STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey were conducted on 1/22/24 through 1/29/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #N9L711.	E 000		
F 000	INITIAL COMMENTS The survey team entered the facility on 1/22/24 to conduct a recertification and complaint investigation survey and exited on 1/26/24. Additional information was obtained on 1/29/24. Therefore, the exit date was changed to 1/29/24. The following intakes were investigated: NC 00212760, NC00212471, NC00209941, NC00210102, NC00207908, NC00207770, NC00210190, NC00211375, NC00208998, NC00211139, NC00205105, and NC00211212. Intake NC00212471 and NC00212760 resulted in immediate jeopardy. 3 of the 30 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity J The tag F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 1/22/24 and was removed on 1/23/24. An extended survey was conducted.	F 000		
F 565 SS=D	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7)	F 565		2/22/24

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

Electronically Signed | 02/16/2024

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F 565	Continued From page 1 §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, staff and resident interviews, the facility failed to provide the	F 565	Corrective Action for those residents that have been affected.	

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F 565	Continued From page 2 Resident Council with responses regarding grievances reported in the Resident Council meeting for 1 of 3 consecutive months (December 2023). Findings included: Review of the Resident Council minutes dated 12/5/2023 indicated the residents had voiced concerns of call lights not being answered in a timely manner and rounds not being done at night. Review of the Resident Council minutes dated 1/3/2024, revealed no updated documentation of concerns from 12/5/2023, Resident Council meeting in the new business and old business section of the minutes. During an interview with Activities Director Assistant #1 on 1/24/24 at 8:45 AM, she revealed she had assisted with the Resident Council meeting on 1/3/2024 since the Activities Director was in a meeting and was not available to attend the Resident Council meeting on 1/3/2024. Activities Director Assistant #1 stated that she did not inquire from the residents during the meeting if issues from the previous month had been resolved or discuss any action taken by the facility. She indicated she was not aware she was supposed to discuss any concerns from previous meetings since it was her first time assisting with the Resident Council meeting. On 01/24/24 at 1:30 PM an interview was conducted with the Resident Council group. There were 6 residents in attendance. The group indicated they did not receive feedback from staff when group concerns were voiced. Resident	F 565	On 1/30/24 The administrator met with the Resident council to review the grievances and shared with the group the audits conducted and stated the issues are resolved. The council was satisfied with the results. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 1/31/24 The Activity Director and her department were education on communication and documentation with the Resident Council on any changes or concerns that the council must be made aware during the Resident Council Monthly Meetings. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Activity Director and or Administrator or his designee will be responsible for documenting communication with the Resident Council regarding council concerns. This will be documented monthly on the Resident Council Minutes and reviewed by the Administrator or his designee to ensure accuracy. The facility plans to monitor its performance to ensure solutions are sustained The Activity Director and Administrator will review the Resident Council minutes monthly. The Activity Director will present the Findings to the Quality Assurance Performance Improvement Monthly for three months or until a pattern of compliance is obtained.	

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F 565	Continued From page 3 Council members verbalized that the Activities Director or Activities Director Assistant attended each meeting and notated the Resident Council's concerns, but they did not receive feedback regarding what they voiced. The Resident Council group stated the facility's response to concerns voiced by the Resident Council during 12/5/23 meeting was not discussed during the 1/3/2024 meeting. Attempts to interview the Activities Director were unsuccessful. During an interview with the facility Administrator on 01/24/24 at 2:50 PM, he stated any concerns brought up during Resident Council meetings were passed to the respective departmental heads who looked into the concerns. The Activities Director or Activities Director Assistant followed up with Resident Council members during Resident Council meetings on the status of previous concerns and steps taken by the facility to resolve the concerns. The Administrator noted the grievances from 12/5/23 Resident Council meeting were not discussed during the 1/3/24 Resident Council meeting or noted in 1/3/24 Resident Council meeting minutes. The Administrator verbalized all concerns discussed during a Resident Council meeting should be addressed and noted if resolved during the follow up Resident Council meeting.	F 565		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		2/22/24

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F 578	Continued From page 4 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written documentation in	F 578	Corrective Action for those residents that have been affected.	

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F 578	Continued From page 5 the medical record that advance directives information and/or opportunity to formulate an advance directive was provided or discussed with the resident or resident representative for 4 of 6 residents reviewed for advance directives (Resident #1, #11, #22 and # 49). Findings included: 1. Resident #1 was admitted to the facility on 12/28/2022, and diagnoses included Diabetes Mellitus, chronic obstructive pulmonary disease and osteoarthritis. The annual Minimum Data Set (MDS) assessment dated 12/6/2023 indicated Resident #1 was cognitively intact. There was no documentation of education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered in Resident #1's medical record. In an interview with Social Worker #1 on 1/24/2024 at 1:58 p.m., she stated the Social Worker was responsible for discussing advance directives on admission and re-admission with the residents. She explained in October 2023, the Corporate Office sent an email informing the Social Workers of the process on providing and documenting advance directives for residents. She stated prior to October 2023 when residents were admitted, she was only collecting and documenting the residents' code status during the care plan meetings and was not providing residents advance directive information to formulate advance directives.	F 578	The Social Service Director provided written documentation in the medical record that advanced directives information and/or opportunity to formulate an advance directive was provided or discussed with the resident or representative for resident # 1 on 2/14/24, for resident # 11 on 1/31/24, on resident # 22 on 2/15/24 , and resident #49 on 2/14/24. Corrective action will be accomplished for those residents to be affected by the same deficient practice. On 2/5/24 the Social Work Director conducted the review of all residents to ensure there was documentation of education regarding Advanced Directives. On 2/14/24 the Administrator sent communication to all responsible parties via Cliniconex application to follow up with the Social Worker to update the Advanced Directives of their loved one. (The Cloniconex application sends out an automated voice message to the resident responsible parties) This Audit was completed on 2/20/24 and any responsible party that was unable to be reached a certified letter was sent on that date as well. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Social Work Director or their designee will review three resident charts weekly to ensure Advanced Directive education is documented and accurate. This will be done for 12 weeks. This will be	

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F 578	Continued From page 6 In an interview with the Administrator on 1/24/2024 at 3:02 p.m., he explained he was not aware of a change in the process for providing residents' advance directive information and the opportunity to formulate an advance directive. He stated advance directive information should be reviewed with the residents or a resident representative and documented in the medical record. 2. Resident #11 was admitted to the facility on 9/22/2023 with diagnosis of Diabetes Mellitus and Chronic Obstructive Pulmonary Disease. The quarterly Minimum Data Set (MDS) assessment dated 12/22/23 indicated Resident #11 was cognitively intact. There was no documentation of education regarding formulation of advance directives and/or an opportunity to formulate an advance directive was offered in Resident #11's medical record. In an interview with Social Worker #1 on 1/24/2024 at 1:58 p.m., she stated the Social Worker was responsible for discussing advance directives on admission and re-admission with the residents. She explained in October 2023, the Corporate Office sent an email informing the Social Workers of the process on providing and documenting advance directives for residents. She stated prior to October 2023 when residents were admitted, she was only collecting and documenting the residents' code status during the care plan meetings and was not providing residents advance directive information to formulate advance directives.	F 578	documented on the audit too that will contain the date reviewed, the resident's name, verification of education, notes, and initials of reviewer. The social worker will meet with all new residents and/or responsible parties to discuss and document advanced directives. The facility plans to monitor its performance to ensure solutions are sustained The Social Work Director or the Administrator/or his designee will present the findings to the Quality Assurance Performance Improvement Monthly for three months or until a pattern of compliance is obtained.	

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F 578	Continued From page 7	F 578		

In an interview with the Administrator on 1/24/2024 at 3:02 p.m., he explained he was not aware of a change in the process for providing residents' advance directive information and the opportunity to formulate an advance directive. He stated advance directive information should be reviewed with the residents or a resident representative and documented in the medical record.

3. Resident #22 was admitted to the facility on 2/10/2023. Diagnoses included dementia and Alzheimer's.

The quarterly Minimum Date Set (MDS) assessment dated 11/16/2023 indicated Resident #22 was severely cognitively impaired.

There was no documentation of education regarding formulation of advance directives and/or an opportunity to formulae an advance directive was offered in Resident #22's medical record.

In an interview with Social Worker #1 on 1/24/2024 at 1:58 p.m., she stated the Social Worker was responsible for discussing advance directives on admission and re-admission with the residents. She explained in October 2023, the Corporate Office sent an email informing the Social Workers of the process on providing and documenting advance directives for residents. She stated prior to October 2023 when residents were admitted, she was only collecting and documenting the residents' code status during the care plan meetings and was not providing residents advance directive information to formulate advance directives.

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F 578	Continued From page 8	F 578		

In an interview with the Administrator on 1/24/2024 at 3:02 p.m., he explained he was not aware of a change in the process for providing residents' advance directive information and the opportunity to formulate an advance directive. He stated advance directive information should be reviewed with the residents or a resident representative and documented in the medical record.
4. Resident #49 was admitted to the facility on 6/7/23 with diagnoses that included, in part, coronary artery disease and diabetes.

The quarterly Minimum Data Set assessment dated 1/19/24 revealed Resident #49 had intact cognition.

Resident #49's medical record was reviewed and there was no documentation of education regarding formulation of advance directives.

On 1/24/24 at 9:25 AM, an interview was conducted with the Admissions Director. She explained there was a statement about advance directives, specifically code status, located in the admissions packet. She stated she had not provided any other advance directive information to residents upon admission but that the Social Worker reviewed advance directives with a resident and/or resident representative (RR) when she met with them after admission.

During an interview with Resident #49 on 1/25/24 at 9:58 AM, she said the facility provided her with written information regarding advance directives when she first arrived at the facility.

Social Worker #1 was interviewed on 1/23/24 at

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F 578	Continued From page 9 2:29 PM. She explained she typically reviewed advance directives with the resident and/or RR upon admission and documented the discussion in a care plan meeting note when she met with the resident and/or RR. She verified she had not documented that advance directive information was shared with the resident and RR since she had not formally met with the resident and RR in a scheduled care plan meeting. In an interview with the Administrator on 1/24/2024 at 3:02 PM, he stated advance directive information should be reviewed with the resident or a resident representative and documented in the medical record.	F 578		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or	F 623		2/22/24

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F 623	Continued From page 10	F 623		

discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual

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F 623	Continued From page 11 and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide written notice of discharge that included resident appeal rights and the contact information for the Ombudsman to the	F 623	Corrective Action for those residents that have been affected. The facility was unable to correct this as the Resident #59 returned to the facility on 12/18/23.	

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F 623	Continued From page 12 resident and/or the resident's representative for 1 of 1 resident who was reviewed for discharge (Resident #6). The findings included: Resident #6 was admitted to the facility on 1/3/23. Review of Resident #6's last Minimum Data Set assessment, a quarterly dated 10/25/23 revealed she had moderate cognitive impairment. Review of Resident #6' s records revealed she was sent to the hospital on 12/12/23. Review of Resident #6's medical record revealed no evidence that written notification of discharge was provided to the resident or resident representative for hospitalization on 12/12/23. She returned to the facility on 12/18/23. An interview was conducted with the Admissions Coordinator on 1/26/24 at 10:11 AM who stated she was unsure who was responsible for sending written notification to residents or resident's representatives when they were discharged to the hospital. An interview was conducted with the Administrator on 1/26/24 at 10:13 AM who reported the Social Worker sent a list of discharged residents to the ombudsman monthly. He reported he believed the Social Worker had a binder in her office with copies of letters sent to resident representatives. A follow-up interview was conducted with the Administrator on 1/26/24 at 11:59 AM. The Social	F 623	Corrective action will be accomplished for those residents affected by the same deficient practice. On 1/25/24 the Social Worker, Business Office Manager, Unit Managers, Director of Nursing, and Assistant Director of Nursing were educated by the Administrator to utilize the correct form to sent the responsible party when a has an resident is send to the hospital. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. On 1/24/24 the clinical team will review all discharges during a.m. meeting and the social worker will note any residents sent to the hospital and send the appropriate notification to their responsible party. The discharge report will be reviewed each clinical meeting and documented. This will include the date of discharge, the resident discharged, where discharged, why discharged, date form sent, and initials of sender. The Administrator or Director of Nursing or their designee will review this weekly for 12 weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Social Worker, Administrator, or Director of Nursing will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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F 623	Continued From page 13 Worker had been sending a letter to resident representatives, but it did not include resident appeal rights or Ombudsman contact information. He stated he was unaware of the required elements of the notice. The Social Worker was unavailable for interview.	F 623		
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: Based on record review and staff interviews the facility failed to accurately code the discharge destination and tube feeding status of 2 of 28 residents reviewed for Minimum Data Set (MDS) assessments (Resident #87 and Resident #13). Findings included: 1. Resident #87 was admitted to the facility on 10/23/23. She was discharged to the community on 11/19/23. Review of Resident #87's medical record revealed she discharged home from the facility on 11/19/23. Resident #87's discharge Minimum Data Set assessment dated 11/19/23 revealed she was coded as discharging to the hospital. The MDS Nurse was unavailable for interview. An interview was conducted with the Corporate	F 641	Corrective Action for those residents that have been affected. On 2/15/24 the MDS staff completed a MDS correction to accurately code the discharge location for resident #87. On 2/16/23 Resident # 13 had a correction to the MDS completed related to parental/IV and tube feeding. Corrective action will be accomplished for those residents affected by the same deficient practice. On 2/5/24 the MDS team initiated an audit of the most recent MDS to validate coding of discharges and IV parental feeding. This was completed On 2/20/24. Measures put into place or systemic changes made to ensure that deficient practice will onto occur. The MDS coordinators will review 3 assessments weekly to ensure accurate MDS coding of discharges and IV nutrition for twelve weeks. This will be documents on the	2/22/24

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F 641	Continued From page 14 Nurse Consultant on 1/26/24 who stated the assessment was not coded correctly and should have reflected Resident #87 discharged to the community. 2. Resident #13 was admitted to the facility on 7/25/22. Review of Resident #13's Minimum Data Set (MDS) assessment dated 10/26/23 revealed Resident #13 was cognitively intact and was documented as receiving parenteral/IV feeding as well as having a feeding tube. During an interview on 1/22/24 at 3:35 PM Resident #13 stated she had never had tube feeding as a resident in the facility and had always eaten her food by mouth. During an interview on 1/23/24 at 2:36 PM Nurse #1 stated to the best of her knowledge Resident #13 did not require a feeding tube during her stay at the facility and had always been able to eat her food by mouth. The MDS nurse was unavailable for interview. During an interview on 1/23/24 at 2:44 PM the Regional Vice President of Clinical Services stated based on record review the resident did not have a tube feeding or parenteral nutritional approach during the Assessment Reference Date (ARD) of the 10/16/23 MDS. She stated the MDS should accurately reflect resident's nutritional	F 641	Audit tool. The date, resident name, assessment, notes or corrections, and initials of auditor. The facility plans to monitor its performance to make sure the solutions are sustained. The MDS coordinator will present the findings to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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F 641	Continued From page 15 status including tube feeding and parenteral nutrition. During an interview on 1/24/24 at 7:49 AM the Administrator stated MDS assessments should accurately reflect resident tube feeding and parenteral nutritional approaches.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F 656		2/22/24

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F 656	Continued From page 16 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop and implement individualized person-centered care plans in the areas of anticoagulant use and post-traumatic stress disorder for 2 of 28 residents reviewed for comprehensive care plans (Resident #91 and Resident #58). Findings included: 1. Resident #91 was admitted to the facility on 9/7/2023 and was diagnosed with multiple fractures to both hands and right shoulder. Physician orders dated 9/7/2023 included an order for Enoxaparin Sodium (an anticoagulant used to prevent blood clots) prefilled syringe 0.4 milliliters subcutaneous injection once a day for deep vein thrombosis (blood clot) prophylaxis for thirty days. On 9/13/2023, physician orders indicated Enoxaparin Sodium injections were	F 656	Corrective Action for those residents that have been affected. On 1/26/24 resident #58 care plan was updated to reflect PTSD. On 2/15/24 resident #91 care plan was updated to reflect he is on anticoagulant. Corrective action will be accomplished for those residents affected by the same deficient practice. On 2/5/24 the MDS team was educated by the Director of Nursing to include anticoagulants and Post Traumatic Stress Disorder (PTSD) of in resident's plans of care. On 2/16/24 the MDS team initiated an audit of all resident to ensure accuracy of individualized person-centered care plans in the areas of anticoagulants and post-traumatic stress disorder. This was completed On 2/20/24.	

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F 656	Continued From page 17 discontinued, and Eliquis (another anticoagulant) two five milligrams' tablets were ordered twice a day for a deep vein thrombus (DVT). Nursing documentation date 9/13/2023 reported Resident #91 diagnostic test reported a DVT in the right leg. The admission Minimal Data Set (MDS) assessment dated 9/14/2023 indicated Resident #91 was cognitively intact and required total assistance with all activities of daily living. The MDS further recorded Resident #91 had received anticoagulants for a 7-day look back period. The September 2023 Medication Administration Record (MAR) for Resident #91 recorded Enoxaparin Sodium and Eliquis was administered daily as ordered by the physician. Resident #91's comprehensive care plan initiated on 9/8/2023 and last revised on 9/15/2023 did not include a focus for the use of anticoagulants for DVT prevention and/or treatment. In an interview with Director of Nursing on 1/24/2024 at 3:05 p.m., she explained the admitting nurse initiated a residents' care plans on admission, the MDS nurse completed the resident's individualized care plan, and the unit nurse manager was to check for completion of the residents' individualized care plan. After reviewing Resident #91's care plan, she stated based on the resident's diagnoses and medications prescribed by the physician to prevent and treat DVT, Resident #91 should have had a care plan area for the use of anticoagulants for DVT. She said she did not have an explanation for the reason the use of	F 656	Measures put into place or systemic changes made to ensure that deficient practice will not occur. The Director of Nursing or Unit Managers will review six care plans weekly to validate anticoagulant and PTSD are care planned appropriately. This will include new admissions as part of the audit. This will done weekly for 12 weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing will present the findings to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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F 656	Continued From page 18	F 656		

anticoagulants was not included in Resident #91's individualized comprehensive care plan.
2. Resident #58 was admitted to the facility on 4/18/22 with diagnoses that included post-traumatic stress disorder and hypertension.

Her most recent Minimum Data Set (MDS) assessment dated 12/23/23, a quarterly revealed she was cognitively intact with no behaviors. Medications administered during the 7-day lookback period included an antipsychotic and an antidepressant medication.

An interview with Resident #58 was conducted 1/24/24 at 2:54 PM who stated she was in a bad car wreck several years ago and continued to deal with trauma symptoms. She reported she should not have survived the accident. Resident #58 reported emotional issues related to pain and losses she suffered as a result. She further stated she had dreamless sleep and difficulty sleeping. Resident #58 stated no one at the facility had addressed her post traumatic stress disorder.

Review of Resident #58's medical record revealed no discussion of her post traumatic stress disorder in psychiatric progress notes.

Resident #58's comprehensive care plan last reviewed 12/19/23 revealed no care plan that addressed post-traumatic stress disorder.

In an interview with Director of Nursing on 1/24/2024 at 3:05 p.m., she explained the admitting nurse initiated a residents' care plans on admission, the MDS nurse completed the resident's individualized care plan, and the unit nurse manager was to check for completion of

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F 656	Continued From page 19 the residents' individualized care plan. An interview was conducted with the Director of Nursing on 1/26/24 at 10:22 AM who stated Resident #58 should have been care planned for post-traumatic stress disorder.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by:	F 657		2/22/24

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F 657	Continued From page 20 Based on record reviews, resident representative interview and staff interviews, the facility failed to conduct quarterly care plan meetings with cognitive residents and/or resident representatives (Resident #22 and Resident #59) and failed to revise a resident's care plan requiring 1:1 supervision for behaviors (Resident #70) for 3 of 28 residents reviewed for care planning. Findings included: 1. Resident #22 was admitted to the facility on 2/10/2023, and diagnoses included dementia and Alzheimer's disease. The Social Worker recorded on 3/5/2023 an initial care plan meeting was held for Resident #22. There was no further documentation of care plan meetings held for Resident #22 in the medical record. The quarterly Minimum Data Set (MDS) assessment dated 11/16/2023 indicated Resident #22 was severely cognitively impaired and required assistance with all activities of daily living. Previous quarterly assessments for Resident #22 were conducted on 8/20/2023, 6/15/2023 and 3/15/2023. In a phone interview with Resident #22's Representative on 1/23/2024 at 8:04 a.m., she stated she had not received invitations from the facility for Resident #22's care plan meetings. In an interview with the Social Worker on 1/24/2024 at 2:11 p.m., she stated since the beginning of January 2024, the MDS department have been notifying her when to schedule care	F 657	Corrective Action for those residents that have been affected. On 1/15/24 the Social Worker conducted a care plan with resident #59. On 2/16/24 a care plan meeting was conducted with resident representative of resident #22 . On 2/15/24 the care plan was revised and updated regarding one to one supervision for resident #70 . Corrective action will be accomplished for those residents affected by the same deficient practice. On 2/15/24 the Social Worker and conducted an audit of all resident medical records to determine the date of the last care plan meeting with the resident or resident representative. Any outstanding care plans have been completed by 2/22/24. On 2/13/14 On 2/14/24 the MDS conducted an audit of all residents to determine that any 1:1 supervision was care planned appropriately. There were not further issues. The Nursing Home Administrator educated the Social Worker on scheduling care plan meetings with the resident and resident representative quarterly and as needed. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. Weekly for twelve weeks the Social Worker will provide the Administrator documentation of invitations of the next week's scheduled care plan meetings. The Administrator or his designee will sign off on these weekly. The MDS coordinator will review weekly for 12	

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F 657	Continued From page 21 plan meetings. She explained prior to January 2024, she was responsible for scheduling initial care plan meetings and was finding it difficult to keep up with scheduling the care plan meetings based on the MDS schedule. She stated Resident #22 had his initial care plan meeting on 3/5/2023. She explained she preferred to coordinate care plan meetings with the resident and resident representatives and then send out invitation letters, and she had reached out to the Resident #22's Representative with no reply. She further stated the Interdisciplinary Team (IDT) had not conducted a care plan meeting for Resident #22 because no new issues had been identified to address for Resident #22. In an interview with the Administrator on 1/26/2023 at 3:24 p.m., he stated care plan meetings should have been scheduled for Resident #22 with the IDT, if Resident #22 and/or Resident #22's representative was not able to attend, and information from the care plan meeting should be shared with Resident #22 and/or Resident #22's Representative. 2. Resident #59 was admitted to the facility on 10/26/21. Review of Resident #59's Minimum Data Set assessment dated 12/13/23 revealed he was assessed as cognitively intact. Review of a note dated 2/8/23 revealed the Social Worker attempted to schedule a quarterly care plan meeting with the resident's responsible party on 2/8/23. Review of a note dated 4/24/23 revealed the Social Worker attempted to schedule a quarterly	F 657	weeks any 1:1 to ensure they are care planned or discontinued appropriately. ON 2/14/24 the MDS was educated on updating care plans once interventions are discontinues. The facility plans to monitor its performance to make sure the solutions are sustained. The Social Worker or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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care plan meeting with the resident's responsible party on 4/24/23. The Social Worker left a voicemail.

Review of a note dated 9/20/23 the Social Worker attempted to schedule an annual care plan meeting with the resident's responsible party on 9/20/23. The resident's responsible party told the social worker he would call her back with a day and time he would be available for an annual care plan meeting.

Review of Resident #59's chart revealed no care plan meeting was documented to have been held for Resident #59 during the survey period of 9/17/22 through 1/29/24.

During an interview on 1/22/24 at 2:38 PM Resident #59 stated he did not know what a care plan meeting was and did not believe he had been involved in a care plan meeting.

During an interview on 1/24/24 at 10:00 AM the Social Worker stated Resident #59 had a friend he requested to participate in a care plan meeting, and they also invited Resident #59 to his care plan meetings. She attempted to schedule one on 9/20/23 with the responsible party as requested by resident. The friend never called back. He was scheduled for another one this month, but the friend had not responded again. She stated because the resident had a responsible party and they did not respond to the care plan invitation, they did not hold care plan meetings for the resident. She stated she and the resident have had one on one meetings, but the resident had not had an official care plan meeting with the interdisciplinary team since she began working in October of 2022. She concluded she

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was responsible for setting up care plan meetings for residents and due to the resident's responsible party not responding to requests, Resident #59 had not had a care plan meeting during her time in the facility.

During an interview on 1/24/24 at 10:11 AM the Administrator stated even when responsible parties were not available for care plan meeting or did not respond to request for care plan meetings, the interdisciplinary team should still conduct a care plan meeting with the resident quarterly.

3. Resident #70 was admitted to the facility on 9/15/23 with diagnoses that included heart failure and hypertension.

Resident #70's most recent quarterly Minimum Data Set (MDS) assessment dated 12/23/23 revealed she had moderate cognitive impairment with no behaviors.

Review of Resident #70's care plan revealed a focus related to attempts to leave the facility and outbursts initiated on 9/25/23 and reviewed 11/13/23. An intervention to address this focus was 1:1 supervision when the resident was out of bed.

Review of Resident #70's medical record revealed no order for 1:1 supervision.

Observations conducted on 1/23/24, 1/25/24, and 1/26/24 revealed she was found in her room out of bed with no 1:1 supervision present.

An interview was conducted with Nurse #5 on 1/25/24 at 1:37 PM who stated she could not

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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 657	Continued From page 24 recall Resident #70 having 1:1 supervision. During an interview with Nurse Aide #3 on 1/25/24 at 1:40 PM, he stated Resident #70 required 1:1 supervision but it was discontinued approximately two months ago. An interview was conducted with Nurse Aide #2 on 1/25/24 at 1:45 PM who stated she recalled Resident #70 being on 1:1 supervision but she believed it was discontinued one month ago. During an interview with the Director of Nursing (DON) on 1/26/24 at 10:17 AM she stated when a resident required 1:1 supervision she would assign a staff member on each shift to provide 1:1 supervision until the resident's behaviors improved. She stated the Administrator would make the decision to discontinue 1:1 supervision after improvement in behaviors for several consectuive days. She stated she was not employed by the facility when Resident #70 had 1:1 supervision. The DON further stated Resident #70 no longer required 1:1 supervision and it should not be on her care plan. She stated it should have been discontined on the care plan when 1:1 supervision ended. She reported the MDS assessment nurse was responsible for updating the care plan. The MDS Nurse was unavailable for interview. During an interview with the Administrator on 1/26/24 at 11:15 AM he stated Resident #70's 1:1 supervision was discontinued on 11/3/23.	F 657		
F 686 SS=E	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		2/22/24

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F 686	Continued From page 25 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to complete and document in the electronic medical record weekly assessments and measurements of a resident's pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #10). Findings included: Resident #10 was admitted to the facility on 12/28/2016 with diagnoses including a Stage 4 pressure ulcer to the buttocks. The quarterly Minimum Data Set (MDS) assessment dated 10/23/2023 indicated Resident #10 was cognitively intact and was receiving treatments for two pressure ulcers. Resident #10's care plan dated revised on10/24/2023 include a focus for pressure ulcers, and interventions included administering, documenting and monitoring effectiveness of medications and treatments as ordered.	F 686	Corrective Action for those residents that have been affected. On 1/31/24 the weekly wound measurements obtained for resident #10 were documented in the medical record. Corrective action will be accomplished for those residents affected by the same deficient practice. On 1/31/24 the treatment nurse was educated by the Director of Nursing on obtaining weekly wound measurements and documenting in the medical record. On 2/16/24 an audit of all wounds was conducted by the Wound Care Nurse, Director of Nursing and Assistant Director of Nursing to identify any additional documentation of weekly wound assessments that needs to be obtained and uploaded in the resident medical record. Measures put into place or systemic changes made to ensure that the deficient	

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F 686	Continued From page 26 Dietary documentation dated 10/27/2023 reported Resident #10 had been readmitted from the hospital due to osteomyelitis to the left hip and had a stage 4 left hip and ischium pressure ulcer. She reported Resident #10 received double meat and protein on meal trays and had refused supplemental and nutritional interventions since March 2023 to aid in wound healing. A review of the physician notes dated 12/14/2023 reported Resident #10 was hospitalized from 10/05/2023 to 10/20/2023 for an infected pressure ulcer and right hip osteomyelitis. Nursing documentation dated 12/21/2023 reported Resident #10 was seen at the wound clinic on 12/15/2023 and received new orders for treatment. Nursing documentation also reported due to receiving no measurements of the pressure ulcers on 12/15/2023, the wound clinic was called to gather information on the pressure ulcers measurements. Physician orders dated 12/21/2023 included an order to cleanse the left trochanter (hip area) and left ischium (buttocks area) with Dakin's solution (use to treat and prevent infections) and allowing Dakin's moistened gauze to soak in wound bed for 10 minutes. No sting skin prep was to be applied around the wound and collagen particles were to be applied into the wound bed. Calcium silver alginate was to be placed directly to the wound bed and the center of the wound filled with fluffed gauze, covered with pad dressing and secured with tape every other day Monday, Wednesday and Friday and as needed. Treatments of Resident #10's pressure ulcers	F 686	practice will not occur. Beginning 2/15/24 each week for 12 weeks the Director of Nursing, Unit Coordinators, or Assistant Director of Nursing will review the medical records of residents with pressure ulcers to validate weekly wound documentation is completed and uploaded, if needed, in the medical record. Any concerns will be addressed at that time. This will be documented on the Audit Tool that notes date, assessment verified in Medical Record, and initials. This will be done for 12 weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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were recorded as completed as ordered on the December 2023 and January 2024 Treatment Administration Record (TAR) except on 1/12/2024, 1/19/2024 and 1/22/2024.

A review of the weekly pressure ulcer observations/assessments from January 2023 to January 2024 documented in the electronic medical record included the following four assessments:

- On 2/17/2023, Wound 1: Stage 4 left ischium improving with moist granulation present and measured 8 x 7.5 x .4 centimeters (cm). Wound 2: Stage 4 left trochanter healing and measured 5 x 6 x 0.2 cm.
- On 7/7/2023, Wound 1: Stage 4 left buttocks was recorded as unchanged with slow and steady improvement, moist and granulated. Measurements were recorded as 9.2 x 7.8 and 1.7 cm and undermining. Wound 2, the left trochanter was recorded as unchanged, moist and granulated with no odor. Measurements were recorded as 4.5 x 4.7 x .4 cm.
- On 7/21/2023, the left buttocks pressure ulcer was measured at 9.2 x 7.8 and 1.7cm and recorded no change in the pressure ulcer.
- On 12/5/2023, wound observations reported notification of wound clinic for assessment of the pressure ulcer to left trochanter and left ischium. Wound observation stated Resident #10's pressure ulcer had a large amount purulent drainage with no odor and measured 9.5 x 8.5 x3 cm.

There were no further weekly pressure ulcer observations/assessments found in the electronic record.

A review of physician wound clinic notes in the electronic medical record from January 2023 to

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January 2024 included the following three assessments of Resident #10's pressure ulcers:

- On 3/29/2023, the wound clinic recorded a large deep wound to the left buttocks area half of the size to the left side of the upper hip area (left trochanter and left ischium). There were no measurements recorded in the report.

- On 8/9/2023, the wound clinic recorded the left trochanter (hip) had improved and measured 5 x 4.9 x .4 cm and was undermining. The left buttocks measured 7.3 x 9.5 x2 cm with undermining.

- On 9/12/2023, the wound clinic reported moderate drainage from the pressure ulcers. The left ischium was recorded having 30 % granulation, no slough and 50 % exudate with a minimal odor that connects with the left trochanter pressure ulcer. The wound clinic recorded there were no signs of infection. The left trochanter pressure ulcer was recorded having 90% slough with no bone and no obvious impediments to healing and the area was debrided with minimal odor noted. The left hip and trochanter area was reported measuring 10 x 9.5 x 2 cm with undermining. The wound clinic also reported an odorless unstageable area to the sacrum measuring 0.8 x 0.6 x 0.2 with 100 % slough that was debrided. The physician wound clinic note recorded osteomyelitis to the left hip and regression of the healing process to the left trochanter pressure ulcer significantly worse and a new sacral injury due to unrelieved pressure. The facility did not provide any further physician wound clinic notes to review.

On 1/26/2024 at 10:17 a.m., Wound Nurse #1 was observed providing treatment to Resident #10's left trochanter and left ischium pressure ulcer as ordered by the physician practicing

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infection control measures. The old dressing was saturated with large amounts of purulent drainage that had a momentarily mild foul odor and the pressure ulcer was covered with scattered areas of the purulent material with pink granulation tissue observed underneath to the pressure area. The left trochanter and left ischium pressure ulcer was observed with no purulent material and only pink granulated tissue after soaking and cleansing with the Dakin's solution for ten minutes. Wound Nurse #1 measured the pressure ulcer as 17.5x 7.5x 2.5cm and noted healing was occurring from the center at the bottom of the pressure ulcer in an upward direction.

In an interview with the Wound Nurse #1 on 1/25/2024 at 11:11 a.m., she stated she had been the wound nurse for the facility since September 2023. She explained weekly assessments of pressure ulcers were conducted on Tuesdays when the facility's wound physician made rounds. She explained during these weekly rounds, pressure ulcers were assessed, measured and treatments changed as needed. She stated she was responsible for entering the assessments into the weekly wound care report on the electronic medical record (EMR). When asked why there were not weekly pressure ulcer assessments documented in Resident #10's EMR, she stated because Resident #10 was not seen by the facility's wound physician. She further stated she had not been conducting weekly assessments and measurements on Resident #10's pressure ulcers because Resident #10 was seen at a wound clinic outside the facility monthly. She explained Resident #10's pressure ulcer assessments were completed during wound clinic visits, and the assessments were not always

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F 686	Continued From page 30 received after the wound clinic visit to document in Resident #10's electronic medical record. She stated she changed Resident #10's dressing every other day on Monday, Wednesday and Friday as ordered, and Resident #10's pressure ulcer was improving. She said she forgot to document treatment was provided to the pressure ulcers on 1/12/2024, 1/19/2024, and 1/22/2024 on the TAR. In an interview with Director of Nursing on 1/25/2024 at 12:15 p.m., she explained pressure ulcer assessments and measurements were to be completed weekly. She stated Wound Nurse #1 was responsible for completing and documenting the weekly assessments, measurements and treatments for Resident #10's pressure ulcers in the electronic medical record.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, Emergency Medical Service (EMS) personnel interview, and staff interview the facility failed to provide supervision to prevent a resident with severe cognitive impairment from exiting the facility unsupervised and without staff's knowledge. On 1/22/24 Resident #83 was found	F 689	Corrective action for affected residents. On 1/22/24 10:15 am resident returned to the facility from Duke Regional. Effective 1/22/24 Resident #83 will remain on 1:1 supervision until no longer indicated as determined by the Interdisciplinary team, Medical Director, and reviewed and	2/22/24

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F 689	Continued From page 31 by EMS personnel approximately 1.9 miles from the facility seated on the ground on a sidewalk outside at 3:05 AM with icicles hanging from his nose and beard. He was treated for hypothermia by EMS and was taken to the hospital. This was for 1 of 3 residents reviewed for accidents. Immediate Jeopardy began on 1/22/24 when Resident #83 exited the facility unsupervised and without staff's knowledge. Immediate Jeopardy was removed on 1/23/24 when the facility implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. Findings included: Resident #83 was admitted to the facility on 11/18/23 with diagnoses that included aphasia (loss of the ability to understand or express speech) and hemiplegia (paralysis of partial or total bodily function) and hemiparesis (one sided weakness) following cerebrovascular disease (a group of conditions affecting blood flow and blood vessels to the brain) affecting right dominant side. Resident #83's quarterly Minimum Data Set (MDS) assessment dated 1/11/24 revealed he was assessed as severely cognitively impairment with no wandering or behaviors. He was assessed as having unclear speech with the inability to understand or be understood. He had no functional impairment with range of motion. Resident #83 required partial/moderate assistance in transitioning from sitting to standing	F 689	approved by the Quality Assurance Performance Improvement (QAPI) Committee. The Interdisciplinary Team includes the DON, Assistant DON, Social Worker, Activities Director, Unit Managers, and NHA. QAPI Committee includes the Medical Director, DON, Assistant DON, Social Worker, Activities Director, NHA, Business Office Manager, Maintenance Director, Rehab Coordinator, and Unit Managers. Corrective Action for those residents that have been affected. On 1/22/24 a Gates wander assessment was completed on all residents. At that time there no other residents that were at High Risk for elopement. On 1/22/24 All staff were education on elopement policy and the new front door procedure. Any new hires will have this education prior to working on the floor. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Administrator/DON/ADON or their designee will conduct elopement drills 3 times weekly for 12 weeks. This will be documented on the audit tool that will note the date, time, shift, notes and initials of the DON or her designee. The Maintenance Director or his designee will check the doors to ensure they are secure 5 times weekly. During each A.M. meeting the IDT will review any new admissions to ensure the have had the Gates Wander assessment completed, & any existing residents that may need a new	

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and chair to bed, and wheeling himself in a manual wheelchair 150 feet.

Review of a wandering assessment dated 1/18/24 revealed Resident #83 was at risk for wandering. The assessment revealed he was ambulatory with a diagnosis of cognitive impairment which led to a score of 9 indicating he was at risk for wandering. The scoring scale for the wandering assessment indicated the following: 0-8 was low risk, 9-10 was at risk, and 11 and up was high risk.

Resident #83's active care plan as of 1/21/24 revealed there was no care plan in place related to wandering.

An incident investigation completed by the Administrator dated 1/22/24 revealed Nurse #2 received a call on 1/22/24 at 3:45 AM from a local emergency department asking if Resident #83 was a patient of the facility as he was in the emergency department. He was brought to them via the police. Nurse #3 stated she last saw Resident #83 at 12:30 AM on 1/22/24. Nurse Aide #1 (NA) #1 stated she last saw Resident #83 between 1:00 AM and 2:40 AM.

During a phone interview with Nurse #2 on 1/26/24 at 8:25 PM she stated she was notified by the local hospital on 1/22/24 at 3:45 AM Resident #83 was in the emergency room. She reported she notified his assigned nurse, and she had no other knowledge of the incident.

A phone interview was conducted with Nurse #3 on 1/26/24 at 12:59 PM who stated on 1/22/24 at 3:45 AM she was notified by Nurse #2 Resident #83 was found by the police and transported by

assessment to determine any course of action needed. This will be done for 12 weeks.

The facility plans to monitor its performance to make sure the solutions are sustained. The Administrator/Director of Nursing or their designee will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.

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EMS staff to a local hospital. She stated she last saw Resident #83 on 1/22/24 at approximately 12:30 AM when she checked his BiPap machine (a machine that supplies pressurized air to airways). She reported he was lying in bed, and she was unsure if he was asleep. Nurse #3 reported she was unable to recall what he was wearing. She stated usually when she saw Resident #83, he was in his bed. She indicated she wasn't familiar with his ability to ambulate.

During an interview with NA #1 on 1/25/24 at 4:03 PM she indicated she was Resident #83's assigned NA on 1/22/24 during the 3rd shift. She reported Resident #83 ate his dinner late on 1/22/24 and she collected his tray at approximately 11:30 PM. Initially she was unable to recall when she last saw Resident #83 so she walked through the events of that night/early morning. She stated around 2:30 AM they finished moving another resident to a different room and she knew she last saw Resident #83 before beginning that move. She estimated the last time she saw Resident #83 was at approximately 1:30 AM. NA #1 stated she was unsure about the exact time because she didn't wear a watch. She indicated the last time she saw Resident #83 he was lying in bed and was awake. She did not recall what he was wearing. She stated she was very surprised he left the building because he moved very slowly. NA #1 stated Resident #83 frequently would take a geriatric chair (a padded chair with a wheeled base) and push it slowly down the hall.

EMS records indicated a call was received from law enforcement at 2:59 AM on 1/22/24 and they were dispatched at 3:00 AM. Resident #83 was found outside approximately 1.9 miles away from

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the facility at 3:05 am. He was sitting on the ground with icicles hanging from his nose and beard. He indicated he was attempting to walk from "home" to the hospital because he "felt sick". Resident #83 was cold to the touch and his temperature when taken read "low". The main impression listed on the EMS report was hypothermia. He was treated with active rewarming and a space blanket was applied. He was transported to the local hospital.

A phone interview was conducted with EMS Staff on 1/29/24 at 4:07 PM who stated Resident #83 was found on the side of the road on a sidewalk in front of a house. He reported Resident #83 was very close to an interstate highway. EMS Staff stated it was very cold and he believed the wind chill was in the teens or single digits. He stated there was no precipitation at that time. He stated Resident #83 had icicles on his nose and beard. EMS Staff stated Resident #83's speech was very garbled, but he stated he had been outside for 4 hours. He stated treatment for hypothermia was provided on the scene which consisted of active warming, heat packs in the arm and groin and a tinfoil blanket with several blankets on top. He stated the 911 call came from the police.

Review of hospital records for Resident #83 for 1/22/24 revealed he was seen with a chief complaint of cold exposure. The record indicated he walked out of his facility and was found near an interstate highway by police and EMS. He was wearing a t-shirt and it was currently 19 degrees Fahrenheit out. He was cold to the touch but his core temperature was 99.6. degrees Fahrenheit. He was noted to be alert to self and was aware he was at the local hospital. He was

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unaware of the situation and was noted to be confused. His family member informed the hospital he resided at the facility and stated he "must have wandered off." His facility was called and "staff member was unaware patient was missing from the facility." Family indicated he was confused at baseline and had a hard time speaking since his most recent CVA (cerebrovascular accident) a few months ago. Diagnostic testing was completed and he was discharged back to the facility later that morning.

Review of a nursing progress note revealed Resident #83 returned to the facility at approximately 10:15 AM on 1/22/2.

Observation on 1/25/24 at 6:35 PM of the intersection where Resident #83 was found by EMS revealed a four-lane road with a turning lane. The street had a posted speed limit of 35 miles per hour. There were sidewalks on each side of the street.

Mapquest.com indicated the location Resident #1 was found was 1.9 miles from the facility and approximately 0.2 miles to the interstate highway. The estimated walking time from the facility to the location he was found was 42 minutes.

On 1/26/24 at 11:41 AM an observation was conducted with the facility Rehabilitation Director who measured the distance from Resident #83's room to the front door. The measurement was 128 feet.

Observation on 1/26/24 at 1:52 PM revealed the front door of the facility faced a four-lane road with a speed limit of 40 miles per hour.

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The recorded temperature on 1/22/24 at 2:51 AM in the area the facility was located was 22 degrees Fahrenheit (www.wunderground.com).

Attempts to interview Resident #83 were not successful.

An interview was conducted on 1/25/24 at 2:50 PM with NA #2 who reported she was familiar with Resident #83's care. She stated he never indicated he wanted to leave the facility and she never observed him leaving the facility. NA #2 stated Resident #83 was intelligent. She added the way to leave the building was to push the black key fob and then push the silver button. NA #2 stated there was someone at the reception desk until midnight. She stated she felt Resident #83 may have watched staff open the door and figured out how to open the door.

During an interview with Receptionist #1 on 1/25/24 at 3:02 PM she stated the front desk was staffed until midnight and the front door was always locked. For someone to leave, either the receptionist electronically unlocked the door or there was a key fob hanging above the silver button you pushed to unlock the door. There was a camera located at the end of the lobby area that viewed the front door.

An interview was conducted with the Administrator on 1/25/24 at 4:30 PM who stated the camera located in the lobby area was not operational.

Observation and an interview were conducted with the Administrator on 1/26/24 at 11:40 AM. The front entrance had 2 sets of double doors. The Administrator indicated the interior door was

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opened using a black key fob that was observed hanging on the door. He further revealed after the black key fob was used the handicap access button could be used open to the interior door. The Administrator was observed to push the black key fob, push the handicap access button and the interior double door opened. The exterior door did not require a key fob to open. It was operated by using the handicap access button.

The Administrator was notified of Immediate Jeopardy on 1/25/24 at 5:35 PM.

The facility provided the following immediate jeopardy removal plan with a removal date of 1/23/24.

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

The facility failed to prevent a Resident from exiting the facility unsupervised. Per report of EMS resident was noted laying on the side of the road. The facility staff reported last seeing the resident at approximately 1:30-2:00 a.m.; the resident was lying in bed. At approximately 3:30 a.m. the Licensed Nurse was made aware by the Charge Nurse in the local emergency department that the resident was being evaluated there, but no treatment was indicated, and transportation would be arranged to transfer the resident back to the facility. When the resident left the facility, he was not appropriately dressed for the cold weather conditions. He was wearing shoes, jogging pants and a short-sleeve shirt. Resident #83 had been brought to the Emergency Department by Emergency Medical Services who

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treated the resident for hypothermia in route to the hospital. Resident #83 was evaluated at the local hospital with no treatment indicated. The DON, Administrator, and Medical Provider were immediately notified. Resident #83's wife was notified.

Resident #83 was admitted to the facility for long-term care on 11/18/23 with diagnoses including cerebral vascular accident. Resident #83 was assessed upon admission for elopement. Resident #83 was not High Risk on Wander Assessment completed on 11/18/23 and 1/18/24. Resident #83 is alert and oriented to person and place with a Brief Interview Mental Status Score of 0 on 1/11/24 Minimum Data Set.

On 1/22/24 at approximately 4:00 a.m. the Administrator (NHA) conducted an Ad Hoc Quality Assurance Performance Improvement (QAPI) Committee meeting via telephone conference with Director of Nursing (DON), and Regional Vice President of Operations to discuss incident, review facility elopement policy and to initiate an immediate performance improvement plan based on root cause analysis. Root cause analysis determined that the facility failed to prevent a resident from exiting the facility by failure to ensure a staff member noted Resident #83 exited the facility. The facility doors were all checked and were secured and functioning. The Root Cause analysis determined that the resident was able to exit the front door by pressing the exit button and key fob release. To prevent recurrence, the QAPI Committee initiated a Front Door Protocol for after hours. The Receptionists work until 11:00 p.m. or 12:00 a.m. seven days a week. The Front Door Protocol includes the key fobs will be secured after hours by the

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Receptionist. One key fob will be locked in the cabinet behind the receptionist desk. The other key fob will be stored behind the receptionist desk in the plastic storage bin which is not accessible to residents. Beginning 1/22/23 all staff will be educated on the Front Door Protocol by the NHA, DON, Assistant DON, Business Office Manager, or their respective Department Manager prior to the start of their next shift.

On 1/22/24 Resident #83 returned to facility at approximately 10:15 a.m. and was assessed by the licensed nurse without injury or pain and vital signs at baseline. An updated Wandering Risk Assessment was completed by the Licensed Nurse and scored High risk for elopement based on exiting the facility on 1/22/24. A wander guard placed to his right ankle and continuous 1:1 staff supervision initiated. His care plan, care card, and physician orders were updated accordingly by the Licensed Nurse to reflect the resident is now High Risk for elopement. The Elopement Binder at the nurses' stations and Receptionist Desk was updated. An Elopement Risk Binder is a binder which contains pertinent information about residents who are at High Risk for Elopement. This includes resident description and picture of the resident. A Post Trauma Assessment was initiated and completed by the Licensed Nurse on 1/22/24 and 1/24/24 with no changes from baseline completed on 11/18/23.

Effective 1/22/24 Resident #83 will remain on 1:1 supervision until no longer indicated as determined by the Interdisciplinary team, Medical Director, and reviewed and approved by the Quality Assurance Performance Improvement (QAPI) Committee. The Interdisciplinary Team includes the DON, Assistant DON, Social Worker,

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Activities Director, Unit Managers, and NHA. QAPI Committee includes the Medical Director, DON, Assistant DON, Social Worker, Activities Director, NHA, Business Office Manager, Maintenance Director, Rehab Coordinator, and Unit Managers.

Residents who exhibit exit-seeking behaviors, residents with cognitive impairment, and residents who are assessed as High Risk for Elopement are at risk of exiting the facility without supervision.

On 1/22/24 at approximately 3:30 a.m., the facility initiated a 100% census verification by the Licensed Nurses and all residents accounted for and safe.

On 1/22/24 all facility doors and windows and wander guard system doors verified as secure and properly functioning by the Maintenance Director and NHA. No concerns identified.

On 1/22/24, the licensed nurses completed an elopement audit by updating Wandering Risk Assessments for all current facility residents to identify those at risk for elopement and to ensure an appropriate care plan and care card in place and current wander guard orders with monitoring for proper placement and function. Elopement risk binders were verified for accuracy, completeness and placement at nurse stations and reception desk with copy of resident profile, photo, and care plan by the Director of Nursing (DON). Residents were also reviewed for any behavior of removing and/or attempting to remove wanderguard device. No additional residents were identified as a current risk.

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F 689	Continued From page 41 On 1/22/24 the Administrator, Admissions Coordinator, Regional Marketing Director, and Social Services Director re-educated all current cognitively intact residents, with a BIMS of nine or greater, who are not at high risk of elopement to please notify the nurse if they would like to exit the facility. Each resident who was educated validated their understanding of the education provided. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. Effective 1/22/24 a Front Door Protocol was initiated for after hours. The Receptionists work until 11:00 p.m. or 12:00 a.m. seven days a week. The Front Door Protocol includes the key fobs will be secured after hours by the Receptionist. One key fob will be locked in the cabinet behind the receptionist desk. The other key fob will be stored behind the receptionist desk in the plastic storage bin. On 1/22/24 the Administrator, Director of Nursing, Assistant Director of Nursing, and Unit Managers educated nursing staff regarding Assessment Wander Protocol, visually seeing each resident every two hours and the requirement for cognitively intact residents to sign out prior to leaving the facility, for resident safety. The Director of Nursing and Assistant Director of Nursing will ensure no staff will be allowed to work, including any newly hired staff and agency staff, without first receiving this education. Effective 1/22/24 a keypad lock was ordered to be placed at the front door as an additional measure to prevent residents from exiting the	F 689		

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facility unsupervised. A code will be required to be entered to exit the facility. This additional measure will be implemented in conjunction with the key fob securing the front door.

On 1/22/24 the Administrator and DON conducted an elopement drill with current facility staff and initiated elopement education with all current facility and agency staff. Education included 1) review of the Elopement policy, 2) Special emphasis on providing routine care rounds every two hours and as needed and visually observing each resident 3) Special emphasis on Front Door Protocol initiated with education provided to all staff 4) IDT including the DON, Assistant DON, Social Worker, Activities Director, Unit Managers, were educated by the NHA to review of residents at-risk for elopement during Monday - Friday morning meeting for changes of condition and behaviors and/or need for revision of care plan with communication to nursing staff with any changes. The NHA was educated on the preceding information by the Regional Vice President of Operations on 1/22/24 in order for the NHA to educate the IDT. Facility and agency staff not receiving initial education on 1/22/24 will not be permitted to work until education is completed. The Assistant Director of Nursing will be responsible for ensuring education completion.

On 1/22/24 at approximately 4:00 a.m. the Regional Vice President of Operations provided education to the Administrator and DON on the elopement policy and facility responsibility of maintaining an effective process to prevent residents from exiting the facility without supervision to ensure safety. 1) Completion of root cause analysis identified front door key fob was not secured allowing resident #83 to exit the

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facility unsupervised. 2) Front Door Protocol to be initiated to secure the front door key fob after the receptionists leave 3) keypad lock to be installed at front door requiring a code to exit the front door after the receptionist leaves 4) interventions to prevent an unsupervised exit from the facility of an at-risk resident and ongoing monitoring to include every 2 hours and as needed visual observations of each resident in the facility, 3) interventions to enhance staff awareness of residents identified at risk and ongoing monitoring and 4) maintaining an effective QAPI program whereby the Interdisciplinary Team (IDT) monitors the effectiveness of the corrective action plan of the elopement prevention program and makes changes to the plan as necessary to maintain compliance with preventing residents from unsupervised exits of the facility. Newly hired DONs will receive education during the orientation process.

Alleged date of immediate jeopardy removal: 1/23/24

Onsite validation of the immediate jeopardy removal plan was completed on 1/26/24. Interviews verified the facility had implemented an afterhours front door protocol where key fobs are secured after the receptionist leaves for the evening. Interviews confirmed nursing staff were educated on visually seeing each resident every two hours and the requirement for cognitively intact residents to sign out prior to leaving the facility. Education included review of the new front door protocol. Record review revealed an elopement drill was conducted 1/22/24. Record review also revealed the administrator and Director of Nursing were educated by the Regional Vice President of Operations on the

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F 689	Continued From page 44 elopement policy and the facility responsibility of maintaining an effective process to ensure residents did not exit the facility without supervision. Observation revealed a new front door keypad with a code required for entry and exit for staff. The immediate jeopardy removal date of 1/23/24 was validated.	F 689		
F 756 SS=E	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 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	F 756		2/22/24

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F 756	Continued From page 45 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 reviews, staff and Pharmacist/Pharmacist Consultant interviews, the facility failed to conduct monthly Medication Regimen Reviews (MRR) (Resident #9) and failed to maintain pharmacy recommendations from the MRR and address the pharmacy recommendations made by the Pharmacist Consultant based on monthly MRR (Resident #1 and Resident #65) for 3 of 5 residents reviewed for unnecessary medications. Findings included: 1. Resident #9 was admitted to the facility 10/23/23. Review of Resident #9's quarterly Minimum Data Set assessment dated 12/14/23 revealed she was assessed as severely cognitively impaired. Her active diagnoses included anemia, ulcerative colitis, end stage renal disease, diabetes mellitus, hyperlipidemia, and dementia. She received scheduled and as needed pain medication. Review of Resident #9's care plan dated 10/25/23 revealed she was care planned for use of anti-anxiety medication injection every Monday, Wednesday, and Friday before Dialysis for	F 756	Corrective Action for those residents that have been affected. The Consultant Pharmacist completed the Monthly Medication Review for Resident #9 on 2/14/24. The Consultant Pharmacist performed medication regimen reviews on 2/14/24 for Residents #1 and on 2/14 24 on resident #65. Corrective action will be accomplished for those residents affected by the same deficient practice. On 2/14/24 the Director of Nursing was educated by the Administrator on conducting the Monthly Medication Regime Reviews MRR and addressing the pharmacy's recommendations. The Director of Nursing, Assistant Director of Nursing, and Unit Managers conducted an audit to ensure the facility has the most recent pharmacy recommendations and the facility has addressed any recommendations. This audit was completed on 2/20/24. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Unit	

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F 756	Continued From page 46 agitation. The interventions included to administer antianxiety medications as ordered by physician, monitor for side effects and effectiveness every shift, educate the resident/family/caregivers about risks, benefits, and the side effects and/or toxic symptoms of anti-anxiety medication drugs being given. Review of Resident #9's health record revealed the consultant pharmacist did not complete a medication regimen review for Resident #9 until 1/8/24. During an interview on 1/25/24 at 8:17 AM Unit Manager #1 stated the Director of Nursing or Assistant Director of Nursing were responsible for ensuring residents were getting their monthly MRRs. She stated she was unaware Resident #9 had not had a MRR by the Pharmacist until January 2024. During an interview on 1/25/24 at 8:33 AM the Consultant Pharmacist stated when the ownership of the facility changed, they did not update her electronic health record system access. This resulted in new residents not being carried over to her caseload. It was discovered during the quality assurance (QA) meeting at the end of December 2023 that she needed a new login. Once she received her new login information, she then did a review on Resident #9 in January 2024. During an interview on 1/25/24 at 8:36 AM the Assistant Director of Nursing stated she was not made aware until the last QA meeting the pharmacist attended that the pharmacist did not have access to the new admission residents. As soon as the Administrator was notified, he called	F 756	Coordinators, Assistant Director of Nursing, Supervisors, the Director of Nursing or her designee will audit fifteen resident MMR each month to validate medication regimen reviews were completed on each resident and addressed timely. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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the pharmacist and updated her login information for her access to the electronic health record. This was why Resident #9 was not reviewed by the pharmacist until January 2024.

During an interview on 1/25/24 at 8:40 AM the Administrator stated when the ownership of the facility changed, the login access to the electronic health records for the pharmacist was not updated and she did not have access to the newly admitted residents. This was identified during a quality assurance meeting on 12/28/23. Access to the chart was then updated and she completed a full review of the new residents including Resident #9. He concluded monthly medication review should be completed monthly.

During an interview on 1/25/24 at 10:09 AM the Director of Nursing (DON) stated she had started working for the facility on 1/8/24. She stated The DON stated she had just been informed she was responsible for ensuring medication regimen reviews were completed monthly for residents. and she had just been informed of this role as she was very new to the facility and learning their processes.

2. Resident #1 was admitted to the facility on 12/28/2023 with diagnoses that included left hip arthritis and left artificial hip joint.

Physician re-admission orders dated 11/30/2023 included to apply Lidocaine external patch 4 % to left hip topically one time a day for pain. There was no physician order to remove the Lidocaine patch 4% after 12 hours.

A review of the January 2024 Medication Administration Record indicated Resident #1 received Lidocaine patch 4% daily. There was no

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documentation that the Lidocaine 4% patch was removed 12 hours after application.

A review of Resident #1's facility generated monthly record reviews from January 2023 to January 2024 reported to see the pharmacist consultant report for consult or any noted irregularities and/or recommendations for the following months. The Pharmacist Consultant provided a copy of the following pharmacy recommendation sent to the Director of Nursing:

- 3/27/2023 Pharmacy recommendations indicated a 12-hour lidocaine patch free period and to remove Lidocaine patch 12 hours after applying.
- 1/23/2024 Pharmacy recommendations indicated a 12-hour lidocaine free period and requested an order to remove old patch twelve hours after applying a new Lidocaine patch.

A review of the facility's generated pharmacy recommendation reports from January 2023 to January 2024 indicated the pharmacist consultant reported a consult or any noted irregularities and/or recommendations for the following months for Resident #1. There was no specific medication information included in the report, and the facility was unable to provide a pharmacy recommendation to review for the following months.

- 4/27/2023
- 10/29/2023
- 12/25/2023

A review of the facility's pharmacy recommendation executive list indicating no pharmacy recommendations for the month record review indicated Resident #1 had no pharmacy recommendations for the following months:

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F 756	Continued From page 49 - 7/25/2023 - 8/23/2023 - 9/26/2023 In an interview with the Director of Nursing (DON) on 1/26/2024 at 8:45 a.m., she explained that pharmacy recommendations were sent via email to the Director of Nursing monthly, and it was the responsibility of the DON to address nursing pharmacy recommendation and to communicate with the physician for orders as needed on pharmacy recommendations. She stated after checking physician orders to verify pharmacy recommendation was completed, the printed pharmacy recommendation was signed at the bottom of the paper symbolizing it was completed and filed in a 3-ring binder in the DON office. After reviewing Resident #1's January 2024 MAR and the physician orders, she stated the pharmacy recommendation for Lidocaine patch removal twelve hours after applying a new Lidocaine patch had not been addressed as requested in the pharmacy recommendation dated 3/27/2023 and re-requested on 1/23/2024. She stated she reported to the facility as interim DON on January 8, 2024, and she could not answer how pharmacy recommendations were managed prior to her arrival to the facility. She explained due to the survey she had not addressed the pharmacy recommendation dated 1/23/2024 at this time. In an interview with the Pharmacist Consultant on 1/26/2024 at 1:03 p.m., she explained monthly record reviews (MRR) notes were recorded in the electronic medical record, the facility could generate a report for all recommendations, and there was an executive summary list of residents with no recommendations for the month. She	F 756		

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F 756	Continued From page 50	F 756		

explained each individual recommendation was emailed to the Director of Nursing (DON) or designated person to address the recommendation. She stated for pharmacy recommendations, including Resident #1's Lidocaine patch 4% removal, not addressed monthly were resubmitted. She stated due to the multiple changes in the DON position, she had not inquired with the DON why Resident #1's recommendations were not being completed within the monthly time period. The Pharmacist Consultant also stated when the facility transferred to a different company, written MRR notes did not transfer into the residents' electronic medical record.

In an interview with the Administrator on 1/27/2024 at 1:45 p.m., he stated the high turnover rate in the last year in the Director of Nursing position affected the completion of pharmacy recommendations.

3. Resident #65 was admitted to the facility on 6/17/2022 with diagnoses including dementia and violent behaviors.

The quarterly Minimum Data Set (MDS) assessment dated 12/15/2023 indicated Resident #65 was cognitively intact and was receiving antipsychotic medications, antidepressive medications, antianxiety medications, anticoagulant medications, antiplatelet medications and diuretics.

Physician orders indicated Resident #65 was ordered the following medications:

- On 11/9/2022, Lorazepam 1 milligram (mg) three times a day for anxiety

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- On 2/14/2023, Eliquis 5 mg bid for deep vein thrombus
- On 3/9/2023, Sertraline HCL 100 mg daily for depression
-On 9/27/2023, Namenda 10 mg twice a day for mild cognitive impairment
- On 12/4/2023 Risperdal 1 mg for vascular dementia

Resident #65's Abnormal Involuntary Movement Scale (AIMS) dated 6/6/2023 reported a score of 0.0. There was no further AIMS assessment documented in Resident #65's electronic medical record.

A review of the January 2024 Medication Administration Record indicated Resident #65 was given medications as ordered and documented monitoring no adverse effects from the use of antipsychotics and anticoagulant medications.

A review of the facility's generated pharmacy recommendation reports from November 2022 to January 2024 indicated the pharmacist consultant reported a consult or any noted irregularities and/or recommendations for the following months for Resident #65, and the facility was unable to provide the recommendations to review:
- 11/23/2022
- 12/28/2022
- 2/27/2023
- 4/26/2023
- 5/23/2023
- 7/25/2023
- 8/23/2023
- 9/26/2023

A review of Resident #65's Pharmacist

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Consultant report for consults or any noted irregularities and/or recommendations dated 1/23/2024 requested an updated AIMS to monitor for the use of Risperdal.

In an interview with the Director of Nursing (DON) on 1/26/2024 at 8:45 a.m., she explained that pharmacy recommendations were sent via email to the Director of Nursing monthly, and it was the responsibility of the DON to address nursing pharmacy recommendation and to communicate with the physician for orders as needed on pharmacy recommendations. She stated after checking physician orders to verify pharmacy recommendation was completed, the printed pharmacy recommendation was signed at the bottom of the paper symbolizing it was completed and filed in a 3-ring binder in the DON office. She stated she reported to the facility as interim DON on January 8, 2024, and she could not answer how pharmacy recommendations were managed prior to her arrival to the facility. The DON stated in the pharmacy recommendations provided for Resident #65 that were located in the DON binder there was no pharmacy recommendation for AIMS assessment and she had not had time to address pharmacy recommendations from 1/23/2024.

In an interview with the Unit Manager #2 on 1/26/2024 at 1:55 p.m., she stated AIMS assessments were conducted on residents receiving antipsychotic medications on admission, quarterly and when there is a significant change. She explained the electronic medical record automatically prompted nurses to conduct an AIMS assessment when due and was unsure why Resident #65's AIMS assessment was not triggered to be completed since June

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F 756	Continued From page 53 2023. In an interview with the Pharmacist Consultant on 1/26/2024 at 1:03 p.m., she explained monthly record reviews (MRR) notes were recorded in the progress notes, the facility could generate a report for all recommendations, and there was an executive summary list of residents with no recommendations for the month. She explained each individual recommendation was emailed to the Director of Nursing (DON) or designated person to address the recommendation. She stated recommendations not addressed monthly were resubmitted, and she thought she had requested an AIMS assessment on Resident #65's pharmacy recommendations in December 2023. She explained AIMS assessments were to be conducted every six months and an AIMS assessment was included on the January 2024 pharmacy recommendations. She stated due to the multiple changes in the DON position, she had not inquired with the DON why recommendations were not being completed within the monthly time period. The Pharmacy Consultant further stated when the facility changed over to a new documentation system this year, MRR notes in the old system did not transfer into the new system. In an interview with the Administrator on 1/27/2024 at 1:45 p.m., he stated the high turnover rate in the last year in the Director of Nursing position affected the completion of pharmacy recommendations.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs.	F 758		2/22/24

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F 758	Continued From page 54	F 758		

§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 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

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F 758	Continued From page 55 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 observation, record review, and staff interviews the facility failed to avoid duplication of an antipsychotic medication in a resident's orders for 1 of 5 residents reviewed for unnecessary medications (Resident #9). Findings included: Resident #9 was admitted to the facility 10/23/23. Review of Resident #9's orders revealed on 10/23/23 she was ordered chlorpromazine HCl (antipsychotic medication) oral tablet give 100 milligrams (mg) by mouth three times a day for dementia with agitation and aggression. Review of Resident #9's quarterly Minimum Data Set assessment dated 12/14/23 revealed she was assessed as severely cognitively impaired and received antipsychotic medication with a documented clinical rationale for the administration of the medication. Review of a pharmacy recommendation dated 1/8/24 revealed the pharmacist recommended for chlorpromazine HCl oral tablet 100 mg by mouth three times a day for dementia with agitation and aggression start date 10/23/23 to have a gradual dose reduction. The physician signed in agreement on 1/18/24.	F 758	Corrective Action for those residents that have been affected. On 1/23/24 the order to discontinue 100 mg of chloropyramine for resident # 9 was completed. Corrective action will be accomplished for those residents affected by the same deficient practice. On 1/18/24 the nurse that errantly transcribed the ordered was educated on transcription of physician orders. On 1/23/24 education began for Licensed Nurses on transcription of orders. The education was provided by the Unit Managers, Assistant Director of Nursing, Director of Nursing or a Nursing Supervisor. On or before 2/20/24 physician orders from 1/1/24 through 2/20/24 were reviewed by Unit Managers, Assistant Director of Nursing, Director of Nursing, or a Nursing Supervisor to ensure no further transcription errors. Any discrepancies were addressed at that time. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Unit Coordinators, Assistant Director of Nursing, Supervisors, The Director of Nursing will audit newly documented	

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F 758	Continued From page 56 Review of Resident #9's orders revealed on 1/18/24 a new order was written for chlorpromazine HCl oral tablet give 50 mg by mouth three times a day. The order for chlorpromazine HCl oral tablet give 100 mg by mouth three times a day was not discontinued. During observation on 1/22/24 at 1:36 PM Resident #9 was observed at nursing station. There were no observed concerns. The resident was awake, alert, and verbal. During an interview on 1/23/24 at 1:21 PM Nurse #4 stated she did not write the order and was just following the Medication Administration Record (MAR). Today Resident #9 got at 8 AM - 50 MG, at 9 AM - 100 MG, at 12 PM 50 MG, and 100 MG would be given at 2 PM. She gave what the MAR indicated she needed to give and the resident was not sedated. During an interview on 1/23/24 at 1:30 PM the Assistant Director of Nursing stated because the new order was a gradual dose reduction, she entered it as a new order due to the change in dosages. When she did this, she forgot to discontinue the 100 mg order after she entered the new order for the 50 mg dose. This resulted in Resident #9 getting both 100 mg and 50 mg doses three times a day instead of just the one 50 mg dose three times a day. She concluded she would discontinue the order for chlorpromazine HCl 100 mg three times a day. During an interview on 1/23/24 at 1:39 PM the Director of Nursing stated the chlorpromazine HCl 100 mg was reduced to chlorpromazine HCl 50 mg per pharmacy recommendation for a gradual	F 758	physician orders three times a week. Any noted discrepancies will be addressed at that time. This audit will continue for three months or until substantial compliance is met. The DON will review this weekly for three months. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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F 758	Continued From page 57 dose reduction and the prior order of chlorpromazine HCl 100 mg should have been discontinued to prevent giving the resident a higher dose than intended.	F 758		
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 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 medications in a locked treatment cart for 1 of 1 treatment carts observed (Treatment Cart #1).	F 761	Corrective Action for those residents that have been affected. The treatment cart was locked on 1/22/24.	2/22/24

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F 761	Continued From page 58 Findings included: During observation on 1/22/24 at 2:04 PM Treatment Cart #1 was observed unlocked outside Room #70. The cart was placed diagonally in the hallway near Room #70. The lock was observed in the unlocked position. At 2:05 PM a housekeeper passed the unlocked treatment cart and at 2:06 PM a dietary staff member passed the unlocked treatment cart. During an interview on 1/22/24 at 2:06 PM Nurse #5 stated treatment carts were to be locked when unattended and she was responsible for Treatment Cart #1. She stated she left it unlocked because she was coming back to it but was then called to help a nurse clean a resident and left it unlocked. She concluded she should have locked it prior to leaving it unattended. During observation on 1/22/24 at 2:10 PM with Nurse #5, Treatment Cart #1 was observed to contain bacitracin ointment USP, vitamin A&D ointment, triple antibiotic ointment, Santyl ointment, nystatin cream, betamethasone dipropionate cream USP 0.05%, ketoconazole cream 2%, nystatin topical powder 100,000 units per gram, zinc oxide ointment 20%, skin protectant moisturizing ointment, hydrogel wound dressing, pain relief gel with menthol, hydrophilic wound dressing, hydrogen peroxide 3% USP, and miconazole nitrate 2%. During an interview on 1/23/24 at 3:29 PM the Director of Nursing stated treatment carts were to be locked when unattended.	F 761	Corrective action will be accomplished for those residents affected by the same deficient practice. On 1/29/24 the Treatment Nurse, unit managers, and Assistant Director of Nursing were educated by the Director of Nursing on locking the cart when not actively using. The Director of Nursing or her designee began educating all licensed nurses on securing medication or treatment carts. All education will be completed by 2/21/24. After 2/21/24 Licensed Nurses will not be permitted to work without first receiving the education. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Unit Coordinators, Assistant Director of Nursing, Supervisors, The Director of Nursing or her designee will perform weekly observation audits to validate medication and treatment carts are secured when not in use. This will include the date, time, the type of cart, locked, notes, initials of observer, & Admin/DON . This cart audit will be done ten times weekly for four weeks, then seven times weekly for four weeks , and then three times weekly for four weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a patter of compliance is obtained.	

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F 809	Continued From page 59	F 809		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to obtain approval from a resident group for a greater than 14-hour time span between the evening meal and breakfast the following day. This affected residents on 5 of 5 resident meal carts (Station 1 1st cart, Special Care Unit (SCU) Hall cart, Station 1 2nd cart, Station 2 1st cart, and Station 2 2nd cart). Findings included: A review of the meal schedule revealed the Station 1 1st cart was scheduled for dinner at	F 809	Corrective Action for those residents that have been affected. On 1/24/24 there was no record of communication with the resident council that they provided permission to have more than 14 hours between meals with a protein nourishing snack. On 2/14/24 the Administrator and Activities aide met with Resident council and the council granted permission to move the meals to stay with in the 14 hour regulation. Corrective action will be accomplished for those residents to be affected by the	2/22/24

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F 809	Continued From page 60 5:00 PM and breakfast at 7:25 AM (indicative of a 14 hour and 25-minute time span between the 2 meals). The SCU Hall cart was scheduled for dinner at 5:15 PM and breakfast at 7:35 AM (indicative of a 14 hour and 20-minute time span between the 2 meals). The Station 1 2nd cart was scheduled for dinner at 5:30 PM and breakfast at 8:00 AM (indicative of a 14 hour and 30-minute time span between the 2 meals). The Station 2 1st cart was scheduled for dinner at 5:45 PM and breakfast at 8:15 AM (indicative of a 14 hour and 30-minute time span between the 2 meals). The Station 2 2nd cart was scheduled for dinner at 6:00 PM and breakfast at 8:30 AM (indicative of a 14 hour and 30-minute time span between the 2 meals). A review of the Resident Council Meeting minutes from June 2023 through January 2024 revealed there was no documentation of a discussion or agreement by the Resident Council of a break greater than 14 hours between dinner and breakfast. During an interview on 1/24/24 at 1:50 PM Resident #16, who was the Resident Council President, stated the Resident Council had never discussed mealtimes including approval of a break greater than 14 hours between dinner and breakfast. During an interview on 1/24/24 at 2:32 PM the Dietary Manager stated she had made the mealtimes schedule and emailed it to the dietitian who approved it. She stated she was not aware she needed to get approval from the Resident Council or resident group to have a span of greater than 14 hours between dinner and breakfast. She stated she was aware of the	F 809	same deficient practice. On 1/31/24 the Dietary Manager & Activity Director and her department were educated on communication with the Resident Council on any changes that the council must be made aware of as well as the Monthly Resident Council Meeting. Measures put into place or systemic changes made to ensure that the deficient practice will not occur. The Activity Director and or Administrator or his designee will be responsible for documenting communication with the Resident Council on any permissions needed or new information shared. This will be documented monthly on the Resident Council Minutes and reviewed by the Administrator or his designee to ensure accuracy. The facility plans to monitor its performance to ensure solutions are sustained The Activity Director and Administrator will review the Resident Council minutes monthly. The Activity Director will present the Findings to the Quality Assurance Performance Improvement Monthly for three months or until a pattern of compliance is obtained.	

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	345081	A. BUILDING _____ B. WING _____	C 01/29/2024

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F 809	Continued From page 61 requirement for a substantial snack and the kitchen staff made a half of a peanut butter and jelly sandwich or some kind of meat slice sandwich for each resident and a bag with an assortment of snacks as well. Her staff provided these substantial snacks to each nursing station before they left at 8:30 PM. During an interview on 1/24/24 at 2:45 PM the Administrator stated there should not be a break greater than 14 hours between dinner and breakfast without resident group or council approval. He further stated he was aware of the regulation and was positive it was discussed with Resident Council, but had no documentation of the discussion with Resident Council and could not remember when this discussion happened.	F 809		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and	F 842		2/22/24

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F 842	Continued From page 62 (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided;	F 842		

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F 842	Continued From page 63 (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete an accurate medical record related to documentation of the treatment for pressure ulcers for 1 of 3 residents reviewed for pressure ulcers (Resident #10). Findings included: Resident #10 was admitted to the facility on 12/28/2016 and diagnoses included pressure ulceration of buttocks. The quarterly Minimum Data Set (MDS) assessment dated 10/23/2023 indicated Resident #10 was cognitively intact and was receiving treatments for two pressure ulcers. Physician orders dated 12/21/2023 included an order to cleanse the left trochanter (hip area) and left ischium (buttocks area) with Dakin's solution (use to treat and prevent infections) and allowing Dakin's moistened gauze to soak in wound bed for 10 minutes. No sting skin prep was to be applied around the wound and collagen particles were to be applied into the wound bed. Calcium silver alginate was to be placed directly to the wound bed and the center of the wound filled with fluffed gauze, covered with pad dressing and secured with tape every other day Monday, Wednesday and Friday and as needed.	F 842	Corrective Action for those residents that have been affected. On 2/15/24 Wound Care Nurse #10 was provided a one to one educational in-service by the Director of Nursing on documenting treatments following provision of service. The treatment for pressure ulcers for resident #10 on dates 1/12/24 & 1/19/24 & 1/22/24 were verified as completed and documented in the treatment administration record (TAR) on 1/25/24. Corrective action will be accomplished for those residents affected by the same deficient practice. On 2/16/24 an audit was completed on all resident pressure ulcers to verify each had the appropriate documentation of treatment in the TAR. On or before 2/20/24 Licensed Nurses were educated by the Director of Nursing, Assistant Director of Nursing, Unit Managers, or Nursing Supervisors on documenting treatments following provision of services. After 2/21/24 no licensed nurse will be permitted to work without first receiving the education. Any newly hired staff will have this education prior to working. Measures put into place or systemic	

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F 842	Continued From page 64 Treatments to the pressure ulcers for 1/12/2024 (Friday), 1/19/2024 (Friday) and 1/22/2024 (Monday) were not documented as provided on the January 2024 Treatment Administration Record (TAR). There was no nursing documentation indicating the treatments to the pressure ulcers for 1/12/2024, 1/19/2024, and 1/22/2024 had been provided. In an interview with Wound Care Nurse #1 on 1/25/2024 at 11:11 a.m., she stated Resident #10's treatment to the pressure ulcer wounds was scheduled for every Monday, Wednesday and Friday. She said she worked on 1/12/2024, 1/19/2024 and 1/22/2024 and provided Resident #10 his treatments to the pressure ulcer wounds. After reviewing Resident #10's TAR on the electronic medical record, she explained treatment of the pressure ulcer wounds was highlighted in a red color indicating she had not documented providing Resident #10's treatments on 1/12/2024, 1/19/2024 and 1/22/2024. She stated treatment to the pressure ulcer wounds was to be documented on the Resident #10's TAR when completed and did not know why she had not documented the treatment was provided. In an interview with Resident #10 on 1/25/2024 at 11:55 a.m., he stated he received treatments to his pressure ulcers on Monday, Wednesday and Friday, and he had received treatments to his pressure ulcer wounds on 1/12/2024, 1/19/2024 and 1/22/2024. In an interview with the Director of Nursing on 1/25/2024 at 12:15 p.m., she stated Wound Care	F 842	changes made to ensure that the deficient practice will not occur. On Beginning 2/15/24 each week the Director of Nursing, Wound Nurse, Unit Coordinators, Administrator, MDS, Assistant Director of nursing will audit six TAR pressure ulcers to validate treatments are documented following provision of care. Any issues will be addressed at that time. This will be documented on the Audit Tool that notes date, treatment performed are ordered and initials. This will be completed weekly for 12 weeks. The facility plans to monitor its performance to make sure the solutions are sustained. The Director of Nursing or her designee will present the finding to the Quality Assurance Improvement committee for three months, or until a pattern of compliance is obtained.	

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F 842	Continued From page 65 Nurse #1 was responsible for documenting treatments to Resident #10's pressure ulcer wounds on the TAR when the care was completed.	F 842		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring,	F 867		2/22/24

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F 867	Continued From page 66	F 867		

including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

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

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

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

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

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F 867	Continued From page 67 §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements.	F 867		

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F 867	Continued From page 68 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, interview with Emergency Medical Service personnel, interview with a Resident Representative, interview with the Pharmacist/Pharmacist Consultant, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification and complaint investigation survey of 5/11/21, the focused infection control and complaint investigation survey of 3/9/22, and the recertification and complaint investigation survey of 9/16/22. This was for 7 deficiencies that were cited in the areas of: Accuracy of Assessments (F641), Develop/Implement Comprehensive Care Plan (F656), Care Plan Timing and Revision (F657), Free of Accident Hazards/Supervision/Devices (F689), Drug Regimen Review, Report Irregular, Act On (F756), Free from Unnecessary Psychotropic Medications/PRN Use (F758), and Label/Store Drugs and Biologicals (F761). These deficiencies were recited on the current recertification and complaint survey of 1/29/24. The duplicate citations during two or more federal surveys of record show a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag is cross referenced to: a. F641 - Based on record review and staff interviews the facility failed to accurately code the discharge destination and tube feeding status of 2 of 28 residents reviewed for Minimum Data Set	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 2/13/24 the Regional Vice President of Clinical Services educated the Nursing Home Administrator and Director of Nursing on developing and maintaining an effective Quality Assurance and Performance Improvement Program. 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: 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 2/13/24 the Regional Vice President of Operations 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	

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F 867	Continued From page 69 (MDS) assessments (Resident #87 and Resident #13). During the recertification and complaint survey of 9/16/22, the facility failed to complete accurate MDS assessments in the areas of mental status and mood assessment, medications, weight, and hospice. An interview with the Administrator on 1/26/24 at 3:30 PM revealed the facility had included MDS accuracy in their QAA meetings based on a prior survey citation which had recently "graduated off" the QAA process. He shared the facility was recently audited for MDS accuracy and "we thought we were ahead of it." He acknowledged the need for MDS accuracy to be reinstituted in the Quality Assurance and Performance Improvement (QAPI) process and thought the contributing factors to the deficient practice included a change in nursing leadership and stated he thought the MDS nurse was overwhelmed with the MDS workload. b. F656- Based on record review and staff interviews, the facility failed to develop and implement individualized person-centered care plans in the areas of anticoagulant use and post-traumatic stress disorder for 2 of 28 residents reviewed for comprehensive care plans (Resident #91 and Resident #58). During the recertification and complaint survey of 9/16/22, the facility failed to develop and implement an individualized person-centered care plan for activities of daily living and indwelling catheter. An interview with the Administrator on 1/26/24 at	F 867	cited. On 2/13/24, under the direction and supervision of the Regional Vice President of Operations and 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. During the QAPI Meeting, the Committee decided to initiate weekly QAPI Meetings to review the status of the plan of correction for beginning the week of 2/13/24 the areas covered are as follows: F641 Accuracy of Assessment, F656 Develop/Implement Comprehensive Care Plan, F 657 Care Plan Timing & Revision, F 689 Free of Accident Hazards/Supervision/Devices, F756 Drug Regime Review, Report Irregular, Act on, F758 Psychotropic medications/PRN use, and F761 Label/Store Drugs and Biologicals. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: An Ad Hoc QAPI meeting was held on 2/13/24 to review the alleged deficient practice cited and implement a Plan of Correction. This meeting included the Administrator, DON, ADON, Unit	

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F 867	Continued From page 70 3:30 PM revealed the facility had included developing/implementing care plans in their QAA meetings based on a prior survey citation which had recently "graduated off" the QAA process. He shared the facility had five different Directors of Nursing (DONs) in the past year, which he thought contributed to the deficient practice. He added there needed to be better communication as a team and thought stability in the DON role would help with consistency. c. F657- Based on record reviews, resident representative interview and staff interviews, the facility failed to conduct quarterly care plan meetings with cognitive residents and/or Resident Representatives (Resident #22 and Resident #59) and failed to revise a resident's care plan requiring 1:1 supervision for behaviors (Resident #70) for 3 of 28 residents reviewed for care planning. During the recertification and complaint survey of 5/11/21, the facility failed to initiate a care plan for a pressure ulcer. During the recertification and complaint survey of 9/16/22, the facility failed to conduct a care plan meeting and failed to revise the care plan for a resident observed using oxygen by nasal cannula. An interview with the Administrator on 1/26/24 at 3:30 PM revealed the facility had included updating care plans in their QAA meetings based on a prior survey citation which had recently "graduated off" the QAA process. He shared the facility had five different DONs in the past year, which he thought contributed to the deficient practice. He added there needed to be better	F 867	Manager, Maintenance Director, MDS Coordinator, Social Services Director, Business Office Manager, Rehab Services Director, Admissions Director, Regional Vice President of Clinical Services and Regional Vice President of Operations. The QAPI Committee will meet weekly for twelve weeks beginning on 2/13/24 , then monthly ongoing, 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. Corporate oversight will be provided in the center's Quality Assurance Performance Meeting to assist the facility in achieving and maintaining compliance.	

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F 867	Continued From page 71	F 867		

communication as a team and thought stability in the DON role would help with consistency.

d. F 689- Based on observations, record review, Emergency Medical Service (EMS) personnel interview, and staff interview the facility failed to provide supervision to prevent a resident with severe cognitive impairment from exiting the facility unsupervised and without staff's knowledge. On 1/22/24 Resident #83 was found by EMS personnel approximately 1.9 miles from the facility seated on the ground on a sidewalk outside at 3:05 AM with icicles hanging from his nose and beard. He was treated for hypothermia by EMS and was taken to the hospital. This was for 1 of 3 residents reviewed for accidents.

During the recertification and complaint survey of 9/16/22, the facility failed to complete smoking assessments on residents observed unsupervised smoking in the facility's designated smoking area, failed to supervise a resident who required supervision while smoking, and failed to secure smoking materials for a resident.

An interview with the Administrator on 1/26/24 at 3:30 PM revealed the interdisciplinary team reviewed accidents and falls daily in their clinical morning meeting. He reported the facility did not have a history of residents with wandering behavior. He thought the contributing factor towards the deficient practice was the accessibility of the key fob and security of the front door.

e. F756- Based on record reviews, staff and Pharmacist/Pharmacist Consultant interviews, the facility failed to conduct monthly Medication Regimen Reviews (MRR) (Resident #9) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345081	A. BUILDING _____ B. WING _____	C 01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT ROSE MANOR LLC	4230 NORTH ROXBORO STREET DURHAM, NC 27704

(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 867	Continued From page 72	F 867		

failed to maintain pharmacy recommendations from the MRR and address the pharmacy recommendations made by the Pharmacist Consultant based on monthly MRR (Resident #1 and Resident #65) for 3 of 5 residents reviewed for unnecessary medications.

During the recertification and complaint survey of 9/16/22, the facility failed to respond to a MRR on the length of time for an as needed psychotropic medication.

An interview with the Administrator on 1/26/24 at 3:30 PM revealed a new corporate company started in October 2023, access to the computer software changed and the pharmacist had not received all the information on new admissions which contributed to the deficient practice.

f. F758- Based on observation, record review, and staff interviews the facility failed to avoid duplication of an antipsychotic medication in a resident's orders for 1 of 5 residents reviewed for unnecessary medications (Resident #9).

During the recertification and complaint survey of 9/16/22, the facility failed to obtain documentation of the rationale to extend as needed psychotropic medication beyond 14 days and failed to have an adequate clinical indication for the use of a psychotic medication.

An interview with the Administrator on 1/26/24 at 3:30 PM revealed the facility routinely reviewed psychotropic medications during their QAA meetings. He thought changes in staffing contributed to the deficient practice and added the facility had recently been able to decrease agency staff and built up their "front line staff."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 867	Continued From page 73 g. F761- Based on observations and staff interviews the facility failed to keep medications in a locked treatment cart for 1 of 1 treatment carts observed (Treatment Cart #1). During the focused infection control and complaint survey of 3/9/22, the facility failed to date three opened insulin medications. An interview with the Administrator on 1/26/24 at 3:30 PM revealed the QAA committee met monthly. Some of the issues reviewed during the monthly meetings were identified through trends, quality measures, grievances and previous survey results. The Administrator explained identified issues were "put on a Quality Assurance and Performance Improvement (QAPI) program" and the facility developed and implemented interventions, monitored outcomes and adjusted the plan as needed. He said the facility had included medication storage in their QAA meetings based on a prior survey citation which had recently "graduated off" the QAA process. He thought contributing factors involved in the deficient practice included nervous staff members during the survey process which resulted in lack of attention to the security of the treatment cart.	F 867		