in the face, eye, lip, and knocked my glasses off. I do not know if I put my hands on her neck."

An interview was conducted with NA #5 on 01/19/23 at 12:35 PM. I could not leave any voice messages on survey 01/11/23 due to her voice mail box not being set-up. I called NA #5's, phone on 01/19/23, and immediately she answered, after a long pause, she confirmed she was NA #5, and agreed to an interview. She said on 11/24/22 around 7:30 - 8:00 PM Resident #44 was observed behind the nursing station, which she explained to the resident was against the HIPAA law. NA #5 said the resident went back to the front of the nursing station and was reaching over the front of the nursing station reaching for snacks. NA #5 said she then walked up to the side of the resident and the resident proceeded to push her away with her hips, then suddenly the resident smacked her in the face, saying it happened so quickly, and kept swinging at her. NA #5 said she pushed the resident away from her and walked away. NA #5 said the resident assaulted her, was against her swinging at her, and she had to push the resident away, before she was able to walk away. NA #5 said she had no intention to abuse Resident #44. NA #5 said in 39 years as an NA, this never happened to her before. She then said Nurse #4 took her statement and walked her to her car.

A Psychotherapy progress note dated 11/28/22 revealed patient denied any nightmares,

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to answer correctly will be immediately removed from the work area and re-educated until they can state the correct responses. The results of the audits will be presented by the Nursing Home Administrator in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.

The Nursing Home Administrator will complete the Facility Reportable Incident Completion Checklist for any allegation of abuse. Upon completion, the Facility Reportable Incident Completion Checklist will be scanned to the Regional Vice President of Operations or Regional Vice President of Clinical for review and recommendation. Monthly for any allegation of abuse, the completed Facility Reportable Incident Completion Checklist will be presented by the Nursing Home Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee. The QAPI Committee will review the Checklist and make recommendations to assure compliance is sustained ongoing.

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flashbacks, exaggerated startle response or change in moods.

An interview was conducted with Resident #44 on 01/10/23 at 11:45 AM. Resident #44 revealed awhile back, she thought somewhere in December/2022, a female staff member grabbed the front of her neck when she was just looking at a box of chocolates at the nursing station. Resident #44 said she refused to press charges when she spoke with the police officer and did not want to get anyone fired. Resident #44 said she could not remember the date, shift, time of day, or the staff member who grabbed the front of her neck. Resident #44 stated when she walked to the nursing station, she saw a big box of chocolates sitting there and was told by a staff member that she could not have any of the candy. Resident #44 she said she just wanted to see what kind of chocolates were in the box when the staff member grabbed her neck. Resident #44 said she later told her psychologist that she was never in any pain during or after the staff member grabbed her neck, only that she was startled that the staff member did it.

An interview was conducted with the Psychologist on 01/10/23 at 12:13 PM. The Psychologist revealed he came to the facility on 11/28/22 to assess Resident #44 after the Social Worker (SW) told him about Resident #44's alleged abuse with NA #5 on 11/24/22. He said when he came in the facility on 11/28/22, his goals were to evaluate Resident #44 emotional status and to see how she was. He said he saw the resident and then let the Social Worker know about his trauma assessment. He said Resident #44 seemed fine after he completed the trauma assessment. The Psychologist said the trauma

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evaluation revealed the resident had no trauma, no Post Traumatic Stress Disorder (PTSD), and no nightmares. He said his job was to make sure emotionally Resident #44 was okay and had no obvious physical signs of abuse.

An interview was conducted with Nurse #4 on 01/11/23 at 1:35 PM. Nurse #4 revealed he was the night supervisor on 11/24/22. Nurse said that evening Medication Aide (MA) #3 came to him immediately after Resident #44 and NA #5's altercation at the nursing station. Nurse #4 said he interviewed all parties involved and then escorted NA #5 out of the building to her car, while MA #3 sat with Resident #44 in her room. Nurse #4 said he called the Police, Administrator, and Director of Nursing. He said he then assessed Resident #44's body and neck area with MA #3 present, which revealed no bruising, no physical injury, and no emotion or crying from the resident. He said resident's only concern, was that she did not want NA #5 to lose her job. Nurse #4 said when the police arrived, they did a body-cam assessment of Resident #44, with him present, which revealed no physical injury. Nurse #4 said he then conducted safety checks of all residents' rooms on the 600-hall, with no residents voicing concerns.

An interview was conducted with MA #3 on 01/11/23 at 4:55 PM revealed on 11/24/22 she saw Resident #44 grab a box of chocolates which were left at the nursing station for the nursing staff by families for the holidays. MA#3 said NA #5 told the resident that she could not eat any of the chocolates because she was NPO, and could not have anything by mouth. MA #3 said NA #5 was lightly tapping the resident's hand while asking the resident to please drop the chocolates

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F 600	Continued From page 21 she had in her hand. MA#3 said the resident then started to push NA#5, and then the resident walked around to the inside of the nursing station and said she did not care and wanted the snack. When the resident reached for the other holiday snacks which were on the inside of the nursing station, NA#5 tried again to push resident's hand away from the food and that was when Resident #44 punched NA #5 in the left eye, knocking her glasses off. MA#3 said NA#5 put her right hand on the front of Resident #44's neck, trying to push the resident away with her right hand while trying to prevent more punches from the resident. MA #3 said she then got in-between them both and took the resident to her room where she stayed until the police arrived. MA#3 said the resident had no pain, no shortness of breath, and was not distressed. MA#3 said she was the only witness who saw the event. MA#3 said she did not remember NA#5 squeezing the resident's neck with her right hand. MA#3 said it was an instant reflex, to grab and push the resident away after being punched in the left eye on her glasses. MA#3 said NA#5 did not intentionally try to choke the resident but she should have walked away. An interview was conducted with NA #3 on 01/11/23 at 5:05 PM. NA #3 revealed on 11/24/22 as she entered the facility through the smoking area door, she observed NA #5 with her right hand on the front of Resident #44's neck. NA #3 said neither Resident #44 nor MA#3 could see her because she was behind them as she was, coming inside from the smoking area door. NA #3 said the distance was too far away to see if NA #5 had squeezed Resident #44"s neck, but she did see NA #5's right hand was on the front of the resident's neck. NA #3 then said MA #3 got in-between them and separated them. NA #3	F 600		

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F 600	Continued From page 22 said the resident was escorted to her room until the police arrived and NA #5 was immediately taken off the floor and escorted to her car by the night supervisor. An interview was conducted on 01/13/23 at 10:35 AM with the Police Detective. The police detective revealed he reviewed the police officer's video body cam assessment conducted on Resident #44 dated 11/24/22 at 10:22 PM with Nurse #4 in attendance. The detective revealed the body cam assessment of Resident #44's body and neck showed no injury around her body or neck area. The detective said he still had a couple of interviews to conduct and that Resident #44's case of assault/strangulation was still open. An interview was conducted with the Reginal Clinical Vice President (RCVP) on 01/13/23 at 4:53 PM. The RCVP stated the previous Administrator no longer worked at the facility. RCVP stated the previous Administrator's investigation of the 11/24/22 alleged abuse event was not abuse. She said the Administrator felt that NA #5 pushing Resident #44 away was a spontaneous reflex response, while being hit in the face. RCVP felt both parties were at fault, but that NA #5 should have walked away, instead of putting her right hand on Resident #44 neck and pushing her away.	F 600		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		2/20/23

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F 641

Continued From page 23

Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for medications recieved (Resident #24) and for falls (Resident #35) for 2 of 33 residents reviewed.

Findings included:

1. Resident #24 was admitted to the facility on 11/02/22. Diagnoses included major depressive disorder, bipolar disorder, and anxiety disorder.

The MDS admission assessment dated 11/07/22 revealed Resident #24 was cognitively intact and was not noted as receiving any antianxiety medications during this review period.

A physician's order was written on 11/02/22 for Clonazepam (medication to treat anxiety) 0.5 milligrams. Give one tablet by mouth every 12 hours as needed for anxiety.

A review of the Medication Administration Record for November 2022 revealed Resident #24 received 8 doses of Clonazepam from 11/02/22 through 11/07/22.

An interview with MDS Nurse #1 on 01/13/23 at 4:10 PM revealed she overlooked that Resident #24 had an order for Clonazepam, and she had received 8 doses. The MDS nurse stated the MDS should have noted she received anti-anxiety medication.

An interview with the Regional Clinical Vice President on 01/13/23 at 4:25 PM revealed she expected the MDS nurses to accurately document the residents' assessments per the guidelines and that the assessments reflect their

F 641

F641 POC

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #24 quarterly MDS dated 11/7/2022 was modified on 1/16/23 to reflect the accuracy for medications.
Resident #35 quarterly assessment was modified on 1/10/23 to reflect the accuracy for falls.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents with medications and falls have been identified as having the potential to be affected. Residents with medications and residents who have experienced falls had their Minimum Data Set (MDS) audited by the MDS Coordinators to validate accuracy of the MDS per the Resident Assessment Instrument (RAI) Manual. Audit was completed on 1/30/23.
Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

MDS Coordinators were educated on 1/23/23 by the Regional Vice President of Clinical Services on MDS coding of sections J1700, J1800, J1900 and section N per the RAI Manual.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

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F 641	Continued From page 24 status. 2. Resident #35 was admitted to the facility on 05/06/22. Diagnoses included, in part, stroke with right sided weakness. Review of a nurse's note written on 11/23/22 at 11:30 PM revealed the nurse had observed the resident lying on his back on the floor beside the bed. No bleeding, open wounds, skin tears, or bruising were noted. His range of motion was normal and vital signs were stable. Resident #35 was helped back to bed and was able to rest. The MDS quarterly assessment dated 01/06/23 revealed Resident #35 was severely cognitively impaired and required extensive assistance with two staff physical assistance with activities of daily living and had impairment on one side to his upper and lower extremities. Resident #35 was not noted as having any falls during this assessment review. An interview with MDS Nurse #1 on 01/13/23 at 4:10 PM revealed she overlooked that Resident #35 had a fall on 11/24/22 and that it should have been noted in the MDS as one fall with no injury. An interview with the Regional Clinical Vice President on 01/13/23 at 4:25 PM revealed she expected the MDS nurses to accurately document the residents' assessments per the guidelines and that the assessments reflect their status.	F 641	Weekly for twelve weeks the MDS Coordinators will audit three Minimum Data Sets per week to validate coding per the RAI Manual of residents prescribed medications and resident who experience falls. The MDS Coordinators will not self-audit. Results of the audits will be presented by the MDS Coordinator in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		2/20/23

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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 observation, record review and staff interviews, the facility failed to provide supervision to prevent accidents by allowing a resident who was identified by the facility as a "supervised smoker" (Resident #67) and a resident who was assessed as "not a current smoker" (Resident #43) to smoke cigarettes without staff supervision for 2 of 5 residents observed smoking cigarettes in the designated smoking area.

Findings included:

Review of the facility policy, "Smoking Policy" (Revised 11/2/2022), documented: "August Healthcare has chosen to be a smoke free building. However, smokers will be allowed to smoke outside the building at the designated smoking area, under the supervision of an assigned staff monitor."

a. Resident #67 was admitted to the facility on 08/19/21 with diagnoses that included dementia, adult failure to thrive, encephalopathy, altered mental status, age related physical debility, and tobacco use.

Review of a quarterly MDS assessment dated 12/28/22 documented Resident #67 had intact cognition. He had felt tired on 2 to 6 days during the assessment look back period. He had

F 689

F689 POC

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.

Resident #43 had smoking assessments completed on or before 2/29/23 by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Nursing Supervisor. The facility is unable to retro-correct the lack of supervision concern identified for resident # 67 and resident #43 during the survey. Smoking materials for resident #67 were secured by the facility for the residents' future use prior to the survey exit.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

On 1/20/23 the Director of Nursing, Assistant Director of Nursing, Unit Manager conducted a 100% interview audit of all residents to ensure the facility is aware of all residents who smoke. The residents identified will have an updated smoking assessment completed to

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F 689

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required extensive assistance from staff with all activities of daily living except for walking, locomotion and eating which required supervision. He had one fall since admission to the facility.

Review of the Smokers List provided on 01/09/23 by the facility documented Resident #67 was a "supervised smoker."

b. Resident #43 was admitted to the facility on 03/02/22 with diagnoses that included hemiplegia and hemiparesis following a cerebral infarction (stroke) affecting the right dominant side. He had a history of tobacco use.

Review of a quarterly Minimum Data Set (MDS) assessment dated 01/07/23 documented he had moderately impaired cognition. He felt tired and sleepy on 12-14 days during the assessment look back period. He had an impairment on one side of both upper and lower extremities. He had received both scheduled and as needed pain medications.

Review of a smoking assessment dated 10/03/22 documented Resident #43 as "not a current smoker."

An observation of the 3:00 PM smoke break on 01/11/23 revealed five residents were in the designated smoking area smoking cigarettes. No facility staff were present or near the smoking area. A resident who was an independent smoker was observed providing Resident #43 a cigarette to smoke and a cigarette lighter.

In an interview with Nurse Aide #1 on 01/11/23 at 3:05 PM she stated there was no staff member to

F 689

determine their level of supervision required. Resident care plans will be updated accordingly by the MDS Coordinators.

On February 10, 2023, the Administrator and Director of Nursing reviewed the smoking policy, to include the smoking schedule with staff assignments, with all the identified residents who smoke. Any concerns were addressed by the Administrator or Director of Nursing.

The Admission's Coordinator will review the smoking policy with all newly admitted residents.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

On or before 2/20/23 Licensed Nurses were educated by the Staff Development Coordinator, Director of Nursing or Unit Manger on completing a smoking assessment upon admission, quarterly and with a significant change in condition. The smoking assessment will determine the level of supervision required and the care plan will be updated by the MDS Coordinator or Nurse Supervisor to reflect the resident's desire to smoke and level of supervision. On 2/14/23 the Regional Vice President of Clinical Services educated the MDS Coordinators and Nursing Supervisors on implementing smoking care plans for residents identified as smokers.

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supervise the smoker 's because the Patient Care Assistant (PCA) who normally took the smoker 's out on smoke break was off and no one else had been assigned. She stated she would go out and supervise the residents who were smoking but did not know the key code to the door to access the smoking area and had to leave the area to obtain the code. When she returned, she supervised the residents who were smoking for the remainder of the break.

The facility Administrator was called to the designated smoking area on 01/11/23 during the 3:00 PM smoke break to observe the process. He stated the residents should not have had smoking items (cigarettes and lighters) in their possession and there should have been a staff member supervising the residents who were smoking. He concluded he would straighten out the situation and acknowledged the potential fire hazard. He immediately instructed staff to collect all smoking items (cigarettes and lighters) from residents and secure them in a locker near the smoking area that was previously designated for cigarette and lighter storage when the items were not in use.

In an interview with the Reginal Clinical Vice President on 01/13/23 at 8:45 AM she stated she expected staff to be outside with the smokers to supervise because of the risk of resident 's burning themselves. She acknowledged it was a safety issue. She also expected cigarettes and lighters to be kept in a secure, locked area when not in use. She would not expect any resident to keep his or her cigarettes or lighters on their person or in their rooms.

F 689

A Smoking Binder has been implemented for the Smoking Monitor to reference. The Smoking Binder is a communication tool which contains the level of supervision required for each resident. The Smoking Monitors were educated by the Administrator or Director of Nursing on the Smoking Binder, to go outside with the residents to the designated smoking area when observing smoking, and to secure all smoking paraphernalia after each smoke break. The Smoking Binder will be updated by the Director of Nursing, Assistant Director of Nursing, Unit Manager or Nursing Supervisor on an as needed basis based on new admissions and changes of condition.

After 2/20/23 no staff will be permitted to work without receiving the aforementioned education from the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nursing Supervisor.

Newly hired licensed nurses and agency nurses will receive education on completing a smoking assessment upon admission, quarterly and with a significant change in condition prior to the start of their next scheduled shift or as part of the new hire orientation by the Staff Development Coordinator or Nursing Supervisor.

During their classroom orientation newly hired Smoking Monitors will be educated by the Administrator, Director of Nursing,

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F 689	Continued From page 28	F 689	Staff Development Coordinator on the Smoking Binder, to go outside with the residents to the designated smoking area when observing smoking, and to secure all smoking paraphernalia after each smoke break. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Three times weekly for twelve weeks at various times the Director of Nursing, Assistant Director of Nursing, Unit Manager or Staff Development Coordinator will complete an audit to ensure the residents’ smoking assessments are up to date, smoking care plans are up to date, the Smoking Binder is up-to-date, and the smoking materials are secured. The Department Heads including the Nursing Home Administrator, Director of Nursing, Unit Manager, Staff Development Coordinator, Business Office Manager, Social Worker, Activities Director, Maintenance Director, Medical Record Coordinator and Housekeeper Director will perform random observation audits weekly for twelve weeks to validate residents are receiving the appropriate supervision based on the information in Smoking Binder, that the Smoking Monitor is outside with the residents to the designated smoking area when observing smoking and that smoking paraphernalia is being collected at the end of the smoke break.	

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F 689	Continued From page 29	F 689	The Administrator or Director of Nursing will report the results of the audits to the Quality Assurance Performance Improvement Committee monthly and make changes to the plan as necessary to assure compliance is sustained ongoing.	
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to have a registered nurse (RN) scheduled for 8 consecutive hours a day for 2 of 92 days (09/02/22 and 09/12/22) reviewed for nurse staffing. This deficient practice had the potential to affect all facility residents. Findings Included: Review of the facility's computerized payroll data from 07/01/22 through 09/30/22 revealed there was no registered nurse (RN) in the building on 9/2/22 and 9/12/22.	F 727	F727 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. The facility currently has a minimum of eight Registered Nurse hours per day. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have the	2/20/23

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F 727	Continued From page 30 An interview was conducted with the Nursing Scheduler on 1/10/23 at 2:10 PM. The Nursing Scheduler stated that she was put in charge of scheduling after the former Director of Nursing (DON) left in October 2022. She further stated that she was aware the facility had not had a Registered Nurse in the building for 8 consecutive hours a day every day, but she was unable to recall which days. The Nursing Scheduler indicated that the facility's nursing staffing was provided by 80% agency staff. An interview was conducted with the Administrator and the Regional Vice President of Operations on 1/12/23 at 4:15 PM. The Administrator stated that he expected the facility to have a RN in the building for at least the required 8 hours a day every day.	F 727	potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On February 10, 2023, the Scheduler was educated by the Nursing Home Administrator to ensure a Registered Nurse is scheduled eight consecutive hours daily. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly for twelve weeks the Nursing Home Administrator (NHA), Director of Nursing (DON) or Assistant Director of Nursing (ADON) will audit the nursing schedule and actual hours worked to validate eight consecutive hours of Registered Nurse coverage per day. Results of the audits will be presented by the NHA or DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		2/20/23

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F 732	Continued From page 31 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to: 1) post complete and accurate nurse staffing data for 1 of 5 days during the survey (01/09/23); 2) utilize and post daily staffing forms for 63 days of 73 days (11/01/22-01/02/23 ; and 3) failed to save the daily staffing forms for	F 732	F732 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.	

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F 732	Continued From page 32 the regulatory timeframe of 18 months for 6 of 18 months reviewed for staffing (08/22, 09/22, 10/22, 11/22, 12/22, 01/23). The findings included: 1. Review of the facility daily nurse staffing forms for the week of the survey 01/09/23 -01/13/23 revealed there were no registered nurse (RN) hours listed on the daily staffing form for 01/09/23. An interview was conducted with the Nursing Scheduler on 01/12/23 at 3:00 P.M. The Nursing Scheduler stated there were no hours listed in the registered nurse (RN) column on the daily staffing form on 01/09/23 because there was not an RN working on the unit that day but there were RNs in the building such as the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and the Minimum Data Set (MDS) Nurse. 2. The facility was unable to provide daily staffing forms for 63 days of 73 days (11/01/22-01/02/23). An interview was completed with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 01/12/23 at 3:04 P.M. The DON stated that the facility did not have the daily staffing forms and had not been using them since she started working at the facility in November 2022. She further stated that the facility started posting the daily staffing forms last week when the new Administrator began working at the facility. 3. The facility was unable to provide the daily staffing forms for the last 6 months reviewed for staffing (08/22, 09/22, 10/22, 11/22, 12/22, 01/23).	F 732	Accurate and complete nurse staffing data is currently posted in the facility. The facility is currently utilizing and posting the staffing forms daily. The staffing forms are currently being secured in the facility for the regulatory timeframe of 18 months. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have been identified as having the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: On 2/10/23 the Administrator provided education to the Staffing Coordinator on having accurate and complete nurse staffing data, posting the forms daily and securing the forms for 18 months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The Administrator, Director of Nursing, Staff Development Coordinator or Assistant Director of Nursing will conduct observational audits twice a week for 12 weeks to validate accurate and complete nurse staffing data, posting the forms daily and securing the forms for 18 months. Results of the observational audits will be presented by the	

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F 732	Continued From page 33 An interview was conducted with the Administrator and the Regional Vice President of Operations on 01/12/23 at 4:15 P.M. The Administrator stated that the facility had not been using the CMS daily staffing form until 01/02/23 when he started working at the facility. He further stated that the Daily Staffing Form should be accurate and posted in the front lobby. The Regional Vice President of Operations indicated that the facility would save the daily staffing forms for the required time frame of 18 months.	F 732	Administrator in the monthly Quality Assurance Performance Improvement (QAPI) meeting monthly for three months. The QAPI committee will review the observational audits and make recommendations based on findings to assure compliance is sustained ongoing.	
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 §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	F 755		2/20/23

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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 observations, record review, staff interviews, Pharmacy Supervisor, Nurse Practitioner and Physician Assistant interviews, the facility failed to follow up on medications that were not available from the pharmacy and failed to follow the pharmacy process for ordering and receiving medications for 2 of 2 residents (Resident #22 and #14).

Findings included:

1. Resident #22 was admitted to the facility on 08/29/16. Diagnoses included schizoaffective disorder, bipolar disorder, high blood pressure, allergies, and gastroesophageal reflux disease (GERD).

A review of the physician orders revealed on 08/22/18 an order for Prilosec (Omeprazole) 20 milligrams (mg) one capsule by mouth one time a day for GERD, an order written on 06/11/20 for Valproic Acid Solution 250 mg per 5 milliliters (ml) give 625 mg by mouth two times daily for schizoaffective disorder, and an order written on 06/22/21 for Cetirizine 10 mg by mouth one time daily for allergies.

The Minimum Data Set (MDS) quarterly assessment dated 12/16/22 revealed Resident #22 was moderately cognitively impaired,

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F755 POC

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

Resident #22 and Resident #14 are currently receiving their medications per physician's order.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents who receive medication have been identified as having the potential to be affected.
On 2/9/23 the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a house-wide baseline audit to compare the Medication Administration Record to medications on hand for each resident to assure each resident had medication readily available per physician order. Any medication that was not readily available was re-ordered and the attending physician or physician's extender was notified for further orders. If needed, a medication variance report was

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demonstrated no behaviors, and received 7 days of an antipsychotic medication during this look back period.

The Medication Administration Record (MAR) review for Resident #22 revealed:

" 01/02/23, 01/03/23, 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23 the Valproic Acid Solution order for 625 mg had the #9 recorded for the 9:00 AM dose on 01/02/23, and 01/03/23 and the #9 recorded for both doses (9:00 AM and 9:00 PM on 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23 and 01/10/23.
" 01/08/23 and 01/11/23 the order for Cetirizine 10 mg had the #9 recorded and on 01/08/23, 01/09/23 and 01/11/23 the MAR revealed the order for Prilosec 20 mg had the #9 recorded.
A review of the key coding on the MAR revealed the #9 meant to "see nurse's notes."

A review of the electronic medication administration notes for Resident #22 on 01/02/23 revealed:

" Valproic Acid Solution note indicated "waiting on pharmacy," On 01/03/23 and 01/04/23 the note indicated the Valproic Acid Solution was "on order," and on 01/08/23 the note indicated the Valproic Acid Solution was "reordered." There were no medication notes for 01/05/23, 01/06/23, 01/09/23, or 01/10/23 indicating why the Valproic Acid Solution was not given.
" 01/08/23, the medication note indicated the Cetirizine 10 mg was "out of stock," and on 01/11/23 the note indicated "contacting pharmacy."
" 01/08/23 the medication note indicated the

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completed.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

Weekly on Thursdays going forward the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, or Nurse Supervisor in Charge will audit each medication cart and re-order medications, if indicated. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, or Nurse Supervisor in Charge will use Polaris Connect Pharmacy System to reorder medications.

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge initiated education to each Licensed Nurse on contacting the pharmacy to have back-up pharmacy send any medication that is not available and to contact the Nurse Manager on call. Any Licensed Nurse who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse will be permitted to work after 2/20/23 without receiving the education.

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse and Certified Medication Aid on actions to take

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Prilosec 20 mg order was "out of stock," and on 01/11/23 the note indicated "contacting pharmacy." There was no medication note indicating why the Prilosec was not given on 01/09/23.

An observation of the medication storage room on 01/11/23 at 8:40 AM revealed there was no back up stock of Prilosec or Cetirizine. The medication storage room was noted to have a medication dispensing machine.

An observation of the medication cart on 01/13/23 at 12:40 PM revealed there was a bottle of Valproic Acid Solution for Resident #22 with a label that indicated the order date was 01/06/23 and an opened date of 01/11/23.

An interview was conducted with Medication Aide (MA) #2 on 01/11/23 at 8:40 AM. She stated on 01/02/23 she documented the #9 which meant see nurses' notes for the Valproic Acid Solution for Resident #22 because it was not available and when she looked in the point click care (PCC) system, (an electronic system that was connected to the pharmacy for reordering and receiving medications), she saw it had been ordered so she recorded "waiting on pharmacy" in the nurses' notes. She stated she believed she told Nurse #10 it was not available on 01/02/23. MA #2 stated the Cetirizine was not available on the medication cart on 01/11/23, so she documented the #9. She stated since the Cetirizine was not available and not in the medication storage room she documented "contacting pharmacy" because when she reviewed the PCC system, she noticed the Cetirizine was ordered on 12/29/22. She stated she did not know when the medication would arrive, and she would check with her nurse

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if a medication is not readily available on 2/20/23. Certified Medication Aids will notify the Licensed Nurse if a medication is unavailable. Licensed Nures will notify the Physician or Physician's Extender for further orders if a medication is unavailable. Any Licensed Nurse or Medication Aid who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 2/20/23 without receiving the education.

Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge on medication reordering to ensure medication is available and actions to take if a medication is not readily available during their classroom orientation, prior to provision of care.

Any agency License Nurse or agency Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge on medication reordering to ensure medication is available and actions to take if a medication is not readily available, prior to provision of care.

Indicate how the facility plans to monitor its performance to make sure that

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to contact the pharmacy. MA #2 stated she documented the #9 for the Prilosec order because the medication was not available on her cart or in the medication storage room, so she recorded "out of stock" on the medication note. MA #2 stated she told Nurse #10 the medication was not available.

An interview with Nurse #10 on 01/11/23 at 3:30 PM revealed she could not recall if she was made aware by MA #2 on 01/02/23 that the Valproic Acid Solution was not available for Resident #22, and she further stated MA #2 did not inform her the Cetirizine or the Prilosec medications were not available and were not given to Resident #22 on 01/11/23. Nurse #10 stated she would notify the physician.

An interview was conducted with the Unit Manager (UM) on 01/11/23 at 3:10 PM. She stated Cetirizine and Prilosec were house stock over the counter (OTC) medications so they would not be in the medication dispensing machine, but they would be stored in the medication storage room. The UM reviewed the PCC electronic system and saw that the medication Cetirizine was reordered on 12/29/22. The UM added, that since it was an over-the-counter medication, it should not have been reordered in the PCC system and even though it was reordered that way, we would not have received this medication from the pharmacy because they do not deliver over the counter medications through the PCC system. She stated the OTC medications were ordered by her through a direct supply company and added that she was not aware the medication needed to be ordered so it was not added to her direct supply list. She stated the Medication Aide should have

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solutions are sustained:

Five times weekly for twelve weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe ten residents' medication administration pass to validate medications are available to be administered per order or that the physician was notified for further orders. During the auditing, if it is noted that a medication is not available and the process was not followed, the Licensed Nurse or Medication Aid will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or Staff Development Coordinator. The Licensed Nurse will not be permitted to provide patient care until they can correctly state the facility's process when medication is not available. Each Thursday for 12 weeks, the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, or Nurse Supervisor in Charge will document that each medication cart was audited, and medications were re-order, if indicated. The Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, Unit Manager, or Nurse Supervisor in Charge will use Polaris Connect Pharmacy System to reorder medications. Additionally, twice daily for four weeks, a house wide observational audit of the Electronic Medical Record Dashboard will be performed by the Director of Nursing, Assistant Director of

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let the nurse or her know it was not available on her cart and we could have gotten the medication ordered for the resident. The UM added that the Prilosec OTC medication was ordered 11/27/22 - and she had a recent order for 01/06/23 which meant the Prilosec should be available on the medication carts. She stated Medication Aides and Nurses have been educated to be sure they notify the Unit Manager or Pharmacy if they do not have the prescribed medications and that it was not acceptable to keep recording #9 and not following up on where the medications were. The UM explained that when ordering medications that the pharmacy provided, the process was to go into PCC, select the medication, hit reorder. Once you hit reorder, it communicated electronically with the pharmacy. The UM stated when the medication was delivered to the facility, the nurse receiving the medications would need to go back into PCC to that reorder and select received. The UM stated if you don't record "received" it will mess up future orders. She stated she has had in services with the Nurses regarding this process, but they don't always do it the way they are supposed to, and it has been causing delays with reorders.

A phone interview was conducted with the Pharmacy Supervisor on 01/13/23 at 10:20 AM. The Pharmacy Supervisor stated the Valproic Acid Solution for Resident #22 was ordered on 01/06/23 and received and signed for at the facility on 01/07/23 at 8:17 AM. The Pharmacy Supervisor stated records showed the facility tried to reorder it again on 01/08/23 which flagged as a "refill too soon." She stated the facility was provided with a listing of the "refill too soon" medications on their delivery manifest. The Pharmacy Supervisor stated there were 3 ways of

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Nursing, Unit Manager, or Nurse Supervisor in Charge to assure each resident's medication is administered per physician order. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.

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ordering medications for the facility: 1) Reorder in the PCC system. Once the medication was delivered and received, the nurse would need to enter "received" in the PCC system. She stated if they do not receive the medication, it would not come through accurately on the pharmacy side and it confuses the reordering system. She stated the pharmacy would then "kick back the order" and indicate "not ready to be reordered" on the manifest; 2) they could use the scanner guns which were provided to all the nursing stations which were connected to the pharmacy electronically by scanning the bar code on the label for reorders and returns; or 3) they could remove the sticker from the medication card/bottle and adhere to a pharmacy reorder sheet and fax to the pharmacy.

An interview was conducted with MA #5 on 01/13/23 at 12:14 PM. MA #5 reported when she worked on the medication cart, she would report to the Charge Nurse assigned to that hall. She stated if she did not see an ordered medication on the cart, she would reorder it on PCC, document on the MAR the #9 and put a note in the nurses notes why the medication was not given and notify the charge nurse that it was not given. She stated on 01/03/23, 01/09/23, and 01/10/23 she recorded the #9 for the Valproic Acid Solution for Resident #22 on the MAR because she did not see the medication in the drawer. She stated she could not remember if she asked the nurse if it had been reordered. During this interview, MA #5 identified the open bottle of Valproic Acid Solution in the medication cart and confirmed it was received on 01/07/23 and opened on 01/11/23. She stated she did not recall any bottles of Valproic Acid Solution being in the medication cart on 01/03/23, 01/09/23 or

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01/10/23. MA #5 stated as far as she knew all the medications, including over the counter medications, were ordered through pharmacy by using the PCC system.

An interview was conducted with Nurse #11 on 01/13/23 at 12:47 PM. Nurse #11 confirmed she worked on 01/06/23 and 01/10/23 and documented the #9 on the MAR for the Valproic Acid Solution for Resident #22. She stated she should have put a nurses note in the electronic medication notes to indicate why it was not given on those days. She stated she could not recall if MA #5 notified her on 01/03/23 that the Valproic Acid Solution was not available to be given. She stated on 01/06/23 and 01/09/23 she checked the medication storage room but there was none in there. During this interview, Nurse #11 reviewed the medication cart and confirmed the bottle of Valproic Acid Solution for Resident #22 was in the medication draw and had been ordered on 01/06/23 and delivered on 01/07/23 with an opened date on 01/11/23. She stated she could not explain why it was not given on 01/08/23 and 01/09/23 if it had been delivered on the 01/07/23. She reviewed the MAR and saw that that the medication had been given for both doses on 01/07/23 and stated "it must have been in the cart if it was given on the 01/07/23. She stated there have been a lot of problems with reordering on PCC and it was hit or miss because some nurses used the PCC system, and some did not. She stated she did not use the PCC system to reorder medications and would just fax the orders, but when she received medications from the pharmacy, she would check to see if any of the medications were in PCC and needed to be "received." She stated if the reorder was done in PCC, the nurses need to be "receiving" the

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F 755	Continued From page 41 medication in PCC and she was not sure that was always getting done. Nurse #11 reported she could not recall being notified by the Medication Aides that the Valproic Acid Solution was not given to Resident #22 on 01/03/23, 01/04/2, or 01/05/23 when she was the Charge Nurse on those days. She stated she administered the Prilosec 20 mg on 01/10/23 and recalled their being plenty available for administration. She stated she could not explain why MA #5 and MA #2 did not administer it on 01/08/23 and 01/11/23. Nurse #3 stated she believed she noted in the Physician book which was kept at the nursing station that the medications were not available, and Resident #22 did not receive them. An interview was conducted with the Nurse Practitioner (NP) on 01/13/22 at 1:10 PM. The NP stated Resident #22 was getting Valproic Acid Solution to treat schizoaffective disorder. She stated she was not aware the resident was not receiving the medication as ordered and that not receiving the medication could cause Resident #22 to have breakthrough symptoms with the potential for negative side effects. The NP also stated she was not aware Resident #22 had not received her Cetirizine or Prilosec. During this interview, the physician notebook was reviewed for January 2023 and there was no documentation to indicate Resident #22 had not received any of these medications. The NP assessed Resident #22 and reported she was had her baseline and had no adverse effects from not receiving the medications as ordered. She stated she reviewed the medical records and spoke with the nursing staff, and she has had no behavioral issues as a result of not receiving the medication. She stated knowing this she would consider reducing the dose.	F 755		

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A phone interview with the Physician Assistant (PA) on 01/13/23 at 3:50 PM revealed this was the first time she was hearing about Resident #22 not receiving her Valproic Acid, Prilosec, or Cetirizine. She stated she would have expected to be notified after missing 1 and no more than 2 doses of the Prilosec and Cetirizine, but she would have wanted to have been notified if she was missing any doses of the Valproic Acid. She stated the resident has a history of schizoaffective disorder and missing those doses could have caused her to become unbalanced. She stated if nurses and medication aides were documenting medication "not available," she would expect them to be following up on the medication to make sure it was available and to notify her for additional orders if needed.

An interview with the Regional Clinical Vice President on 01/13/23 at 4:55 PM revealed there was a systems problem with ordering and receiving medications as well as notifying the Charge Nurse when a medication was not available. She stated she would expect nursing staff to be sure the residents were receiving their prescribed medications and to make sure Medication Aides were notifying the Charge Nurses when the medications were not available.

2. Resident # 14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease, and high cholesterol.

Review of the physician's order revealed an order was written on 05/12/22 for Atorvastatin Calcium 10 mg; one tablet daily for high cholesterol and on 05/13/22 an order for Lisinopril tablet 2.5 mg; give

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one tablet daily for high blood pressure.

Review of the Medication Administration Record (MAR) for January 2023 revealed on 01/03/23 the #9 was documented by Nurse #12 for the Atorvastatin. The Lisinopril order was noted to have the letter "X" recorded on 01/06/23 by MA #4, and on 01/07/23 and 01/08/23 by MA #6 under the blood pressure with the #9 and #5 recorded which meant to see nurses' notes.

Review of the electronic medication nursing notes by Nurse #12 on 01/03/23, the note stated Atorvastatin was "not available," and on 01/06/23 by MA #4, 01/07/23 and 01/08/23 by MA #6 the note stated Lisinopril "not available."

Review of Resident #14's blood pressure revealed on 01/06/23 it was recorded as 142/88 mm/hg and on 01/08/23 the blood pressure was 126/70 mm/hg. There were no blood pressure readings on 01/07/23.

An observation of the medication dispensing cart with the Unit Manager on 01/13/23 revealed Lipitor 2.5 mg and Atorvastatin 10 mg were both in stock.

A phone interview with the Pharmacy Supervisor on 01/13/23 at 10:20 AM revealed the pharmacy dispensed Lisinopril 2.5 mg on the evening of the 01/09/23 and it was received on the morning of 01/10/23. She stated the Lisinopril was last filled on 11/26/22 and there was no record of the medication being removed from the medication dispensing unit. The Pharmacy Supervisor stated the Atorvastatin was last filled on 01/08/23 and delivered on 01/09/23 at 8:39 AM. She stated there was no record of the Atorvastatin being

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removed from the medication dispensing unit. The Pharmacy Supervisor stated the facility should not have needed the Atorvastatin because we provided a 30-day supply on 12/10/22 therefore, on 01/03/23 they should have had 7 tablets left. The Pharmacy Supervisor stated with Resident #14 missing 3 days of Lisinopril medication, it could cause the resident to have an increased blood pressure, but it was not likely that the resident would notice it as it was a very mild dose.

An interview with Medication Aide (MA) #4 on 01/11/23 revealed the Lisinopril was not available so she documented the #9 on the MAR "not available." She stated she did not know when it was ordered or when it was coming in, so she just puts the #9. MA #4 stated she did not have access to the medication dispensing unit and the nurse would have to get it. She stated she could not remember if she told the nurse or not on 01/06/23.

Medication Aide #6 who recorded the #5 and #9 on the MAR on 01/07/23 and 01/08/23 was not available for an interview.

Nurse #12 who recorded the #9 for the Atorvastatin on 01/03/23 was not available for an interview.

An interview with Nurse #11 on 01/13/23 at 12:47 PM revealed the Atorvastatin and the Lisinopril were both available in the medication dispensing unit and if the Medication Aide came to her to let her know there was none available on the cart, she would have removed them from the medication dispensing unit. She stated neither MA #4 nor MA #6 ever came to her regarding

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F 755	Continued From page 45 needing those medications not being available for Resident #14. A phone interview was conducted with the Physician Assistant (PA) on 01/13/23 at 3:50 PM. The PA stated she was not made aware Resident #14 had not received these medications. She stated if nurses and medication aides were documenting medication "not available," she would expect them to be following up on the medication to make sure it was available and to notify her for additional orders if needed. The PA stated given that the Lisinopril was a low dose it was not likely that it would affect the resident's blood pressure with 3 doses being missed. An interview with the Regional Clinical Vice President on 01/13/23 at 4:55 PM revealed there was a systems problem with ordering and receiving medications as well as notifying the Charge Nurse when a medication was not available. She stated she would expect nursing staff to be sure the residents were receiving their prescribed medications and to make sure Medication Aides were notifying the Charge Nurses when the medications were not available.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any	F 756		2/20/23

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irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, Pharmacist Consultant, Physician and Physician Assistant interviews the facility failed to act upon the Pharmacist's recommendation from the monthly Consultant Pharmacist Medication Regimen Review for 1 of 5 residents (Resident #24) observed for unnecessary medications.

Findings included:

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Resident Affected:

Resident #24 as needed order for Clonazepam was discontinued per physician’s order on 1/13/2023.

Residents with Potential to be Affected:

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Resident #24 was admitted to the facility on 11/02/22. Diagnoses included major depressive disorder, bipolar disorder, and anxiety disorder.

A physician's order was written on 11/02/22 for Clonazepam (medication to treat anxiety) 0.5 milligrams. Give one tablet by mouth every 12 hours as needed for anxiety. The order did not include a 14-day limited duration which would have a stop date of 11/16/22. This order was in place until 01/11/23.

The Minimum Data Set 5-day admission assessment dated 11/07/22 revealed Resident #24 was cognitively intact, demonstrated no behaviors and received 6 days of an antidepressant and 5 days of opioids (narcotic pain medication). She was not coded as receiving any antianxiety medications during this review period.

During a medication regimen review, a Consultant Pharmacist recommendation dated 11/27/22 revealed Resident #24 had an as needed (PRN) order for a psychotropic drug, Clonazepam 0.5 mg, which had been in place for greater than 14 days without a stop date. The recommendation was to consider either (1) discontinuing the PRN order, or (2) provide rationale for extended time period and indicate a specific duration. Record review revealed the recommendation was not acted upon. The facility was not able to provide a signed MMR from the physician for this recommendation.

The December MRR's were requested and reviewed and there was no recommendation regarding the Clonazepam 0.5 milligram order for

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Effective February13, 2023 the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a 100% audit of all residents on as needed psychotropic medications to ensure there was an appropriate stop date and contact the physician or physician's extender for further orders if needed or ensure a rationale and duration for continued use is documented. On February13, 2023 the Director of Nursing conducted an audit of Consulting Pharmacist Recommendations for the past three months. Those residents identified as not having timely follow-up were reviewed by the Physician with further orders, if any, implemented.

Systematic Changes:

On 1/23/23 the Regional Vice President of Clinical Services educated the Nurse Management Leaders (Director of Nursing, Assistant Director of Nursing, and Unit Manager) on reviewing and providing to the attending physician or physician extender the pharmacy recommendations. The Staff Development Coordinator, Director of Nursing or Nursing Supervisor educated Licensed Nurses when receiving physician or physician extender orders to obtain a 14-day stop date for all psychotropic medications prescribed on an as needed basis or to ensure a rationale and duration for continued use is documented. The Director of Nursing will be responsible for ensuring pharmacy recommendations are communicated to

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Resident #24.

An interview with the Director of Nursing (DON) on 01/11/23 at 4:45 PM. The DON stated the pharmacy medication regimen reviews were done monthly and submitted to the DON via email by the Pharmacist Consultant. She stated when she received the recommendations, she printed them off and gave them to the Assistant Director of Nursing to manage.

An interview with the Assistant Director of Nursing (ADON) on 01/11/23 at 4:45 PM revealed she had placed the pharmacy recommendations in the Physician and Physician Assistant's box in their office to review and sign. The ADON stated she recalled the providers signing them and returning the recommendations to her for the month of November, but she could not find them. She stated her process was when she received the recommendations back from the providers she would review and implement any new orders they had indicated on the recommendation and put a check mark on the recommendation, so she knew it was reviewed, but she was unable to find the reviewed and signed recommendations from November.

An interview with the Physician 01/12/23 at 12:10 PM revealed he had not received the pharmacy recommendations and if had he would have addressed the recommendation and signed it. The Physician stated he was aware the Clonazepam order should have been discontinued after 14 days since it was an as needed medication or a rationale should have been provided to continue the medication.

An interview with the Physician Assistant on

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the physician or physician extender and follow-up recommendations / orders are implemented by the Nurse Management Leaders. After 2/20/23 no Licensed Nurses will be permitted to work without receiving the aforementioned education from the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nurse Supervisor.

Newly hired licensed nurses and agency nurses will receive education, prior to working or as part of the new hire orientation, by the Staff Development Coordinator or Nursing Supervisor on obtaining a 14-day stop date for all psychotropic medications prescribed on an as needed basis or ensure a rationale and duration for continued use is documented.

Monitoring:

The Director of Nursing or Unit Manager will conduct audits of ten residents with as needed psychotropic medication orders for 14-day stop dates or rationale and duration for continued use is documented. Monitoring will be completed weekly for three months and as necessary thereafter. The Consultant Pharmacist Recommendation to be audited for completion by the Director of Nursing each month for three months. The Administrator or Director of Nursing will report the audit findings to the Quality Assurance Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance

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F 756	Continued From page 49 01/13/23 at 3:50 PM via phone stated she recalled the ADON bringing the pharmacy recommendations to her back in November, and she reviewed and signed them and brought them back to the ADON and put them on her desk but could not recall specifically if one of them was for Resident #24's PRN order for Clonazepam. A phone interview was conducted with the Consulting Pharmacist on 01/18/23 at 11:27 AM. The Consulting Pharmacist stated during her December pharmacy reviews she did not see a response to her recommendation from 11/27/22. The Pharmacist read a note from her December Pharmacy Report dated 12/27/22 that the recommendation for the Clonazepam order for Resident #24 was not acted upon and she submitted a separate MRR for the facility to review the active recommendation that was lacking a final response.	F 756	Performance Improvement Committee will make recommendations to the plan as necessary to assure compliance is sustained ongoing.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		2/20/23

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F 758	Continued From page 50 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, Nurse Practitioner and Pharmacist Consultant interviews the facility failed to ensure an as needed (PRN) psychotropic medication (medications used to manage behaviors and psychiatric symptoms) was limited to 14 days or document the continued	F 758	F 758 POC Resident Affected: Resident #24 as needed order for Clonazepam was discontinued per	

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use with a rationale and duration for 1 of 5 residents (Resident #24) reviewed for unnecessary medications.

Findings included:

Resident #24 was admitted to the facility on 11/02/22. Diagnoses included major depressive disorder, bipolar disorder, and anxiety disorder.

A physician's order was written on 11/02/22 for Clonazepam (medication to treat anxiety) 0.5 milligrams. Give one tablet by mouth every 12 hours as needed for anxiety. The order did not include a 14-day limited duration which would have a stop date of 11/16/22. This order was in place until 01/11/23.

The Minimum Data Set 5-day admission assessment dated 11/07/22 revealed Resident #24 was cognitively intact, demonstrated no behaviors and received 6 days of an antidepressant and 5 days of opioid (narcotic pain medication). She was not coded as receiving any antianxiety medications during this review period.

A review of the Medication Administration Record from November 2, 2022, through January 11, 2023, revealed Resident #24 received the ordered Clonazepam as needed for 37 doses in November of which 19 of those doses were after 11/16/22, 36 doses were administered in December, and 13 doses were administered in January.

An interview with the Director of Nursing (DON) on 01/11/23 at 4:45 PM revealed the as needed Clonazepam 0.5 mg was an active order up until today (01/11/23) and the order should have had a

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physician’s order on 1/13/2023.

Residents with Potential to be Affected:

Effective February13, 2023 the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a 100% audit of all residents on as needed psychotropic medications to ensure there was an appropriate stop date and contact the physician or physician’s extender for further orders if needed or ensure a rationale and duration for continued use is documented. On February13, 2023 the Director of Nursing conducted an audit of Consulting Pharmacist Recommendations for the past three months. Those residents identified as not having timely follow-up were reviewed by the Physician with further orders, if any, implemented.

Systematic Changes:

The Staff Development Coordinator, Director of Nursing or Nursing Supervisor educated Licensed Nurses when receiving physician or physician extender orders to obtain a 14-day stop date for all psychotropic medications prescribed on an as needed basis or to ensure a rationale and duration for continued use is documented. After 2/20/23 Licensed Nurses will not be permitted to work without receiving the aforementioned education from the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nurse Supervisor.

On 1/23/23 the Regional Vice President of

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stop date. The DON stated the nurse that put the order in the system should have clarified the order with the physician and obtained a stop date.

An interview was conducted with Nurse #8 on 01/11/23 and 12:20 PM. She stated the PRN psychotropics should have a stop date and she should have clarified the order with the provider. She stated she overlooked it when putting the orders in for Resident #24.

An interview with Nurse Practitioner #2 on 01/12/23 at 1:10 PM revealed she had not realized the PRN Clonazepam order did not have a stop date until yesterday when she was given the pharmacy recommendations, and she changed it to be scheduled twice daily.

A phone interview was conducted with the Consulting Pharmacist on 01/18/23 at 11:27 AM. The Consulting Pharmacist stated anytime there were orders for as needed psychotropics they should always include a stop date and added that no psychotropic medication should go beyond 14 days unless there was a clinical reason. The Consulting Pharmacist stated it was important to keep the residents on the lowest dose and frequency as necessary to treat their condition.

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Clinical Services educated the Nurse Management Leaders (Director of Nursing, Assistant Director of Nursing, and Unit Manager) on reviewing and providing to the attending physician or physician extender the pharmacy recommendations. The Director of Nursing will be responsible for ensuring pharmacy recommendations are communicated to the physician or physician extender and follow-up recommendations / orders are implemented by the Nurse Management Leaders.

Newly hired licensed nurses and agency nurses will receive education, prior to working or as part of the new hire orientation, by the Staff Development Coordinator or Nursing Supervisor on obtaining a 14-day stop date for all psychotropic medications prescribed on an as needed basis or ensure a rationale and duration for continued use is documented.

Monitoring:

The Director of Nursing or Unit Manager will conduct audits of ten residents with as needed psychotropic medication orders for 14-day stop dates or rationale and duration for continued use is documented. Monitoring will be completed weekly for three months and as necessary thereafter. The Consultant Pharmacist Recommendation to be audited for completion by the Director of Nursing each month for three months. The

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F 758	Continued From page 53	F 758	Administrator or Director of Nursing will report the audit findings to the Quality Assurance Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance Performance Improvement Committee will make recommendations to the plan as necessary to assure compliance is sustained ongoing.	
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 observations, record review, and staff interviews the facility failed to maintain a medication error rate of less than 5% as evidenced by 3 medication errors out of 27 opportunities resulting in a medication error rate of 10.71% for 2 of 4 residents (Resident #14 and Resident #24) observed for medication administration. Findings included: 1) Resident #24 was admitted to the facility on 11/02/22. Diagnoses included hypertensive (high blood pressure) chronic kidney disease. The Minimum Data Set 5-day admission assessment dated 11/07/22 revealed Resident #24 was cognitively intact.	F 759	F759 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #22 and Resident #14 are currently receiving their medications per physician's order. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who have physician's orders for medication have been identified as having the potential to be affected.	2/20/23

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Physician orders written on 11/06/22 revealed an order for Carvedilol 12.5 milligrams (mg) give one tablet by mouth twice daily for high blood pressure and an order for Amlodipine Besylate 5 mg give one tablet by mouth daily for high blood pressure. No blood pressure or pulse parameters were written as part of the physicians' orders to indicate blood pressure medications should be held.

The Medication Administration Record (MAR) for January 2023 revealed the Amlodipine and Carvedilol orders were noted to have a block to record blood pressure and pulse along with the prescribed time to be given. On 01/11/23 the blocks for the blood pressure and pulse readings were marked with an "x" and the #11 was recorded next to the administration time for the Amlodipine and Carvedilol medications with Medication Aide (MA) #4's initials. Review of the key coding for charting at the bottom of the MAR revealed #11 meant to "hold per parameters."

An observation of medication administration with MA #4 on 01/11/23 with Resident #24 at 9:20 AM was conducted. MA #4 dispensed the following medications in the medication cup: Atorvastatin 40 mg one tablet, Lamotrigine 100 mg one tablet, Omeprazole 20 mg one tablet, Tramadol 50 mg one tablet and Clonazepam 0.5 mg one tablet. MA #1 administered the medications to Resident #24 at 9:21 AM and stated that completed her medication pass for Resident #24.

During a reconciliation review of all medications that were ordered to be given to Resident #24 at the time of her medication pass on 01/11/23 at 9:20 AM revealed Carvedilol 12.5 mg and Amlodipine Besylate 5 mg were not given as

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Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse and Certified Medication Aid on the rights of medication administration, following physician’s orders for medication administration and not rushing through medication administration pass. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 2/20/23 without receiving the education.

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse and Certified Medication Aid on actions to take if they have concerns about administering a medication per physician’s order to include notification of a licensed nurse or physician for further direction. Any Licensed Nurse or Medication Aid who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 2/20/23 without

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ordered.

During an interview with MA #4 on 01/11/23 at 12:20 PM, MA #4 revealed she held the blood pressure medications because her blood pressure was low. MA #4 was unable to find the recordings of what the blood pressure was but stated she believed it was 102/82 and she felt that was too low to administer the resident her blood pressure medications. MA #4 stated she had not notified the charge nurse at this time, and she was waiting to finish her medication pass. MA #4 stated there were no parameters ordered to hold the medication and she should have notified the nurse before making the decision to hold the blood pressure medications.

An interview was conducted with the Director of Nursing (DON) on 01/12/23 at 4:45 PM. The DON reported she would have expected MA #4 to notify the nurse in charge what the blood pressure and pulse reading was and the MA should not have made the decision to withhold the blood pressure medications.

2) Resident # 14 was admitted to the facility on 09/03/13 with diagnosis to include high blood pressure and coronary artery disease.

The annual MDS assessment dated 10/28/22 revealed Resident #14 was cognitively intact.

A review of the physician orders revealed an order written on 05/13/22 for Metoprolol Succinate Extended Release 25 mg; give one tablet by mouth daily for high blood pressure.

An observation of medication administration with Medication Aide (MA) #4 on 01/11/23 with

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receiving the education.

Each Licensed Nurse and Medication Aid will have a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor completed on or before 2/20/23. Any Licensed Nurse and Medication Aid who does not pass the Medication Administration Pass Competency will have immediate one to one re-education and will not be permitted to work without direct supervision by the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor. The Licensed Nurse or Medication Aid will be given another Medication Administration Pass Competency and must pass the competency in order to work independently.

After 2/20/23 no Licensed Nurse and Medication Aid will be permitted to administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.

Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge on following physician's orders for

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Resident #14 at 9:30 AM was conducted. MA #4 very quickly withdrew all the medication cards from the medication cart of the meds that were to be dispensed which included Lisinopril 2.5 mg, Protonix 40 mg, Potassium Chloride 10 milliequivalents, Prednisone 5 mg, Sertraline 150 mg, Simethicone 80 mg, Metoprolol Succinate 25 mg, and Aspirin 81 mg. MA #1 was observed moving very swiftly while putting one tablet of a 50 mg Sertraline and one tablet of 100 mg Sertraline in the medication cup followed by 1 tablet each of all the other medications except the Metoprolol Succinate and putting the cards back in the cart. MA #1 was noted to not remove any medication from the Metoprolol Succinate card, but quickly placed the card back in the medication cart. MA #1 closed her medication cart, locked the cart, and began to walk away from the cart to the resident's room. MA #1 was asked if she had completed dispensing all of Resident #14's medication and she replied, "Yes." MA #4 was asked to count the number of medications she had dispensed in her cup. The MA counted her pills for a total of 8. At this time, the medications that were recorded as removed from the cards were reviewed with MA #4. MA #4 stated she forgot to put the Metoprolol Succinate in the medication cup and had put the card away. MA #4 removed the Metoprolol and added it to the medication cup to be administered to Resident #14. MA #4 stated she needed to slow down when she was dispensing her medications.

An interview was conducted with the Director of Nursing (DON) on 01/12/23 at 4:45 PM. The DON reported she would expect MA #4 to take her time during the medication pass to make sure she was not omitting any medications that needed to be administered.

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medication administration and not rushing through medication administration pass and actions to take if they have concerns about administering a medication per physician's order to include notification of a licensed nurse or physician for further direction during their classroom orientation, prior to provision of care.

Any agency License Nurse or agency Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge on following physician's orders for medication administration and not rushing through medication administration pass and actions to take if they have concerns about administering a medication per physician's order to include notification of a licensed nurse or physician for further direction, prior to provision of care.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Five times weekly for twelve weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe ten residents' medication administration pass to validate medications were administered per order or that the physician was notified for further orders. During the auditing, if it is noted that that the process was not followed, the Licensed Nurse or

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F 759	Continued From page 57	F 759	Medication Aid will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or Staff Development Coordinator. The Licensed Nurse or Medication Aid will not be permitted to provide patient care until they can correctly state the facility's process for ordering medication. Additionally, twice daily for four weeks, a house wide observational audit of the Electronic Medical Record Dashboard will be performed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge to assure each resident's medication is administered per physician order. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.	
F 760 SS=E	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 observations, record review, staff interviews, Pharmacy Supervisor, Pharmacy Consultant, Nurse Practitioner and Physician Assistant interviews, the facility failed to	F 760	F760 POC Address how corrective action will be accomplished for those residents found to	2/20/23

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administer 14 doses of Valproic Acid Solution for 1 of 2 residents observed for significant medication errors (Resident #22).

Findings included:

Resident #22 was admitted to the facility on 08/29/16. Diagnoses included schizoaffective disorder and bipolar disorder.

A review of the physician orders revealed an order was written on 06/11/20 for Valproic Acid Solution 250 mg per 5 milliliters (ml) give 625 mg by mouth two times daily for schizoaffective disorder.

The Minimum Data Set (MDS) quarterly assessment dated 12/16/22 revealed Resident #22 was moderately cognitively impaired, demonstrated no behaviors, and received 7 days of an antipsychotic medication during this look back period.

The Medication Administration Record (MAR) review for Resident #22 revealed:

" On 01/02/23, 01/03/23, 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23 the Valproic Acid Solution order for 625 mg had the #9 recorded for the 9:00 AM dose on 01/02/23, and 01/03/23 and the #9 recorded for both doses (9:00 AM and 9:00 PM on 01/04/23, 01/05/23, 01/06/23, 01/08/23, 01/09/23, and 01/10/23.
A review of the key coding on the MAR revealed the #9 meant to "see nurse's notes."

A review of the electronic medication administration notes for Resident #22 on 01/02/23 revealed:

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have been affected by the deficient practice:

Resident #22 is currently receiving their medications per physician's order.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents who have physician's orders for medication have been identified as having the potential to be affected.

Residents who receive medication have been identified as having the potential to be affected.
On 2/13/23 the Director of Nursing, Assistant Director of Nursing, and Unit Manager conducted a house-wide baseline audit to compare the Medication Administration Record to medications on hand for each resident to assure each resident had medication readily available per physician order. Any medication that was not readily available was re-ordered and the attending physician or physician's extender was notified for further orders. If needed, a medication variance report was completed.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided

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" Valproic Acid Solution note indicated "waiting on pharmacy," On 01/03/23 and 01/04/23 the note indicated the Valproic Acid Solution was "on order,"
" On 01/08/23 the note indicated the Valproic Acid Solution was "reordered."
" There were no medication notes for 01/05/23, 01/06/23, 01/09/23, or 01/10/23 indicating why the Valproic Acid Solution was not given.

An observation of the medication cart on 01/13/23 at 12:40 PM revealed there was a bottle of Valproic Acid Solution for Resident #22 with a label that indicated the order date was 01/06/23 and an opened date of 01/11/23.

An interview was conducted with Medication Aide (MA) #2 on 01/11/23 at 8:40 AM. She stated on 01/02/23 she documented the #9 which meant see nurses' notes for the Valproic Acid Solution for Resident #22 because it was not available and when she looked in the point click care (PCC) system (an electronic system that was connected to the pharmacy for reordering and receiving medications), she saw it had been reordered so she recorded "waiting on pharmacy" in the nurses' notes. She stated she believed she told Nurse #10 it was not available on 01/02/23.

An interview with Nurse #10 on 01/11/23 at 3:30 PM revealed she could not recall if she was made aware by MA #2 on 01/02/23 that the Valproic Acid Solution was not available for Resident #22.

An interview was conducted with the Unit Manager (UM) on 01/11/23 at 3:10 PM. She stated the Medication Aide should have let the nurse or her know the Valproic Acid Solution was

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education to each Licensed Nurse and Certified Medication Aid on following physician's orders for medication administration. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 2/20/23 without receiving the education.

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse on timely medication reordering to ensure medication is available. Any Licensed Nurse who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse will be permitted to work after 2/20/23 without receiving the education.

The Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge provided education to each Licensed Nurse and Certified Medication Aid on actions to take if a medication is not readily available. Any Licensed Nurse or Medication Aid who did not receive the education by 2/20/23 will not be permitted to work and will receive the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be

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not available on her cart and we could have gotten the medication ordered for the resident. She stated Medication Aides and Nurses have been educated to be sure they notify the Unit Manager or Pharmacy if they do not have the prescribed medications and that it was not acceptable to keep recording #9 and not following up on where the medications were.

A phone interview was conducted with the Pharmacy Supervisor on 01/13/23 at 10:20 AM. The Pharmacy Supervisor stated the Valproic Acid Solution for Resident #22 was ordered on 01/06/23 and received and signed for at the facility on 01/07/23 at 8:17 AM. The Pharmacy Supervisor stated missing doses of the Valproic Acid could cause the resident to have increased behavioral issue and could be distressful on the resident.

An interview was conducted with MA #5 on 01/13/23 at 12:14 PM. MA #5 reported when she worked on the medication cart, she would report to the Charge Nurse assigned to that hall. She stated if she did not see an ordered medication on the cart, she would reorder it on PCC, document on the MAR the #9 and put a note in the nurses notes why the medication was not given and notify the charge nurse that it was not given. She stated on 01/03/23, 01/09/23, and 01/10/23 she recorded the #9 for the Valproic Acid Solution for Resident #22 on the MAR because she did not see the medication in the drawer. She stated she could not remember if she asked the nurse if it had been reordered. During this interview, MA #5 identified the open bottle of Valproic Acid Solution in the medication cart and confirmed it was received on 01/07/23 and opened on 01/11/23. She stated she did not

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permitted to work after 2/20/23 without receiving the education.

Each Licensed Nurse and Medication Aid will have a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor completed on or before 2/20/23. Any Licensed Nurse and Medication Aid who does not pass the Medication Administration Pass Competency will have immediate one to one re-education and will not be permitted to work without direct supervision by the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor. The Licensed Nurse or Medication Aid will be given another Medication Administration Pass Competency and must pass the competency in order to work independently.

After 2/20/23 no Licensed Nurse and Medication Aid will be permitted to administer medications without having a Medication Administration Pass Competency with the Director of Nursing, Assistant Director of Nursing, Unit Manager, Staff Development Coordinator or Nursing Supervisor.

Any newly hired License Nurse and newly hired Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge

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recall any bottles of Valproic Acid Solution being in the medication cart on 01/03/23, 01/09/23 or 01/10/23.

An interview was conducted with Nurse #11 on 01/13/23 at 12:47 PM. Nurse #11 confirmed she worked on 01/06/23 and 01/10/23 and documented the #9 on the MAR for the Valproic Acid Solution for Resident #22. She stated she should have put a nurses note in the electronic medication notes to indicate why it was not given on those days. She stated on 01/06/23 and 01/10/23 she checked the medication storage room but there was none in there. She stated she could not recall if MA #5 notified her on 01/03/23 that the Valproic Acid Solution was not available to be given. During this interview, Nurse #11 reviewed the medication cart and confirmed the bottle of Valproic Acid Solution for Resident #22 was in the medication draw and had been ordered on 01/06/23 and delivered on 01/07/23 with an opened date on 01/11/23. She stated she could not explain why it was not given on 01/08/23 and 01/09/23 if it had been delivered on the 01/07/23. She reviewed the MAR and saw that that the medication had been given for both doses on 01/07/23 and stated "it must have been in the cart if it was given on the 01/07/23.
Nurse #11 reported she could not recall being notified by the Medication Aides that the Valproic Acid Solution was not given to Resident #22 on 01/04/23 or 01/05/23 when she was the Charge Nurse on those days. Nurse #11 stated she believed she noted in the Physician's communication book which was kept at the nursing station that the medications were not available, and Resident #22 did not receive them.

An interview was conducted with the Nurse

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on following physician's orders for medication administration on timely medication reordering to ensure medication is available, and on actions to take if a medication is not readily available during their classroom orientation, prior to provision of care.

Any agency License Nurse or agency Certified Medication Aid will receive the education from the Staff Development Coordinator, Director of Nursing, Unit Manager, or Nurse Supervisor in Charge, on following physician's orders for medication administration on timely medication reordering to ensure medication is available, and on actions to take if a medication is not readily available prior to provision of care.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

Five times weekly for twelve weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe ten residents' medication administration pass to validate competency to include medications were administered per order or that the physician was notified for further orders. During the auditing, if it is noted that that the process was not followed, the Licensed Nurse or Medication Aid will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or

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F 760	Continued From page 62 Practitioner (NP) on 01/13/22 at 1:10 PM. The NP stated Resident #22 was getting Valproic Acid Solution to treat schizoaffective disorder. She stated she was not aware the resident was not receiving the medication as ordered and that not receiving the medication could cause Resident #22 to have breakthrough symptoms with the potential for negative side effects. During this interview, the physician communication book was reviewed for January 2023 and there was no documentation to indicate Resident #22 had not received the Valproic Acid Solution. The NP assessed Resident #22 and reported she was had her baseline and had no adverse effects from not receiving the medications as ordered. She stated she reviewed the medical records and spoke with the nursing staff, and she has had no behavioral issues as a result of not receiving the medication. She stated knowing this she would consider reducing the dose. A phone interview with the Physician Assistant (PA) on 01/13/23 at 3:50 PM revealed this was the first time she was hearing about Resident #22 not receiving her Valproic Acid. The PA stated she would have wanted to have been notified if she was missing any doses of the Valproic Acid. She stated the resident has a history of schizoaffective disorder and missing those doses could have caused her to become unbalanced. She stated if nurses and medication aides were documenting medication "not available," she would expect them to be following up on the medication to make sure it was available and to notify her for additional orders if needed. An interview with the Regional Clinical Vice President on 01/13/23 at 4:55 PM revealed there was a systems problem with ordering and	F 760	Staff Development Coordinator. The Licensed Nurse or Medication Aid will not be permitted to provide patient care until they can correctly state the facility's process for ordering medication. Additionally, twice daily for four weeks, a house wide observational audit of the Electronic Medical Record Dashboard will be performed by the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge to assure each resident's medication is administered per physician order. The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.	

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F 760	Continued From page 63 receiving medications as well as notifying the Charge Nurse when a medication was not available. She stated she would expect nursing staff to be sure the residents were receiving their prescribed medications and to make sure Medication Aides were notifying the Charge Nurses when the medications were not available. A phone interview was conducted with the Pharmacy Consultant on 01/18/23 at 11:27 AM. She stated if a medication was not available, she would expect the nursing staff to research as to when it was reordered and when it would arrive and to notify the physician for additional orders until the medication arrived. She stated just documenting the #9 and not following through was not what she would expect the nursing staff to be doing, and added, "there needs to be follow up." The Pharmacy Consultant stated she did not feel Resident #22 was as risk for any serious outcome as a result of not receiving the Valproic Acid because it was being given for her schizoaffective disorder and not to treat seizures.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761		2/20/23

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F 761	Continued From page 64 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed (500 hall medication cart) during a medication pass. Findings included: During a medication administration observation on 01/11/23 at 9:20 AM with Medication Aide (MA) #4 on the 500 hall, MA #4 was observed dispensing her medications into a medication cup and bringing them to the resident without first locking her cart. MA #4 had the medication cart facing a resident's room. Several staff were observed in the hallway at this time including two residents in their wheelchairs propelling by the cart. An interview was conducted with MA #4 on 01/11/23 at 9:22 AM. The MA stated she was rushing to finish her medication pass and she should have made sure the medication cart was secured before she walked away from it.	F 761	F 761 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: When not attended, the 500 Hall medication cart is currently being locked with medications secured. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents residing in the facility have the potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The Staff Development Coordinator	

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F 761	Continued From page 65 A second medication administration observation on 01/11/23 at 9:30 AM with MA #4 on the 500 hall was conducted. During the observation, MA #4 had the medication cart facing the resident's room. She was unable to locate a resident's nasal spray in her medication cart. She locked the cart, but left the top drawer opened and exposed several opened bottles of over-the-counter medications, insulin injection pens, nasal spray bottles and eye drops and walked away stating she would check the medication storage room for the nasal spray. MA #4 was away from her unsecured cart for 4 minutes. Several staff were observed in the hallway at this time including three residents in their wheelchairs propelling by the cart. An interview was conducted with MA #4 on 01/11/23 at 9:34 AM. MA #4 stated she was rushing, and she did not realize she left the top drawer opened when she locked the cart. An interview was conducted with the Director of Nursing on 01/22/23 at 4:40 PM. The DON stated she expected the nursing staff to secure their medication carts anytime they were leaving their carts unattended.	F 761	educated the Licensed Nurses and Certified Medication Aides to secure the medication cart when not in use and to not leave medications unattended. After 2/20/23 no Licensed Nurses of Certified Medication Aides will be permitted to work without receiving the aforementioned education from the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, or Nurse Supervisor. Newly hired Licensed Nurses and Certified Medication Aides will be educated during their classroom orientation period to secure the medication cart when not in use and to not leave medications unattended. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Five times weekly for twelve weeks the Director of Nursing, Assistant Director of Nursing, Unit Manager, or Nurse Supervisor in Charge will randomly observe each medication cart to validate that medications are stored in a locked medication cart when unattended. During the auditing, if it is noted that that the process was not followed, the Licensed Nurse or Medication Aid will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing or Staff Development Coordinator. The Licensed Nurse or Medication Aid will not be permitted to provide patient care until they can correctly state the facility's process for ordering medication. The audits will be	

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F 761	Continued From page 66	F 761	presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility's Quality Assurance & Performance Improvement Program (QAPI) failed to maintain implemented procedures and monitor interventions that the committee put into place following a recertification and complaint investigation on 11/19/21 and complaint investigations on 04/21/22 and 11/08/22. This was for 4 deficiencies that were originally cited in the areas of safe, homelike environment, accurate coding of the minimum data set assessments, significant medication errors and medication storage and were subsequently recited on the current recertification, complaint and follow up survey of 01/20/23. The continued failure during 4 surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 867	F867 POC Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: August Healthcare Vice President, Regional Vice President of Clinical Services and Regional Vice President of Operations assisted the facility leaders with the review and evaluation of the statement of deficiencies (SOD) and in the development of the plan of correction (POC). Address how the facility will identify other residents having the potential to be affected by the same deficient practice:	2/20/23

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F 867

Continued From page 67

Findings included:

This tag is cross referenced to:

F584: Based on observations and staff interviews the facility failed to: 1a) repair torn floor linoleum in 3 of 13 resident rooms (508, 600, and 603), 1b) failed to remove the black greenish substance from the commode base caulking in 4 of 13 resident rooms (506, 508, 510, and 615), 1c) failed to ensure the ceilings were free from damaged drywall in 2 of 4 shower rooms (500 and 600 halls), 1d) failed to repair a broken wall cabinet door in 1 of 13 resident rooms (502), 1e) failed to replace rough, worn, splintered hand-rails on the 500 and 600 halls, 1f) failed to repair leaking commode bases in 4 of 13 resident rooms (506, 508, 510, and 612). 1g) failed to repair drywall wall damage in 3 of 13 resident rooms (501, 508, and 615), 1h) failed to replace broken or missing floor tile in 8 of 13 resident rooms (502, 508, 600, 609, 610, 612, 614, and 615), and 1i) failed to replace broken window blinds in 2 of 13 resident rooms (600 and 613). During the complaint investigation survey on 11/08/22 the facility failed to eliminate a strong urine odor noted on the 500/600 hall section of the facilities' long term care section of the building for 2 of 6 halls observed.

During the complaint investigation survey on 04/21/22 the facility failed to maintain a clean and sanitary environment by mold growing on the wall in 1 of 3 rooms observed for environment (room 200).

F641: Based on record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for

F 867

Residents residing in the facility have the potential to be affected.
The measures the facility will take to ensure the problem will be corrected and will not reoccur:
On 2/13/23 the Regional Vice President of Clinical Services provided education and training to the Facility Administrator regarding the Quality Assessment Performance Improvement (QAPI) process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited. On 2/13/23, under the direction and supervision of the Regional Vice President of Clinical Services, the Administrator provided education and training to the Director of Nursing, Assistant Director of Nursing, Unit Manager, MDS Coordinator (MDSC), Maintenance Director, Staff Development and Social Service Director on the QAPI process and the need of maintaining implemented procedures and monitoring those interventions put in place after deficient practice has been alleged and cited.
Indicate how the facility plans to monitor its performance to make sure that solutions are sustained:

An Ad Hoc QAPI meeting was held on 2/14/2023, to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab

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F 867	Continued From page 68 medications received (Resident #24) and falls (Resident #35) for 2 of 33 residents reviewed. During the annual recertification and complaint survey on 11/19/21 the facility failed to accurately code an MDS assessment for activities of daily living whose MDS assessment was coded as extensive assistance for eating and toileting use for a dependent resident (Resident #5); and failed to accurately code an MDS assessment for range of motion (Resident #15) for 2 of 18 residents whose MDS were assessed. F760: Based on observations, record review, staff interviews, Pharmacy Supervisor, Pharmacy Consultant, Nurse Practitioner and Physician Assistant interviews, the facility failed to administer 14 doses of Valproic Acid Solution for 1 of 2 residents observed for significant medication errors (Resident #22). During the complaint investigation survey on 11/08/22 the facility failed to accurately administer medications when Resident #1 was administered medications belonging to Resident #6 to include Metoprolol (a blood pressure medication) 50 milligrams (mg) and Xanax (an antianxiety medication) 1 mg resulting in Resident #1 having increased sleepiness and a decrease in blood pressure which required her to be sent to the Emergency Room for further evaluation for 1 of 2 residents reviewed for medication errors. F761: Based on observations and staff interviews the facility failed to keep unattended medications stored in a locked medication cart for 1 of 3 medication carts observed (500 hall medication cart) during a medication pass.	F 867	Services Director, Admissions Director, and Regional Vice President of Clinical Services. The QAPI Committee will meet weekly for (4) weeks starting on 02/14/23, then monthly until substantial compliance is obtained, to monitor the implementation of the plan of correction, including the education component and the ongoing audits, to evaluate the effectiveness of the plan of correction and if necessary, provide additional education and request additional audits / reports. The Administrator is responsible for ensuring this plan of correction is implemented.	

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F 867	Continued From page 69 During the complaint investigation survey on 11/08/22 the facility failed to keep unattended medications stored in a locked medication cart for 1 of 2 medication carts observed (500 hall medication cart). An interview was conducted with the Regional Director of Clinical Services (RDCS) and the Administrator on 01/13/23 at 4:53 PM and stated they believed their QAPI plan was ineffective for significant medication errors and medication storage because they stopped auditing and monitoring too soon and did not continue to make sure the nursing staff stayed in compliance. The RDCS and the Administrator stated they believed their QAPI plan was ineffective for clean, safe homelike environment because they failed to identify all the problems that needed repairs.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		2/20/23

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F 880	Continued From page 70 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880 Continued From page 71

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interviews the facility failed to establish a water management program for Legionella and other opportunistic waterborne pathogens. This had the potential to affect all facility residents.

The findings included:

In an interview with the Administrator on 01/11/23 at 10:40 AM he stated the facility did not have a water management program for Legionella or other waterborne pathogens.

In an interview with the Maintenance Director on 01/11/23 at 1:30 PM he stated the facility did not have a water management program for Legionella or other opportunistic waterborne pathogens but the new company who bought the facility was sending in an outside contractor who would routinely check the water for Legionella and other pathogens. He provided a copy of the new owner ' s policy titled, "Legionella/Water-Borne Pathogen Management Program", dated 11/01/22. He concluded he would not be involved in the process.

F 880

Directed Plan of Correction

F880
Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:

The facility is unable to correct that the previous management company did not have Legionella testing in place. On 11/1/22 when the facility changed management, the Legionella /Water Borne Pathogen Management Program was initiated. No specific residents were identified as having been affected by the alleged deficient practice. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by the Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services regarding the need for Legionella and other opportunistic water-borne pathogen testing.
Address how the facility will identify other residents having the potential to be affected by the same deficient practice:

Residents residing in the facility have the

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F 880	Continued From page 72	F 880	potential to be affected. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: A root cause analysis determined that lack of education contributed to non-compliance with Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by the Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services regarding the need for Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services that it is the responsibility of the Maintenance Director to oversee the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by Nursing Home Administrator and SPICE Certified Regional Vice President of Clinical Services on the policy for Legionella / Water-Borne Pathogen Program. On 2/13/23 Legionella and other opportunistic water-borne pathogen testing by Environmental Chemist	

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F 880	Continued From page 73	F 880	Incorporated was scheduled for 2/14/23 and every six months. Legionella and other opportunistic water-borne pathogen testing will be conducted on 2/14/23 by Environmental Chemist Incorporated. Weekly going forward the Maintenance Director will run water for a minimum of five minutes to ensure there is residual / standing water in the pipes. The Governing Body to include the Vice President, the Regional Vice President of Operations or the Regional Vice President of Clinical Services will review the Water Flow Audits and results of Legionella and other opportunistic water-borne pathogen testing during routine visits. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Weekly for twelve weeks the Maintenance Director will perform documented Water Flow Tests by running water in empty resident rooms to ensure water flows through the pipes preventing standing water. Weekly for twelve weeks the Nursing Home Administrator (NHA) will randomly audit the Water Flow Tests conducted by the Maintenance Director to validate completion and findings. NHA will present the result of the weekly audits to the facility's Quality Assurance and Performance Improvement Committee monthly for a minimum of three months. The Quality Assurance and Performance Improvement Committee will review the results of the audit, making	

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F 880	Continued From page 74	F 880	recommendations as needed, to assure compliance is sustained ongoing. The Governing Body to include the Vice President, the Regional Vice President of Operations or the Regional Vice President of Clinical Services will review the Water Flow Audits and results of Legionella and other opportunistic water-borne pathogen testing during routine visits. The timeline for completion of education for Legionella and other water-borne pathogen testing is 1/19/23. A root cause analysis determined that lack of education contributed to non-compliance with Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by the SPICE Certified Regional Vice President of Clinical Services regarding the need for Legionella and other opportunistic water-borne pathogen testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by SPICE Certified Regional Vice President of Clinical Services that it is the responsibility of the Maintenance Director to oversee the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by SPICE Certified Regional Vice President of Clinical Services on the policy for Legionella / Water-Borne Pathogen Program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345236	A. BUILDING ______ B. WING ______	C 01/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 75	F 880	Legionella and other opportunistic water-borne pathogen testing will be conducted on 2/14/23 by Environmental Chemist Incorporated. On 2/13/23 Legionella and other opportunistic water-borne pathogen testing by Environmental Chemist Incorporated was scheduled for the facility every six months. The Governing Body to include the Vice President, the Regional Vice President of Operations or the Regional Vice President of Clinical Services will review the Legionella and other opportunistic water-borne pathogen testing during routine visits. On 2/13/23 a Root Cause Analysis was completed by the Regional Vice President of Operations, Regional Vice President of Clinical Operations, Nursing Home Administrator, Staff Development Coordinator, Director of Nursing and Maintenance Director. The results of the Root Cause Analysis revealed the facility Maintenance Director lacked a functional understanding of the procedure and program for water safety management for Legionella and other water-borne pathogen testing. The previous management company did not have Legionella testing contract in place. On 11/1/22 when the facility changed management, the Legionella /Water Borne Pathogen Management Program was initiated. On 1/19/23 the Maintenance Director was provided a one-to-one educational in-service by the Nursing Home	

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F 880	Continued From page 76	F 880	Administrator and the SPICE Certified Regional Vice President of Clinical Services regarding the need for Legionella and other opportunistic water-borne pathogen testing. I attest that on 1/19/23 I provided the Maintenance Director with a one-to-one educational in-service. I am SPICE Certified an I am the Regional Vice President of Clinical Services for August Healthcare. I attest that I educated the Maintenance Director on the need for Legionella and other opportunistic water-borne pathogen testing. I attest that on 1/19/23 I provided the Maintenance Director a one-to-one educational in-service to include it is the responsibility of the Maintenance Director to oversee the Legionella and other opportunistic water-borne pathogen testing, even though an outside company will be conducting the testing. I attest that on 1/19/23 I provided the Maintenance Director a one-to-one educational in-service on the policy for Legionella / Water-Borne Pathogen Program. On 2/13/23 a Quality Assurance and Performance Improvement Committee was held. Members present include the Nursing Home Administrator, Director of Nursing, Maintenance Director, Assistant Director of Nursing, Staff Development Coordinator, Regional Vice President of Operations and Regional Vice President of Clinical Services reviewed the results of the root cause analysis. The lab company, Environmental Chemist	

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F 880	Continued From page 77	F 880	Incorporated is scheduled to test the water for legionella and other water-borne pathogens on 2/14/23 and every six months thereafter. The QAPI Committee will review the results of the testing upon receipt and make recommendations accordingly. The QAPI Committee will meet monthly to review the audits for Infection Control for the Directed Plan of Correction. The Governing Body to include the Vice President, the Regional Vice President of Operations or the Regional Vice President of Clinical Services will review the Water Flow Audits and results of Legionella and other opportunistic water-borne pathogen testing during routine visits.	