STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345357	A. BUILDING _____ B. WING _____	C 03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRUITTHEALTH-NEUSE	1303 HEALTH DRIVE NEW BERN, NC 28560

(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 000	INITIAL COMMENTS The survey team entered the facility on 3/12/24 to conduct a complaint investigation survey. The survey was conducted onsite on 3/12/24 through 3/13/24 with additional information obtained remotely on 3/14/24. On 3/15/24 the survey team returned to the facility to validate the immediate jeopardy removal plan and exited on 3/15/24. The survey team returned to the facility on 3/19/24 to obtain additional information and exited on 3/19/24. Therefore, the exit date was changed to 3/19/24. The following intakes were investigation: NC00209369, NC00209832, NC00211405, NC00211438, NC00212441, NC00213276, NC00213528, NC00213537, and NC00214474. Intake NC00212441 resulted in immediate jeopardy. 9 of the 37 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 1/18/24 and was removed on 3/15/24. A partial extended survey was conducted.	F 000		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		4/10/24

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

Electronically Signed | 04/07/2024

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F 689	Continued From page 1 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and family, staff, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to provide care in a safe manner for 1 of 5 residents (Resident #1) reviewed for supervision to prevent accidents. Resident #1 was diagnosed with cerebellar ataxia (a condition that causes poor muscle control that causes clumsy movements), and functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord) and was dependent on staff for assistance with care. On 1/18/24 Nursing Assistant (NA) #1 was providing Resident #1 with care when the resident experienced spastic/uncontrolled movements and the resident fell off the side of the bed striking his head on a bedside table causing a laceration on his forehead above his left eye before he fell onto the fall mat on the floor. Resident #1 was transferred to the Emergency Department and was treated for a left frontal scalp hematoma (a pool of mostly clotted blood) with a significant laceration with active bleeding that required 7 sutures for closure. Immediate jeopardy began on 1/18/24 when NA #1 failed to provide care safely to Resident #1. The immediate jeopardy was removed on 3/15/24 when the facility provided an acceptable credible	F 689	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: *On 01/18/2024 at 10:50AM, at the time of the fall, the bed was the proper height for providing activities of daily living (ADL) care for Resident #1 (proper bed height can vary from resident to resident and based upon the height of the care provider); NA # 1 was at bedside and in the process of changing the resident□s shirt. The following safety precautions were in place at the time of the incident: siderail, fall mats on floor on both sides of bed, and safety wedges in place bilaterally for edge of bed awareness. During this provision of care, Resident # 1 began flailing, fell out of bed and hit the bedside table resulting in a laceration to left eyebrow. NA #1 called for assistance and three staff members responded (registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant (CNA)). 911 was called and Resident #1 was transported to the emergency room (ER) at 3:12PM. Resident # 1 returned to the facility at 1:27AM on 01/19/2024. *Resident # 1 fell from his bed secondary	

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F 689	Continued From page 2	F 689		

allegation of immediate jeopardy removal. The facility remains out of compliance at a lower level and severity of "D" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place were effective.

Findings included:

Resident #1 was admitted to the facility on 2/28/23 with a diagnosis that included stroke with right side hemiplegia (paralysis of one side of the body) and hemiparesis (muscle weakness of one side of the body), functional quadriplegia, cerebellar ataxia, muscle weakness, lack of coordination and intellectual disability.

The quarterly Minimum Data Set (MDS) dated 10/23/23 revealed that Resident #1's cognition was severely impaired, and he was dependent on staff for activities of daily living (ADL) assistance, dressing, and bed mobility. He was coded to have received antiplatelets and had 1 fall with no injury since prior assessment on 8/7/23. He did not have behaviors.

Review of the care plan for Resident #1 dated 10/20/23 included the following:

- At risk for falls related to muscle weakness, cerebral vascular accident (stroke) with right sided hemiplegia, functional quadriplegia, intellectual disability, and cerebellum ataxia with a goal that Resident #1 would not have negative outcomes related to falls without appropriate nursing intervention through the next review (start date 2/28/23) with interventions that included to use a wider bed, floor mats beside bed, assist with toileting and transfers, keep the environment

to uncontrollable flailing due to exacerbation of his diagnosis of cerebral ataxia.

*On 01/18/2024, prior to resident□s return to the facility, room furnishings were rearranged by an LPN to prevent further injury and assist in facilitating an optimally safe environment.

*On 01/19/2024, pharmacy recommended an adjustment to Resident # 1□s dosage of medication used for muscle spasms; nurse practitioner (NP) approved recommendation; new order implemented.

*On 02/07/2024, an additional fall mat was placed on the left side of bed.

*On 02/07/2024, care plan was updated to reflect, provide 2 or more person assist with ADLs as needed.

*On 02/15/2024, mattress with bolsters in place for edge of bed reminder.

*On 02/20/2024, a pharmacy consultant conducted medication review for purposes to reduce falls. Vitamin D added. Per the National Institute of Medicine, Vitamin D has a direct influence on muscle strength and is regulated by specific vitamin D receptors in muscle tissue&Insufficient vitamin D is associated with lower physical performance and greater declines in physical functioning...

*On 03/06/2024, medical director (MD)/

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F 689	Continued From page 3 safe, and call light within reach. - Impaired physical mobility and required 1-2 person assist with ADLs related to right side hemiplegia with interventions that included to provide 1-2 person assist with ADLs as needed. In an interview with Nurse #2 on 3/12/24 at 12:08 pm it was revealed that Resident #1 had a diagnosis of cerebellar ataxia, had a recent deterioration in his condition and had become more spastic (uncontrolled movement) with increased muscle spasms and became more agitated at times. She stated he was at risk of falls because of his diagnosis. She indicated that some of the staff interventions used were: they approached him calmly as not to startle him, they kept his bed in a low position, padded the side rails with pillows, checked for incontinence and changed him as needed, and had floor mats on both sides of the bed to help prevent self-injury. The interview further revealed that Resident #1 had a wider bed to help prevent falls and that staff got him up in a chair and took him to activities to help keep him occupied and so they could keep a closer eye on him. Nurse #2 stated that a family member familiar to him visited daily and that helped. The interview further revealed that many different fall interventions had been exhausted for Resident #1 and he was reviewed in fall meetings regularly and medication reviews were done, and medications were adjusted as necessary. Nurse #2 stated he was prescribed lorazepam 0.5 milligrams at bedtime for anxiety and baclofen to help control his muscle spasms. Review of an Event Witness Statement dated 1/18/24 at 10:50 am written by NA #1 read "went into the room and took his [Resident #1's] shirt	F 689	NP reviewed medications for purposes to reduce falls. Medication used to decrease anxiety was added to the resident□s medication regimen. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. *All residents have the potential to be affected if staff fail to follow safe resident care practices. Safe resident care practices include but are not limited to the following: bed in optimal position for resident safety, bed at appropriate height during the provision of ADL care, after providing ADL care staff are to ensure all ordered fall interventions are in place prior to leaving the room, staff are to utilize tablets to access resident specific safe care interventions, etc. *On 03/02/2024 & 03/03/2024, Director of Health Services (DHS)/ Director of Nursing (DON) conducted a review of residents at high risk for falls (as identified by our Electronic Health Record (EHR) clinical risk insight report) related to diagnosis and/ or physical/ cognitive limitations. Safety interventions were reviewed to ensure individual needs for assistance with ADLs are being met and are identified on the care plan as well as the C.NAs documentation tool. Individual resident needs for assistance with ADLs are identified through the following but are not limited to: care plan meetings, multiple nursing resident assessment tools, MDS	

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F 689	Continued From page 4 off, he started moving around and fell off the bed". The statement was signed as witnessed by Nurse #3. Review of a Facility Event Investigation Form dated 1/18/24 at 10:50 am completed by Nurse #3 and signed by the Director of Nursing (DON) revealed that Nurse #3 responded to an NA's call for assistance because a resident had fallen out of bed. The review further revealed that Resident #1 was being assisted with dressing and changing when he started jumping and fell off of bed. The record had a hand drawn diagram that indicated that Resident #1 laid on the floor between both beds with a night stand near his head, it was noted that he was on his left side with his arms up by his chest, legs outstretched, and with blood on the floor coming from under him from an area on the upper left forehead. The record review further indicated that the care plan was updated to include 2 or more persons when ADL care was provided or for bed mobility. The form was dated and signed by the DON as investigation completed on 1/23/24. Review of a nurse's progress noted dated 1/18/24 at 3:12 pm written by Nurse #3 revealed that she was called to Resident #1's room by the NA and Resident #1 was on the floor between the beds in his room. The review further revealed he had fallen off his bed when the NA attempted to change and dress him. He was noted to have bled from an area on the left side of his forehead. 911 was called and Resident #1 was transported to the hospital for evaluation and treatment. Review of a nurse's progress noted dated 1/18/24 at 3:28 pm written by Nurse #3 revealed that pressure was applied to Resident #1's head for	F 689	assessments, therapy evaluations, residents history and physical, etc. Any outstanding interventions were entered as identified during the audit process by the respective auditing clinical manager; the C.NA documentation tool is automatically updated when a care plan intervention is added or updated in the EHR. *On 03/13/2024 & 03/14/2024, clinical managers completed 100% audit of ADL care plans to ensure any resident specific safety interventions are in place and appropriate. Audit outcome reflected a need to improve timely entry of new safety interventions (e.g., fall mats, wedges, etc.). Any outstanding interventions were entered as identified during the audit process by the respective auditing clinical manager. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. *On 01/20/2024, Clinical Competency Coordinator (CCC) completed education with CNAs regarding safety awareness and precautions while providing ADL care. Education included the importance of understanding the residents physical and cognitive condition/ limitations in providing safe care. C.NAs have access to care needs and interventions through the tablets provided for C.NA documentation.	

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F 689	Continued From page 5 bleeding, and he grimaced when pressure was applied. In a phone interview with NA #1 on 3/12/24 at 4:22 pm she stated that she was assigned to Resident #1 on 1/18/24 when he fell out of bed. She stated that she went into his room to give him a bath. She indicated he let her take his shirt off and at that point in time he started making his movements "like he did". She explained that was when she remembered that he had a history of flailing around with agitated movements when he received care so she was going to go get someone to assist her. She indicated she left the side of the bed without lowering the bed. She stated that he then "went off" the other side of the bed so she ran out of the room to go get the nurse. NA #1 stated that Nurse #3 came into the room. She stated that when he started to move around in bed after she removed his shirt that she talked to him so he would not move as much. She indicated that she had his bed up to a working height that permitted her to provide care on the same plane (level) as Resident #1 when he fell. She further stated that Resident #1 typically moved around a lot but would let her do his care but this day he moved so fast that he fell off the other side of the bed (opposite from where she was standing) and hit his head on the bedside table before he fell onto the floor mats that were beside his bed. She stated that she then ran over to where he laid on the floor and asked him if he was ok and he said he was. NA #1 indicated that there was blood everywhere, on the privacy curtain, on the floor, and on his head and upper body. The interview further indicated that NA #1 recalled that Resident #1 had moved around a lot since she started working at the facility in July of 2023 and because of that 2	F 689	*On 03/13/2024, CCC provided education (additional to education provided on 01/20/2024) to RNs, LPNs, and C.NAs which included checking room environment for safety prior to leaving the room (e.g., ensuring bed is in optimum position for individual resident safety, any fall interventions are in place prior to leaving room, etc.). Staff who did not receive education were removed from the schedule until education can be provided. Facility does not utilize agency staff. *On 03/13/2024, an ad hoc Quality Assurance and Process Improvement (QAPI) meeting was held. Attendees were Administrator, Admin-in-Training (AIT), Director of Health Services (DHS), Unit Coordinators, Infection Preventionist (IP), CCC, Skin Integrity Nurse, and Senior Nurse Consultant (via conference call). Items discussed included: creating a safety task force reviewing all ADL care plans to ensure interventions reflect current and individualized resident needs. The task force will focus on resident safety during ADL care utilizing visual observation rounds, the clinical event log, the resident care plan, and a quality assurance (QA) tracking tool. *On 03/14/2024, CCC provided education to the Nursing Staff (Licensed Nurses and C.NAs) on providing ADL care in compliance with individual safety interventions per the residents□ plan of care. Nurses and CNAs are to review the CNA Care profile in electronic health record (EHR) available on documentation	

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F 689	Continued From page 6 people usually worked with Resident #1. She further stated that she knew she should use 2 people when she provided care to Resident #1 because when she became employed at the facility other staff (no specific staff names provided) told her that. She indicated that there were no staffing issues on the morning of 1/18/24 when she provided care to Resident #1. She explained that she was not thinking that day and was just "moving" to get her patient care completed and as soon as she removed his shirt that she thought she needed to go get someone else to assist her when he started with his agitated "movements". In a phone interview with the Administrator on 3/14/24 at 3:11 pm she stated that NA #1 wanted the surveyor to call her back so that she could clarify some information that she had given in a previous interview on 3/12/24 at 4:22 pm. The Administrator stated that NA #1 had never left the bedside on 1/18/24 when the resident fell out of the bed. In a follow up phone interview with NA #1 on 3/14/24 at 3:31 pm she indicated that her statement in a phone interview on 3/12/24 at 4:22 PM was correct but clarified that she never left his bedside prior to the fall. She explained that she stood beside the bed the entire time. She stated that she took his shirt off and thought "in my head" that she needed to go get someone to help when he got agitated. NA #1 stated that she stood beside his bed but did not grab him or hold him when he thrashed around because she did not want to restrain him but didn't want him to fall off the bed so she hovered her hand over his body without touching him. She stated she was on the side of the bed closest to the door and kept her	F 689	devices for information on resident specific care needs. Staff who did not receive education were removed from the schedule until education can be provided. Facility does not utilize agency staff. CCC monitors education for completion. *On 03/14/2024 & 03/15/2024, clinical staff (RNs, LPNs, & C.NAs) educated by the CCC on the importance of optimizing resident safety during the provision of ADL care and post care. Education included the following but not limited to: understanding resident limitations/ capabilities, knowledge of where and how to locate resident specific safety interventions, gathering care products prior to initiating resident care, after care has been started resident is not to be left unattended, after care is provided checking the environment to ensure all safety interventions are in place (e.g., fall mats, bed in lowest position (if applicable to resident need), etc.). Staff who did not receive education were removed from the schedule until education can be provided. This education will be added to new clinical team member orientation; classroom orientation is completed prior to unit/ room assignments. *Effective 03/14/2024, CCC will provide education to new clinical team members orientation (RNs, LPNs, C.NAs) regarding the importance of understanding your residents and meeting their individual needs. This education will include where and how to find information on interventions needed for the provision of	

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F 689	Continued From page 7 hand hovered over him and that he "thrashed" toward her side of the bed. She felt that if she stood there and hovered her hand over him that she was not restraining him and if he moved to her side of the bed that he would not fall and hit the floor. She indicated that he then suddenly sat up and threw himself toward the opposite side of the bed and fell off the bed (from where NA #1 was standing) before she could stop him. She rationalized that when he sat up, she thought he was going to lay back down but he didn't and he instead "flung" himself off the opposite side of the bed. During an interview with Nurse #3 on 3/12/24 at 3:09 pm she stated that Resident #1 would get anxious when he was left alone or if staff tried to change him. She stated that his behavior was "childlike" and when he became anxious or agitated that he would swing his body, arms, and legs and that he could fall out of the bed. She described his movements as flailing and that he would flail and move around a lot when staff tried to provide care. She stated that interventions were in place for him that included lower bed position and fall mats on the floor. The interview further revealed that he had a fall in January 2024, but she could not recall the date, when NA #1, who was unfamiliar with him and did not know how anxious he would get, assisted him with morning care and he flipped himself off the bed. She stated that NA #1 had the bed raised while she gave him care and worked without assistance with him the day he fell. After he fell his care plan was changed so that 2 or more staff assisted Resident #1 when care was provided. She recalled that blood was everywhere, and she called a code green (to indicate a fall) and after she saw the amount of blood that she called 911	F 689	safe care for each resident. Classroom orientation is completed prior to unit/ room assignments. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. *QAPI Committee implementing a Safety Task Force to conduct a root cause analysis of events occurring during the provision of care. *The task force will focus on resident safety during ADL care utilizing visual observation rounds, the clinical event log, the resident care plan, and a quality assurance (QA) tracking tool. *The task force will report monthly to the QAPI Committee for monitoring sustained compliance. Task force members to include DHS and/or designee, CCC, Skin Integrity Nurse, and Unit Coordinators DATE OF COMPLIANCE: APRIL 10, 2024	

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F 689	Continued From page 8	F 689		

(EMS-Emergency Medical Services) and stayed with him until EMS arrived. Nurse #3 further indicated that she attempted to get a brief on him after he fell when he was on the floor while she waited for EMS to arrive, but he twisted all around and she could not. She stated that he had a laceration to his left forehead that bled a lot.

In an interview with a family member on 3/12/24 at 3:00 pm it was revealed that Resident #1 fell out of his bed on 1/18/24 and was taken to the hospital where he received sutures to his forehead. She stated that she arrived at the facility on 1/18/24, the day he fell off the bed, just before he was transported to the hospital and that his face was covered with blood.

Review of hospital emergency department (ED) records dated 1/18/24 revealed Resident #1 was received in the ED on 1/18/24 at 1:11 pm from EMS (Emergency Medical Services) with a chief complaint of a fall out of bed with a laceration above the left eye. Resident #5 was assessed to have the worst possible pain as rated on a numeric/faces pain scale (a pain scale that assigns a number to a face to assess pain in an individual that is unable to report pain. A 0 point 'happy face' represents the absence or lack of pain. A 10 point 'crying face' represents the worst possible or most excruciating pain). The physician was called to the bedside immediately due to the nature of Resident #1's laceration. He was assessed by the physician to have a large hematoma above his left eye with a significant laceration that actively bled and the bleeding was not well controlled with applied pressure. Resident #1 was placed in a "C" (cervical) collar (to prevent movement of the head and neck) and lidocaine (a medication to numb) and epinephrine

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F 689	Continued From page 9	F 689		

(a medication to constrict blood vessels) were ordered to get as rapid a closure [of the laceration] as possible. 7 sutures were placed to close the laceration. Resident #1 received fentanyl (pain medication) 25 micrograms/0.5 milliliters via intravenous push (medication given all at one time). A CT (computerized tomography) brain scan (a diagnostic imaging exam that uses X-ray technology to produce images of the inside of the body) was done with the findings of a left frontal scalp hematoma (a pool of mostly clotted blood) with no intercranial (in the brain) bleeding. Resident #1 was discharged back to the facility from the hospital on 1/18/24 at 6:03 pm.

In an interview with the DON on 3/13/24 at 10:17 am it was revealed that the facility provided fall prevention training for staff when every fall occurred. She stated that it was discussed in the training how the fall happened, how the fall could be prevented, if the care plan needed to be updated, and how many staff should have been used. She indicated that Resident #1 received care using the number of staff that he was care planned for at the time of the fall which was 1-2 staff members.

During an interview with NA #2 on 3/13/24 at 1:31 pm she stated that Resident #1 moved around a lot during his care and that she noticed that his movement increased around the time he had a fall but did not recall if the increased movement started prior to his fall in January 2024. She described his movement as "jerk-like" and stated that when he was rolled over in bed that he would jerk his body and swing his arms and legs. She stated that he had always had these types of movements since he was admitted about a year ago but it had gotten worse. She stated that he

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had always required 2 staff to assist with all his care since he was admitted to the facility about a year ago because he moved a lot. NA #2 stated that she believed it was not safe to work with Resident #1 without assistance from another staff for the safety of Resident #1 and the staff since he kicked and moved around so much during ADL care and when he was handled in any way. She indicated that that staff had received training specific to his care periodically since he was admitted prior to his fall in January of 2024. She was unable to provide specific dates that training occurred prior to the 1/18/24 fall. She further indicated that the trainings were informal and usually in a group and delivered verbally by nurse supervisors, usually after he had a fall or any change in care needs. The training typically included things like to keeping the bed in a low position, using floor fall mats beside his bed, and to always use 2 staff when care was provided.

In an interview with NA #3 on 3/13/24 at 1:56 pm she stated that she had worked at the facility for about 9 months and that she had often worked with Resident #1. She stated that she and other staff had always used 2 people when they transferred or did ADL care with Resident #1 because he got agitated and had muscle spasms in his legs and that his limbs started to move around and he "flopped like a fish out of water" and she could not contain him alone. She further stated that his condition had worsened since the beginning of 2024. She stated that NA's were taught how to go into the computer to see the care plan and she could see how many people were needed to assist a resident, but that they received in-services each time Resident #1 had a fall and were educated verbally by a nurse supervisor to get assistance when she worked

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Resident #1 so she did.

In an interview with the Administrator on 3/13/24 at 4:15 pm she stated that at the time of the fall that Resident #1 was a 1-2 person assist. She stated that the care plan had been updated on 2/7/24 from a 1-2 person assist to a 2 or more person assist after his fall on 1/18/24.

In an interview with the MD on 3/14/24 at 3:41 pm it was revealed that Resident #1's falls were directly related to his diagnosis of cerebellar ataxia and that his spasticity had increased recently so his medication baclofen had been increased in the past few months but she was unsure of the date. She stated that he was at risk for falls related to his diagnosis.

In an interview with NP #2 on 3/15/24 at 1:35 pm revealed that Resident #1 had a diagnosis of spinal cerebellar ataxia which caused uncontrolled movements and that his condition had worsened in the past few months.

The Administrator was notified of immediate jeopardy on 3/13/24 at 3:53 pm

The facility provided the following credible allegation of immediate jeopardy removal:

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

" On 01/18/2024 at 10:50AM, at the time of the fall, the bed was the proper height for providing activities of daily living (ADL) care for Resident #1 (proper bed height can vary from resident to resident and based upon the height of the care

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provider); NA # 1 was at bedside and in the process of changing the resident's shirt. The following safety precautions were in place at the time of the incident: siderail, fall mats on floor on both sides of bed, and safety wedges in place bilaterally for edge of bed awareness. During this provision of care, Resident # 1 began flailing, fell out of bed and hit the bedside table resulting in a laceration to left eyebrow. NA #1 called for assistance and three staff members responded (registered nurse (RN), licensed practical nurse (LPN), certified nursing assistant (CNA). 911 was called and Resident #1 was transported to the emergency room (ER) at 3:12PM. Resident # 1 returned to the facility at 1:27AM on 01/19/2024.
" Resident # 1 fell from his bed secondary to uncontrollable flailing due to exacerbation of his diagnosis of cerebral ataxia.
" On 01/18/2024, prior to resident's return to the facility, room furnishings were rearranged by an LPN to prevent further injury and assist in facilitating an optimally safe environment.
" On 01/19/2024, pharmacy recommended an adjustment to Resident # 1's dosage of medication used for muscle spasms; nurse practitioner (NP) approved recommendation; new order implemented.
" On 01/20/2024, Clinical Competency Coordinator (CCC) completed education with CNAs regarding safety awareness and precautions while providing ADL care. Education included the importance of understanding the resident's physical and cognitive condition/ limitations in providing safe care. CNAs have access to care needs and interventions through the tablets provided for CNA documentation.
" On 02/07/2024, an additional fall mat was placed on the left side of bed.
" On 02/07/2024, care plan was updated to

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reflect, "provide 2 or more person assist with ADLs as needed".
" On 02/15/2024, mattress with bolsters in place for edge of bed reminder.
" On 02/20/2024, a pharmacy consultant conducted medication review for purposes to reduce falls. Vitamin D added. Per the National Institute of Medicine, "Vitamin D has a direct influence on muscle strength and is regulated by specific vitamin D receptors in muscle tissue ...Insufficient vitamin D is associated with lower physical performance and greater declines in physical functioning..."
" On 03/02/2024 & 03/03/2024, Director of Health Services (DHS)/ Director of Nursing (DON) conducted a review of residents at high risk for falls (as identified by our Electronic Health Record (EHR) clinical risk insight report) related to diagnosis and/ or physical/ cognitive limitations. Safety interventions were reviewed to ensure individual needs for assistance with ADLs are being met and are identified on the care plan as well as the CNAs documentation tool. Individual resident needs for assistance with ADLs may be identified through any of the following, but are not limited to: care plan meetings, multiple nursing resident assessment tools, Minimum Data Set assessments, therapy evaluations, residents' history and physical, etc. Any outstanding interventions were entered as identified during the audit process by the respective auditing clinical manager; the CNA documentation tool is automatically updated when a care plan intervention is added or updated in the EHR.
" On 03/06/2024, medical director (MD)/ NP reviewed medications for purposes to reduce falls. Medication used to decrease anxiety was added to the resident's medication regimen.
" All residents have the potential to be affected if

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staff fail to follow safe resident care practices. Safe resident care practices include but are not limited to the following: bed in optimal position for resident safety, bed at appropriate height during the provision of ADL care, after providing ADL care staff are to ensure all ordered fall interventions are in place prior to leaving the room, staff are to utilize tablets to access resident specific safe care interventions, etc.

Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete:

" On 03/13/2024, CCC provided education (additional to education provided on 01/20/2024) to RNs, LPNs, and CNAs which included checking room environment for safety prior to leaving the room (e.g., ensuring bed is in optimum position for individual resident safety, any fall interventions are in place prior to leaving room, etc.). Staff who did not receive education were removed from the schedule until education can be provided. Facility does not utilize agency staff.
" On 03/14/2024 & 03/15/2024, clinical staff (RNs, LPNs, & CNAs) educated by the CCC on the importance of optimizing resident safety during the provision of ADL care and post care. Education included the following but not limited to: understanding resident limitations/ capabilities, knowledge of where and how to locate resident specific safety interventions, gathering care products prior to initiating resident care, after care has been started resident is not to be left unattended, after care is provided checking the environment to ensure all safety interventions are in place (e.g., fall mats, bed in lowest position (if

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applicable to resident need), etc.). Staff who did not receive education were removed from the schedule until education can be provided. This education will be added to new clinical team member orientation; classroom orientation is completed prior to unit/ room assignments.
" On 03/13/2024, an ad hoc Quality Assurance and Process Improvement (QAPI) meeting was held. Attendees were Administrator, Admin-in-Training (AIT), Director of Health Services (DHS), Unit Coordinators, Infection Preventionist (IP), CCC, Skin Integrity Nurse, and Senior Nurse Consultant (via conference call). Items discussed included: creating a safety task force reviewing all ADL care plans to ensure interventions reflect current and individualized resident needs. The task force will focus on resident safety during ADL care utilizing visual observation rounds, the clinical event log, the resident care plan, and a quality assurance (QA) tracking tool.
" On 03/13/2024 & 03/14/2024, clinical managers completed 100% audit of ADL care plans to ensure any resident specific safety interventions are in place and appropriate. Audit outcome reflected a need to improve timely entry of new safety interventions (e.g., fall mats, wedges, etc.). Any outstanding interventions were entered as identified during the audit process by the respective auditing clinical manager.
" On 03/14/2024, CCC provided education to the Nursing Staff (Licensed Nurses and C.NAs) on providing ADL care in compliance with individual safety interventions per the residents' plan of care. Nurses and CNAs are to review the CNA Care profile in electronic health record (EHR) available on documentation devices for information on resident specific care needs. Staff who did not receive education were removed

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from the schedule until education can be provided. Facility does not utilize agency staff. CCC monitors education for completion.
" Effective 03/14/2024, CCC will provide education to new clinical team members orientation (RNs, LPNs, CNAs) regarding the importance of understanding your residents and meeting their individual needs. This education will include where and how to find information on interventions needed for the provision of safe care for each resident. Classroom orientation is completed prior to unit/ room assignments.

Date of Immediate Jeopardy Removal: 3/15/24

The credible allegation of immediate jeopardy removal was verified on 3/15/24. Interviews were conducted with a sample of Nursing Assistants and Nurses to verify education was conducted for Nurses and NAs regarding safe delivery of care for residents. Documentation of in-service records was reviewed. A review of audits of ADL care plans dated 3/13/24 and 3/14/24 were verified to be completed. In an interview with the Clinical Competency Coordinator on 3/15/24 at 4:05 pm, he stated that all Nurses, Nursing Assistants, and therapists had been educated on providing care for all residents, how to access the electronic medical record and find the care plan and if in doubt to ask a nurse, supervisor or therapy. He stated that he was responsible for orienting new nurses and nursing assistants on providing safe care to residents for all residents. He further stated that orientation had been updated to include Resident Safety Awareness/training for nursing staff that included falls, what to do, interventions, and who to notify.

An observation of the Resident #1's room and

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F 689	Continued From page 17 environment revealed that Resident #1 was in bed and fall mats were in place on both sides of the bed, the bed was in a low position, furniture had been arranged a safe distance away from the bed, side rails hand been padded, and mattress bolsters were in place at the edges of the bed. A family member of Resident #1 was in the room sitting at his bedside. During the survey, observations were made of care being provided to multiple residents and no concerns were identified with the safe provision of care. The facility's immediate jeopardy removal date of 3/15/24 was validated.	F 689		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to administer prescribed narcotic pain medication for 1 of 2 residents (Resident # 3) reviewed for pain management. Resident #3 was admitted on 12/1/23 and did not receive his prescribed pain medication for 5 days after he was admitted to the facility resulting in the resident experiencing increased pain rated as a 7 on a 0-10 pain scale (on a numeric pain scale designed to evaluate	F 697	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 no longer resides at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	4/10/24

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F 697	Continued From page 18 pain in individuals using a number value with 0 being no pain and 10 being the worst pain possible). Findings included: Resident #3 was admitted to the facility on 12/1/23 with a diagnosis that included chronic osteomyelitis (serious infection of the bone). Review of Physician orders dated 12/1/23 indicated that Resident #3 was prescribed oxycodone 10 milligram (mg) tablet, take one tablet every four hours PRN (as needed) for chronic pain. Review of the December 2023 Medication Administration Record (MAR) revealed that on 12/1/23, 12/2/23, 12/3/23, 12/4/23, and 12/5/23 that Resident #3 did not receive his PRN oxycodone. This was evidenced by an "x" mark placed in the date box that indicated that the medication had not been administered. A pain assessment had been completed by Nurse #4 on 12/3/23 for Resident #3 and was documented as a 7. In a phone interview with Nurse #4 on 3/14/24 at 11:12 am it was revealed that he did not recall Resident #3 or if he had pain because he worked the short-term rehabilitation unit, and his residents only stayed a short time and there was a lot of turnover of residents. He stated that he did not recall if or what he may have communicated to the Physician about Resident #3's pain medication. He stated that if the pain medication was not available the nurses could have gotten it out of the "pyxis" (a locked medication dispenser intended to be utilized when	F 697	The Director of Health Services and Nure Managers have reviewed all new readmissions from 3/5/24 to 4/5/24 to ensure pain medication was appropriately ordered and received. Out of thirty-seven residents, fifteen were noted to have pain medication ordered; and, of the fifteen identified residents, fourteen received ordered pain medication from pharmacy and/or received pain medications from pyxis (emergency medication). Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. The Director of Health Services (DHS), Nurse Managers and Pharmacist will educate the Nurses on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy. This education will be completed by 4/10/24. All Nurses who have not completed their education by 4/10/24 will be removed from the schedule until the education is completed. Education on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy has been added to the general orientation for all Nurses. The Director of Health Services and Nurse Managers are validating that all licensed nursing personnel have access to and knowledge of how to utilize the pyxis. This review will be completed by	

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F 697	Continued From page 19 a resident was out of or did not have a medication until their medication was delivered from the pharmacy), or they could have contacted the Physician to get something else ordered that could be pulled from back up medication supply until the Resident #3's medication became available. He stated that he could not recall if he had asked for an alternative medication for Resident #3. Record review of a Request for Treatment dated 12/5/23 completed by Nurse #3 for Resident #3 indicated that Nurse #3 made a written request to the contract physicians' group requesting that oxycodone 10 mg tablets be called into the pharmacy ASAP (as soon as possible) to make sure "scripts" were in so she could get them out of the "pyxis". In a phone interview with Nurse #3 on 3/14/24 at 3:18 pm she stated that she was assigned to care for Resident #3 on 12/5/23 and that he did not complain of pain but wanted to know where his oxycodone was. She stated he would ask her when it would come each time she brought him his routine scheduled medications throughout the day. She further indicated that Resident #3 was calm and not "freaking out" and she let him know that his pain medication would be in that night. Nurse #3 stated that she was surprised when she came in to work that his medications were not in yet. She further indicated that when she learned that his pain medication had not been delivered that she filled out a Request for Treatment form that she faxed to the provider to get the signed orders so the pharmacy would send his pain medication. Record review of pharmacy delivery records	F 697	4/9/2024. Nurses who are unable to access the pyxis will be given access by the Director of Health Services immediately. The Nurse Navigator and/or Social Worker and Nurse Managers are interviewing new residents within 24 hours and daily for seven days to inquire about pain levels. When a resident is exhibiting pain the Nurse Navigator/Social Worker and/or Nurse Manager notifies the Licensed Nurse for administration of available pain medication and or physician notification if pain medication is not prescribed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nurse Navigator will report the analysis of the New Resident interview for pain levels to the Quality Assurance and Performance improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. DATE OF COMPLIANCE: APRIL 10, 2024	

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indicated that Resident #3's medication, oxycodone 10 mg tablets, were signed as delivered to the facility on 12/5/23 and received by Nurse #6.

The MAR indicated that Resident #3 received his first dose of oxycodone on 12/6/23 at 12:26 am. There was no documented pain level.

Review of the Admission Minimum Data Set (MDS) dated 12/7/23 revealed Resident #3 was cognitively intact and was coded to receive an opioid pain medication. He was assessed to have no pain.

Review of a nurse progress note dated 12/18/23 written by Nurse #3 revealed that Resident #3 was discharged to the hospital on 12/18/23 and he did not return to the facility.

In a phone interview with Resident #3 on 3/14/24 at 9:29 am he stated that he had pain every day after admission until his pain medication came in. He described the pain in his hips, back, and shoulders as a 7 or 8 on a 0-10 pain scale. Resident #3 stated that he finally started to receive his pain medication around the 5th day after admission and then his pain level became more tolerable and stated that a pain level of 7 or 8 was not tolerable to him. He stated that he was offered acetaminophen, but he could not take that because of other health issues. Resident #3 stated that after his pain medication came in from the pharmacy that things "calmed" down for him.

An interview with the Director of Nursing on 3/13/24 at 4:30 pm revealed that she was unaware that Resident #3 did not get his narcotic pain medication for 5 days and that a resident

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F 697	Continued From page 21 should not have had to go 5 days without a pain medication. In an interview with the Administrator on 3/13/24 at 4:45 pm she stated that she would have expected that Resident #3 would have received his medications as ordered and not missed doses. The interview further revealed the facility had a "pyxis" on-site that nurses could access to obtain needed medications. She stated that if the resident's pain medication was not available that the nurse could have called the Physician to get an order for something that was available in the "pyxis" until his medication was available. In a phone interview with the facility Medical Director (MD) on 3/14/24 at 3:41 pm it was revealed that other than the pain that Resident #3 had to endure for the 5 days without the medication that he did not suffer any harm from the missed doses of pain medication. During a phone interview with NP #1 on 3/15/24 at 2:11pm she stated that she was not aware that Resident #3 did not get his prescribed narcotic pain medication as ordered and that Resident #3 should not have had to wait 5 days for his medications to become available to him.	F 697		
F 755 SS=G	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of	F 755		4/10/24

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F 755	Continued From page 22 a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, Pharmacist, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to obtain narcotic medications from the pharmacy for 1 of 10 resident (Resident # 3) reviewed for pharmacy services. This caused Resident #3 to miss 5 days of pain medication, 4 days of anti-anxiety medication and 3 days of sedative/hypnotic medication that resulted in increased pain, anxiety, and inability to sleep for Resident #3. Findings included:	F 755	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 no longer resides at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Health Services and Nure	

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F 755	Continued From page 23 Resident #3 was admitted to the facility on 12/1/23 with a diagnosis that included atrial fibrillation (an irregular rapid heart rate), anxiety disorder, chronic osteomyelitis (serious infection of the bone), and insomnia. Review of the Admission Minimum Data Set (MDS) dated 12/7/23 revealed Resident #3 was cognitively intact and was coded to receive an opioid, anxiolytic, and hypnotic. Review of Physician orders dated 12/1/23 indicated that Resident #3 was prescribed lorazepam 1 mg tablet, take one tablet 3 times a day for anxiety disorder, oxycodone 10 mg tablet, take one tablet every four hours PRN (as needed) for chronic pain, and zolpidem 10 mg tablet, take one table at bedtime for obstruction sleep apnea. Review of the December 2023 Medication Administration Record (MAR) revealed that on 12/1/23, 12/2/23, 12/3/23, 12/4/23, and 12/5/23 that Resident #3 did not receive his PRN oxycodone and on 12/2/23, 12/3/23, 12/4/23, and 12/5/23 he did not receive his scheduled lorazepam. The review further revealed that he did not receive his scheduled zolpidem on 12/1/23, 12/2/23, or 12/3/23. This was evidenced by nursing initials placed in parenthesis and a reason documented on the MAR as Not Administered: Drug/Item Unavailable. Record review of pharmacy delivery records indicated that the medications Zolpidem 10 mg tablets, lorazepam 1 mg tablets, and oxycodone 10 mg tablets were signed as delivered to the facility on 12/5/23 and received by Nurse #6.	F 755	Managers have reviewed all new readmissions from 3/5/24 to 4/5/24 to ensure pain medication was appropriately ordered and received. Out of thirty-seven residents, fifteen were noted to have pain medication ordered; and, of the fifteen identified residents, fourteen received ordered pain medication from pharmacy and/or received pain medications from pyxis (emergency medication). Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. The Director of Health Services (DHS), Nurse Managers and Pharmacist will educate the Nurses on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy. This education will be completed by 4/10/24. All Nurses who have not completed their education by 4/10/24 will be removed from the schedule until the education is completed. Education on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy has been added to the general orientation for all Nurses. The Director of Health Services and Nurse Managers are validating that all licensed nursing personnel have access to and knowledge of how to utilize the pyxis. This review will be completed by 4/9/2024. Nurses who are unable to access the pyxis will be given access by	

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F 755	Continued From page 24 Review of a nurse progress note dated 12/18/23 written by Nurse #3 revealed that Resident #3 was discharged to the hospital on 12/18/23 for an unrelated concern and he did not return to the facility. In an interview with Nurse #3 on 3/13/24 at 3:23 pm she stated that she was unsure why the pharmacy did not send the medication and thought that they were waiting for a Physician to approve it. The interview further revealed that the hospital should have sent written prescriptions for the narcotics to the facility with Resident #3 but that they did not always do that. Nurse #3 stated that the pharmacy is notified when a newly admitted residents orders are entered into the EMR and recalled that they were waiting for the hard script (written narcotic prescription signed by the prescriber) and that the providers for the facility would not provide a written prescription for narcotics until the provider evaluated the resident. She further indicated that the process was that a nurse would put a note in the providers mailbox and the provider would get it the next morning and would evaluate the resident and then write a hard script. Nurse #3 further indicated that they had a backup medication system (a locked medication dispenser intended to be utilized when a resident was out of or did not have a medication until their medication was delivered from the pharmacy) at the facility but that she did not know the process of how to get into the system to get medications for a resident. Nurse #2 indicated that the pharmacy had to have the active signed written prescription before they would send a narcotic medication. In an interview with the Unit 2 Coordinator on 3/13/24 at 3:28 pm it was revealed that Resident	F 755	the Director of Health Services immediately. The Nurse Navigator and/or Social Worker and Nurse Managers are interviewing new residents within 24 hours and daily for seven days to inquire about pain levels. When a resident is exhibiting pain the Nurse Navigator/Social Worker and/or Nurse Manager notifies the Licensed Nurse for administration of available pain medication and or physician notification if pain medication is not prescribed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nurse Navigator will report the analysis of the New Resident interview for pain levels to the Quality Assurance and Performance improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. DATE OF COMPLIANCE: APRIL 10, 2024	

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#3 was admitted in the evening on 12/1/23 and that the hospital did not send the signed hard scripts with him for the narcotics. She stated that it was facility policy that the facility physician or nurse practitioners could not send narcotic prescriptions to the pharmacy until a provider had seen and evaluated the resident. The Unit 2 Coordinator provided a fax confirmation that showed the facility faxed the hard scripts to the pharmacy on 12/1/23 at 9:41 pm.

Review of a fax transaction form dated 12/1/23 revealed the facility had faxed Resident #3's hard scripts for his narcotic medication to the pharmacy at 9:41pm and that the result was "OK". The faxed form had handwriting that read "came from [hospital name] on 12/1 scripts not signed please send in new scripts for all meds attached so resident can have scheduled and as needed". Attached to the form were 3 unsigned hard scripts for lorazepam 1 mg, oxycodone 10 mg, and zolpidem 10 mg. This form was not signed by the sender.

In a phone interview with Resident #3 on 3/14/24 at 9:29 am he stated that he had pain every day until his pain medication came in. He described the pain in his hips, back, and shoulders as a 7 or 8 on a 0-10 pain scale. Resident #3 stated that he finally started to receive his pain medication around the 5th day after admission and then his pain level became more tolerable and stated that a pain level of 7 or 8 was not tolerable to him. The interview further revealed that Resident #3 could not sleep until his zolpidem came in and that he had been taking lorazepam for 4 or 5 years and that his atrial fibrillation could get worse if he did not have his lorazepam. Resident #3 stated that after these medications came in from

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the pharmacy that things "calmed" down for him.

An interview with the DON on 3/13/24 at 4:30 pm revealed that she was unaware that Resident #3 did not get his narcotic medication for 5 days and that the process was that if a resident was admitted without a hard script from where they discharged from that staff should have to called the facility's on-call provider to get an order to get something out of the facility's back up medication supply. She stated that the pharmacy would then have called the nurse on duty to give her a code to get the narcotic from the back-up medication supply. She further stated that nothing should have prevented staff from calling the Physician to get an e-script (electronic prescription) sent by the Physician to the pharmacy or that the Physician could have sent a STAT (urgent or rush) order and it would have been directed to a back-up pharmacy that was just across the street from the facility and that pharmacy would have delivered the medication to the facility. The interview further revealed that the facility did not have a policy that stated that a Physician was required to see and evaluate a resident before they wrote a hard script or sent an e-script to the pharmacy for a narcotic.

In an interview with the Administrator on 3/13/24 at 4:45 pm she stated that if a resident was admitted late on a Friday that she hoped that the hospital would have sent a hard script or would have e-scripted the order to the pharmacy. She further added that for the same night delivery of a medication that the pharmacy would have had to receive the order by 3:00 pm the same day. The interview further revealed the facility had a "pixis" (a locked machine that contained a supply of back up medications) on-site that nurses could

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access to obtain needed medications. She stated that if the resident was admitted without the hard script that the nurse could have called the Physician to get an order for something that was available in the "pixis" until their medication was available. She stated that the facility did not have a policy that stated that the Physician had to see and evaluate a resident before they could write a hard script for a narcotic medication but that she had heard that the contracted physician group required that.

In a phone interview with Nurse # 4 on 3/14/24 at 11:12 am it was revealed that he stated that he did not recall Resident #3 because he worked the short-term rehabilitation unit and his residents only stayed a short time and there was a lot of turnover of residents. He stated that he did not recall if or what he may have communicated to the Physician about Resident #3's medications. He stated that when residents were admitted late on a Friday that the facility had issues with getting signed hard scripts from the on-call Physician. He stated that an alternative would be that if the medication was not in the back-up supply that they could get something else ordered that could be pulled from back up medication supply until they could get the hard scripts signed, but if the on-call Physician or provider did not have the ability to do an e-script then they were "stuck". He stated that he could not recall if he asked for an alternative medication for Resident #3. Nurse #4 described his process to ensure that he does not run out of medications for a resident is that when he counted narcotics with another nurse that he noted how low a narcotic was getting and he would go to the medical provider that was on that day and get new prescriptions and that he did the same process with newly admitted residents.

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He further stated that if a resident came in late on Friday and the prescriptions were not signed that he could not pull the medication from back-up supply if they did not have an active e-script and without a signed prescription there was nothing that he could do. He stated if the order got e-scripted on a Friday night that it would not have arrived until Saturday night. He further indicated that he thought the problem was a process issue.

In a phone interview with Nurse #3 on 3/14/24 at 3:18 pm she stated that she was assigned to care for Resident #3 on 12/5/23 and that wanted to know where his lorazepam and oxycodone were. She recalled he was prescribed lorazepam 3 times a day and would ask her if they were in his medication cup when she brought him his medications. She stated he would ask her when they would come it. She further indicated that Resident #3 was calm and not "freaking out" and she let him know that his medications would be in that night (12/5/23). Nurse #3 stated that she was upset that his medications had not come in yet because she had worked on Friday but not the weekend and was surprised when she came in that his medications were not in yet and she wanted to know why. She further indicated that she then filled out a Request for Treatment form that she faxed to the provider to get the signed orders.

Record review of a Request for Treatment dated 12/5/23 completed by Nurse #3 for Resident #3 indicated that Nurse #3 made a written request to the contract physicians' group requesting that oxycodone 10 mg tablets, and lorazepam 1 mg tablets be called into the pharmacy ASAP (as soon as possible) to make sure "scripts" are in and we can get them out of the "pyxis".

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In a phone interview with the facility Medical Director (MD) on 3/14/24 at 3:41 pm it was revealed that getting signed hard scripts from the hospital for residents at discharge had been a night mare, that the resident was supposed to come from the hospital with a 3 or more day supply of prescribed narcotics but they never came with anything and the policy for the facility is that if you don't get prescriptions sent in to their pharmacy that you will not get the medication until the next day, especially narcotics. The interview further revealed that the contracted physicians' group that she was employed by did require that a Physician see and evaluate a resident before a hard script for a narcotic was written, but that she did not require that and permitted her NP's to write a hard script for a narcotic even if the resident had not been see and evaluated by the Physician. She stated that the NP should have had enough confidence in the nurse to believe the nurse and should have e-scripted the order to the pharmacy. The MD further indicated that medical providers are always on call 24 hours a day 7 days a week to include holidays so staff could have called at any time and talked to a provider to get an e-script. She stated that, other than anxiety and pain that Resident #3 had to endure for the 5 days without the medication that he did not suffer any harm from the missed doses of medication.

In a phone interview with Nurse # 5 on 3/15/24 at 9:51 am revealed that she did not recall Resident #3 but there was a protocol for obtaining medication for newly admitted residents. She stated that they used to have access to the "pyxis" and would just go pull the medication that the resident needed. She stated that now the

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process is they faxed the medication list to the pharmacy, and the medications came in later that night. She stated that lately that she could not get into the new "pyxis" to pull medications out for residents. The interview further revealed that if she received a hard script not signed by a physician that she would call the on-call physician to get an order sent to the pharmacy and the pharmacy would send a code to the nurse so that she could pull the narcotic from the new "pixis". She stated an on-call physician could be reached 24 hours a day 7 days a week.

In a phone interview with the pharmacist 3/15/24 at 11:14 am it was revealed that that the faxed prescriptions for Resident #3 were not received by the pharmacy until after 2:00 pm on Saturday 12/2/23 so no one at pharmacy saw the prescriptions until Monday 12/4/23. The pharmacist stated their records indicated that Resident #3's hard scripts came over at 5:30 pm on Saturday after their cut off time of 2 pm. He further stated that the pharmacy is closed on Sundays, so they didn't see the order and follow-up until Monday 12/4/23. He stated the original faxed hard scripts received by the pharmacy on 12/2/23 were not signed by the prescriber so the prescription could not be filled on 12/4/23. He indicated that on 12/4/23 that the pharmacy notified a nurse at the facility by phone that they needed new signed hard scripts. He stated that on 12/5/23 the pharmacy received the signed hard scripts from the facility MD and that the medications were sent to the facility that night. The interview further revealed that the facility should have used the back-up pharmacy after the established cut off times of 5:50 pm on weekdays and 2:00 pm on Saturdays. The Pharmacist stated that the facility should have notified the

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F 755	Continued From page 31 Physician that they needed signed hard scripts and the physician could have sent the signed hard scripts to the back-up pharmacy. He stated the nurses would not have been able to access the "pyxis" because the hard scripts had not been signed. During a phone interview with NP #1 on 3/15/24 at 2:11pm it was revealed that she was familiar with Resident #3 and that the contracted physicians' group had a triage line for after hours and the facility had instruction on how to use this line and could call it 24 hours a day 7 day a week. She indicated that facility nurses recently told her that they did not know about the triage line or that they could have called it. She stated that the staff should have called the DON who could have provided them with that triage number.	F 755		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, resident, famiy, Pharmacist, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to administer prescribed medications for 1 of 10 resident (Resident # 3) reviewed to ensure residents are free from significant medication errors. Resident #3 was admitted on 12/1/23 and did not receive his prescribed pain medication for 5 days, his anti-anxiety medication for 4 days, and did not receive his prescribed sedative/hypnotic medication for 3 days after he was admitted to the facility which caused	F 760	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #3 no longer resides at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	4/10/24

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F 760	Continued From page 32 Resident #3 to experience pain, anxiety, and inability to sleep. Findings included: Resident #3 was admitted to the facility on 12/1/23 with a diagnosis that included atrial fibrillation (an irregular rapid heart rate), anxiety disorder, chronic osteomyelitis (serious infection of the bone), and insomnia. Review of the Admission Minimum Data Set (MDS) dated 12/7/23 revealed Resident #3 was cognitively intact and was coded to receive an opioid, anxiolytic, and hypnotic. Review of Physician orders dated 12/1/23 indicated that Resident #3 was prescribed lorazepam 1 mg tablet, take one tablet 3 times a day for anxiety disorder, oxycodone 10 milligrams (mg) tablet, take one tablet every four hours PRN (as needed) for chronic pain, and zolpidem 10 mg tablet, take one table at bedtime for obstruction sleep apnea. Review of the December 2023 Medication Administration Record (MAR) revealed that on 12/1/23, 12/2/23, 12/3/23, 12/4/23, and 12/5/23 that Resident #3 did not receive his PRN oxycodone and on 12/2/23, 12/3/23, 12/4/23, and 12/5/23 he did not receive his scheduled lorazepam. The review further revealed that he did not receive his scheduled zolpidem on 12/1/23, 12/2/23, or 12/3/23. This was evidenced by nursing initials placed in parenthesis and a reason documented on the MAR as Not Administered: Drug/Item Unavailable. Record review of pharmacy delivery records	F 760	The Director of Health Services and Nure Managers have reviewed all new readmissions from 3/5/24 to 4/5/24 to ensure pain medication was appropriately ordered and received. Out of thirty-seven residents, fifteen were noted to have pain medication ordered; and, of the fifteen identified residents, fourteen received ordered pain medication from pharmacy and/or received pain medications from pyxis (emergency medication). Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. The Director of Health Services (DHS), Nurse Managers and Pharmacist will educate the Nurses on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy. This education will be completed by 4/10/24. All Nurses who have not completed their education by 4/10/24 will be removed from the schedule until the education is completed. Education on ordering, receiving, utilizing the emergency backup pyxis and/or receiving medications from the backup pharmacy has been added to the general orientation for all Nurses. The Director of Health Services and Nurse Managers are validating that all licensed nursing personnel have access to and knowledge of how to utilize the pyxis. This review will be completed by 4/9/2024. Nurses who are unable to	

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F 760	Continued From page 33 indicated that the medications Zolpidem 10 mg tablets, lorazepam 1 mg tablets, and oxycodone 10 mg tablets were signed as delivered to the facility on 12/5/23 (no time indicated) and received by Nurse #6. Review of a nurse progress note dated 12/18/23 written by Nurse #3 revealed that Resident #3 was discharged to the hospital on 12/18/23 for an unrelated concern and he did not return to the facility. In an interview with Nurse #3 on 3/13/24 at 3:23 pm During the interview Nurse #3 had difficulty accessing the information in the electronic medical record (EMR) and asked for assistance from Nurse #2 who indicated that the parenthesis around a nurse initial on MAR indicated that the medication was not given. She further stated that Resident #3 did not receive his first dose of oxycodone until 12/6/23 and that it had been documented that the medication was not available on the dates prior to 12/6/23 and there were no notes that indicated that a provider had been contacted. In a phone interview with a family member of Resident #3 on 3/14/24 at 9:24 am she indicated that Resident #3 was no longer a resident at the facility. She stated that he did not have pain medication for the first 5 days after he was admitted to the facility the staff told her that the discharge Physician at the hospital should have ordered the medications that Resident #3 required. She stated that he was in pain most of the time all the time due to osteomyelitis in his hip and femur, and degeneration in his spine and shoulders. She stated that he had pain from the day he was admitted to the facility and that he	F 760	access the pyxis will be given access by the Director of Health Services immediately. The Nurse Navigator and/or Social Worker and Nurse Managers are interviewing new residents within 24 hours and daily for seven days to inquire about pain levels. When a resident is exhibiting pain the Nurse Navigator/Social Worker and/or Nurse Manager notifies the Licensed Nurse for administration of available pain medication and or physician notification if pain medication is not prescribed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Nurse Navigator will report the analysis of the New Resident interview for pain levels to the Quality Assurance and Performance improvement Committee monthly until three months of sustained compliance is maintained then quarterly thereafter. DATE OF COMPLIANCE: APRIL 10, 2024	

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consistently reported to the staff that his pain level was at a 7 out of 10 (on a numeric pain scale designed to evaluate pain in individuals using a number value with 0 being no pain and 10 being the worst pain possible). She stated that his pain was controlled after he started to receive his pain medications.

In a phone interview with Resident #3 on 3/14/24 at 9:29 am he stated that he had pain every day until his pain medication came in. He described the pain in his hips, back, and shoulders as a 7 or 8 on a 0-10 pain scale. Resident #3 stated that he finally started to receive his pain medication around the 5th day after admission and then his pain level became more tolerable and stated that a pain level of 7 or 8 was not tolerable to him. He stated that he was offered acetaminophen, but he could not take that because of his kidneys and liver problems, and he could not take ibuprofen because it did not work for him. The interview further revealed that Resident #3 could not sleep until his zolpidem came in and that he had been taking lorazepam for 4 or 5 years and that his atrial fibrillation could get worse if he did not have his lorazepam. Resident #3 stated that after these medications came in from the pharmacy that things "calmed" down for him.

An interview with the DON on 3/13/24 at 4:30 pm revealed that she was unaware that Resident #3 did not get his narcotic medication for 5 days after he was admitted and that a resident should not have had to go 5 days without a pain medication or any other medication.

In an interview with the Administrator on 3/13/24 at 4:45 pm she stated that she would have expected that Resident #3 would have received

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his medications as ordered and not missed doses. She indicated that if a resident was admitted late on a Friday that she hoped that the hospital would have sent a hard script or would have e-scripted the order to the pharmacy. She further added that for the same night delivery of a medication that the pharmacy would have had to receive the order by 3:00 pm the same day. The interview further revealed the facility had a "pixis" (a locked machine that contained a supply of back up medications) on-site that nurses could access to obtain needed medications. She stated that if the resident was admitted without the hard script that the nurse could have called the Physician to get an order for something that was available in the "pyxis" until their medication was available. She stated that the facility did not have a policy that stated that the Physician had to see and evaluate a resident before they could write a hard script for a narcotic medication but that she had heard that the contracted physician group required that.

In a phone interview with Nurse #3 on 3/14/24 at 3:18 pm she stated that she was assigned to care for Resident #3 on 12/5/23 and that he did not complain of pain and just wanted to know where his lorazepam and oxycodone were. She recalled he was prescribed lorazepam 3 times a day and he would ask her if they were in his medication cup when she brought him his medications. She stated he would ask her when his medications would come in. She further indicated that Resident #3 was calm and not "freaking out" and she let him know that his medications would be in that night (12/5/23). Nurse #3 stated that she was upset that his medications had not come in yet because she had worked on Friday but not the weekend and was surprised when she came in

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F 760	Continued From page 36 that his medications were not in yet and she wanted to know why. During a phone interview with NP #1 on 3/15/24 at 2:11pm it was revealed that she was not aware that Resident #3 did not get his prescribed narcotics as ordered and she would have expected that Resident #3 would not have had to wait 5 days for his medications to become available to him.	F 760		
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of	F 791		4/10/24

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F 791	Continued From page 37 what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Dental Hygienist and Physician interviews the facility failed to obtain emergency dental services for 1 of 1 resident (Resident # 5) reviewed for routine and emergency dental services. Findings included: Resident #5 was admitted to the facility on 2/7/23 with a diagnosis that included diabetes mellitus. Review of the Quarterly Minimum Data Set (MDS) dated 1/5/24 revealed Resident #5 was cognitively intact. In a review of a nurse progress note dated 2/4/24 written by Nurse #1 revealed a family member of Resident # 5 had requested for a dental appointment to be arranged. Review of a Dental Hygienist progress note dated	F 791	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #5 is no longer at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. The Social Worker will review all prior dental recommendations for the past 90 days to ensure all residents requiring dental services or emergency dental services were provided dental services. Audit to be completed by 4/9/24. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not	

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F 791	Continued From page 38 2/12/24 revealed that Resident #5 had been evaluated by the dental hygienist and had reported pain and off and on swelling of the lower left tooth #20 and had a large carious lesion or lost filling with food impaction. The note further revealed that there was no infection noted but that Resident #5 stated that the tooth ached often. The note indicated that Resident #5 needed to be seen for an emergency visit. It was documented that the facility Social Worker had been notified in person and by email and the contract dental Clinical Support Manager had been notified by email. Review of a nurse progress note dated 2/28/24 written by Unit Coordinator #2 revealed that Resident #5 was discharged to the hospital on 2/28/24 for another unrelated condition. She did not return to the facility. An interview with the Social Worker (SW) on 3/12/24 at 4:10 pm it was revealed that when a resident asked for a dental appointment, she would first ask them if they were seen by an outside dentist because they could not see the in-house facility contracted dentist and an out-side private dentist because insurance would not pay for both. She further indicated that the facility contracted dental provider visited monthly and the dentist and dental hygienist rotated every other month. She further indicated that after a resident had been seen that their progress notes were uploaded to the computer. She stated the process after a request for dental services were made was that the SW notified the contract dental clinic and they processed for eligibility and insurance and the resident was place on a list to be seen on the next scheduled visit date. She stated that Resident #5 was seen on 2/12/24 for	F 791	reoccur. ARIA (dental services) will provide education to the Social Worker and Nurse Managers on the required forms for Dental Services. Including the initial referral and triage forms. This education will be completed by 4/10/24. Any Social Worker and/or Nurse Manager not educated by 4/10/24 will be removed from the schedule. This dental form education has been added to the general orientation for all newly hired Social Workers and/or Nurse Managers. Social Services Director will educate the Nursing staff on how to inform the Social Worker if a resident request and/or requires dental services. This education will be completed for all Nursing staff by 4/10/24 to ensure prompt and timely request of dental services. Any Nursing Staff not educated by 4/10/24 will be removed from the schedule. This dental education has been added to the general orientation for all newly hired Nursing Staff. The Social Services Director will email the Director of Health Services and Unit Coordinators a copy of the dental services report to ensure timely follow of dental services required. The Director of Health Services will utilize the dental service report to validate all dental services have been scheduled within 72 hours of notification of need monthly until three months of sustained compliance is maintained then quarterly	

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F 791	Continued From page 39 an initial screen by the in-house dental clinic after a request was made by a family member of Resident #5 to be seen, she was not sure when that request was made but believed it was in February of 2024. She further indicated that progress notes were entered into the computer and that she could see that a follow-up emergency was to be scheduled. In a follow-up interview with the SW on 3/13/24 at 3:25 pm it was revealed that when she alerted the in-house dental provider that Resident #5 wanted to be seen they sent her a referral to fill out and return to them and she did that and they put her on the list to be seen on 2/12/24 during the next scheduled visit. She further indicated that she was not sure what the in-house dental providers process was for follow-up emergency dental care and was not sure how the facility would follow-up on emergency dental care that was identified by the dental hygienist when she saw the resident and stated that she would have hoped that the in-house dental provider would have taken care of that. She further indicated that she was unaware of a triage form that she would have been required to complete and the dental provider did not send her anything else to complete for Resident #5 so she did not send a triage form to them after Resident #5's initial dental screen by the dental hygienist on 2/12/24. In a phone interview with the contracted dental providers Clinical Support Manager on 3/13/24 at 12:48 pm it was revealed that she scheduled appointments for the dental providers. She stated her records showed that Resident #5 had been screened by the hygienist for a chipped tooth and filling that had fallen out and that she was getting her in their system. Resident #5 was scheduled to	F 791	thereafter. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Health Services will present the analysis of the dental services report to the Quality Assurance and Performance Improvement Committee monthly until three months of sustained compliance then quarterly thereafter. DATE OF COMPLIANCE: APRIL 10, 2024	

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be seen by a dentist on 3/29/24 but if an emergency visit were required that she would try to get someone out sooner but Resident #5 discharged before that could be arranged. She further indicated that the facility should have sent over a triage form so they could have referred it out to the community if their dentist could not provide care prior to the next regular scheduled visit on 3/29/24. She stated that her notes indicated that the social worker had been notified and that she should have submitted that triage form but had not. She further stated that the resident should have been seen within 48 hours of the date she was screened, and the problem identified but that they did not have a dentist available to make the emergency visit.

In a phone interview on 3/14/24 at 6:40 pm with Nurse #1 it was revealed that she was assigned to care for Resident #5 three days a week regularly and that Resident #5 did report she had a broken tooth but did not report associated pain. Nurse #1 did not recall what date it was reported to her but that she would have left a note with the transport driver/appointment scheduler to arrange an appointment. She recalled that Resident #5 did get an appointment and was seen by a dentist in the recent past but did not recall the date. The interview further revealed that Resident #5 would eat whatever she wanted whenever she wanted it and ate candy, chips, and ice without difficulty or complaints of pain.

In an interview on 3/13/24 at 11:04 am with the Administrator in Training (AIT) it was revealed that the facility used an in-house contracted vendor for dental services. He stated it was the facility's responsibility to ensure that care was provided. He further indicated that if the facility

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did not get the needed correspondence for the follow-up care from the dental provider timely that the facility SW should have reached out to the dental provider to determine why.

In an interview with the Director of Nursing (DON) on 3/13/24 at 4:34 pm revealed that she was not aware that a resident had needed emergency dental care, and that the SW would be responsible to make sure the necessary care was provided.

In an interview with the Administrator on 03/13/24 at 4:45 pm she stated that she was not aware Resident #5 had requested dental care. She stated if she needed emergency dental care that she would have expected that an appointment would have been scheduled for the follow-up care. She further indicated that she was unaware of a triage form that the contract dental provider required for an emergency referral. The Administrator further indicated that Resident #5 was verbal and oriented and would let the facility know when she had concerns and she had not made her aware of a dental concern.

In a phone interview with a family member on 3/14/24 at 10:39 am she indicated Resident #5 was no longer a resident at the facility. She stated she told the facility in December that Resident #5 had a toothache, and nothing was done. She stated that she told the SW before and after Christmas that Resident #5 had a broken tooth and needed dental care. She stated that Resident #5 was seen by the in-house dentist around February. The family member stated that after she was seen by the dentist that the SW told her she would follow-up with the dentist on what care was needed. She stated that Resident #5 was at

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specialty facility at this time for treatment for another concern and she still has not received dental care. She stated she had not requested dental care there because she was not sure how that worked in that facility.

During a phone interview with the Dental Hygienist on 3/14/24 at 1:59 pm she indicated that she received a note entered on 2/9/24 by the Clinical Support Manager that the SW at the facility put in a request for Resident #5 to be seen by the in-house dental clinic for a chipped tooth. The interview further revealed that Resident #5 was screened by the Dental Hygienist on 2/12/24 and that Resident #5 reported pain and aching in her left lower #20 tooth that often kept her awake, so she put in for a limited or emergency evaluation visit for tooth #20 for a dentist to follow up for treatment. She indicated there were no signs of a (fistula) infection noted on this visit. She stated that this information was provided to the in-house dental clinic Clinical Support Manager by email and that she communicated with the facility SW verbally and in an email. The interview further revealed that the Dental Hygienist stated that she would have assumed that the Clinical Support Manager would have scheduled the emergency visit with the dentist but was unsure if she had scheduled for the follow-up visit. She stated that the facility SW did not further contact her regarding the required follow-up care. She stated that when she evaluated Resident #5 that she put in a visit exam code 140 to the Clinical Support Manager that indicated that the resident should be seen prior to the next scheduled routine visit. She was not sure who should have initiated the emergency dental visit but that their Clinical Support Manager knew that code 140 code had been entered on 2/12/24. The

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interview further revealed that the resident had not been enrolled as a patient with the in-house dental clinic on 2/12/24 when she was screened but was screened because it was her job to make sure patients were not having pain. She stated that she would have to have been enrolled by the facility into the program before being seen for the follow-up emergency visit and that would have been the facility's responsibility.

In a phone interview with the facility Medical Director (MD) on 3/14/24 at 3:41 pm it was revealed that she admitted Resident #5 to the facility in December and did a physical to include an oral assessment and that she did not see any dental concerns at that time. The interview further revealed that Resident #5 did not offer any complaints to her that she wanted dental care or had a concern and did not report mouth pain. The MD stated that when she saw Resident #5 on 2/25/24 that she was eating candy, ice cream and drank cold drinks without difficulty and that if she had tooth pain that she would not have been able to tolerate those foods without pain. She stated that she did not report dental concerns or pain at that time. The interview further revealed that the MD had not been made aware of dental issues for Resident #5 and she would have expected some type of notification to the MD or Nurse Practitioner (NP) so they could have followed up.

A phone interview with the Business Office Manager on 3/15/24 at 10:57 am revealed Resident #5's payor was BCBS and Medicaid.

In a phone interview with Nurse #2 on 3/15/24 at 11:11 revealed that Resident never complained of a broken tooth, mouth pain or that she desired dental care during her stay as a resident at the

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F 791	Continued From page 44 facility. He stated she was prescribed pain medication for another medical condition but not for dental pain and never requested pain medication for dental pain. During a phone interview with Nurse Practitioner #1 on 3/15/24 at 2:11pm it was revealed that Resident #5 was treated for a sore throat during her stay but never any dental pain issues. She stated she was unaware that Resident #5 had a dental concern and that Resident #5 never complained to her about a dental concern, broken tooth or pain and never asked for a referral to see at dentist during her stay as a resident at the facility.	F 791		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less	F 843		4/10/24

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F 843	Continued From page 45 restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a transfer agreement in place for transferring residents to the local hospital for evaluation and treatment, which had the potential to effect 90 of 90 residents who resided in the facility. The findings included: A review of the facility contracts with local entities revealed the facility had not executed a transfer agreement with the local hospital. On 3/15/2024 at 4:40 p.m. in an interview with the Administrator she stated the facility did not have a written transfer agreement with the local hospital to transfer the residents for treatment as needed. She stated they did not know the facility was to have a transfer agreement with the local hospital and explained residents had been transported and accepted at the local hospital for evaluation and treatment as needed. She further indicated that the facility did not have a policy on hospital transfer agreements. She indicated that she would get a transfer agreement in place.	F 843	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: No residents were identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practice. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. The Senior Nurse Consulted educated the Administrator and Administrator in Training on the requirement for a Hospital Transfer agreement on 4/4/2024. This education has been added to the general orientation of any Administrator and/or Administrator in Administration.	

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F 843	Continued From page 46	F 843	On 3/15/2024 the Administrator contacted the corporate contracts department to obtain a transfer agreement with the local hospital. The Administrator will contact Corporate Contracting weekly for four weeks. If attempts to secure an agreement after four weeks is unsuccessful, in accordance with F843/ ¿483.70(j)(2): The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Administrator will present the analysis of obtaining the transfer agreement to the Quality Assurance and Performance Improvement Committee monthly until the transfer agreement in obtained. DATE OF COMPLIANCE: APRIL 10, 2024	
F 867 SS=D	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	F 867		4/10/24

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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, 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

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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.

§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

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F 867	Continued From page 49 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. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and family, Responsible Party, Pharmacist, Medical Director, Nurse Practitioner (NP) and staff interviews, the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the focused infection control and complaint investigation survey of 10/4/21, the recertification and complaint investigation survey of and 4/21/22, and the recertification and complaint investigation survey of 7/13/23. This was for re-cited deficiencies in the areas of	F 867	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: F580 NOTIFICATION OF CHANGES Resident #2 no longer resides at the facility. F689 FREE OF ACCIDENT HAZARDS Resident #1 care plan interventions □ focused on preventing serious injuries during falls (recurrent falls related to	

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F 867	Continued From page 50 Notification of Change (F580), Free of Accident Hazards/Supervision/Devices (F689), Significant Medication Errors (760). The continued failure during three federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: F580: Based on staff interview, responsible party (RP) interview, and record review, the facility failed to provide a written notification of room change to the RP for 1 of 1 resident (#2) reviewed for notification of room change. During the focused infection control and complaint investigation survey of 10/4/21 the facility was cited for failing to notify the physician of a medication error allegation. During the recertification and complaint investigation survey of 7/13/23 the facility was cited for failing to notify the of the resident's Medical Doctor of a resident's refusals of medications. In an interview with the Administrator on 3/15/24 at 5:30 pm she stated that she was not sure where the breakdown was, but the facility would review its process and would get corrective action in place. F689: Based on observation, record reviews and family, staff, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to provide care in a safe manner for 1 of 5 residents (Resident #1) reviewed for supervision to prevent	F 867	diagnosis). F760 FREE OF SIGNIFICANT MEDICATION ERRORS Resident #3 no longer resides at the facility. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be affected by the deficient practices. Address what measures will be put into place or systematic changes made to ensure that the deficient practice will not reoccur. The Senior Nurse Consultant provided education to the Administrator and Administrator in Training on the functionality of the Quality Assurance management tools on 4/4/24. This included utilization of the 5 Whys for root cause analysis and Plan □ Do □ Study □ Act, for implementing performance improvement plans. The Senior Nurse Consultant provided education on 4/5/24 to the facility Leadership Team on the PDSA (plan, do, study, act) model for performance improvement. All Leadership Team Members who have not completed their education by 4/10/24 will be removed from the schedule until the education is completed. Implement PDSA model for QAA priority activities as identified by the	

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F 867	Continued From page 51 accidents. Resident #1 was diagnosed with cerebellar ataxia (a condition that causes poor muscle control that causes clumsy movements), and functional quadriplegia (complete immobility due to severe disability or frailty from another medical condition without injury to the brain or spinal cord) and was dependent on staff for assistance with care. On 1/18/24 Nursing Assistant (NA) #1 was providing Resident #1 with care when the resident experienced spastic/uncontrolled movements and the resident fell off the side of the bed striking his head on a bedside table causing a laceration on his forehead above his left eye before he fell onto the fall mat on the floor. Resident #1 was transferred to the Emergency Department and was treated for a left frontal scalp hematoma (a pool of mostly clotted blood) with a significant laceration with active bleeding that required 7 sutures for closure. During the recertification and complaint investigation survey of 4/21/22 the facility was cited for failing to provide an environment without a potential accident hazard when resident rooms were observed to have a heat/air wall unit without a cover exposing the wires and coils and a wall plug outlet loose from the wall allowing access to the wires. In an interview with the Administrator on 3/15/24 at 5:30 pm she stated that she was not aware of a previous F689 and thought that it must have occurred prior to her employment at the facility. The Administrator stated the facility would review its process and would get corrective action in place. F760: Based on record review, and staff,	F 867	QAPI Committee. Education on the QAPI/ QAA policy and PDSA model has been added to the orientation for all new Leadership Team Members. The Area Vice President and/or Senior Nurse Consultant will attend the monthly Quality Assurance and Performance Improvement Committee meeting monthly to validate the 5 Why□s and Plan □ DO □ Study □ Act models are utilized for Performance Improvement projects. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Area Vice President and/or Senior Nurse Consultant will present the analysis of the utilization of the 5 Why□s and Plan □ Do □ Study □ Act during Quality Assurance and Performance Improvement Committee meetings monthly until three months of sustained compliance in maintained the quarterly thereafter. DATE OF COMPLIANCE: APRIL 10, 2024	

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F 867	Continued From page 52 resident, Pharmacist, Medical Director (MD), and Nurse Practitioner (NP) interviews the facility failed to administer prescribed medications for 1 of 10 resident (Resident # 3) reviewed to ensure residents are free from significant medication errors. Resident #3 was admitted on 12/1/23 and did not receive his prescribed pain medication for 5 days, his anti-anxiety medication for 4 days, and did not receive his prescribed sedative/hypnotic medication for 3 days after he was admitted to the facility which caused Resident #3 to experience pain, anxiety, and inability to sleep. During the focused infection control and complaint investigation survey of 10/4/21 the facility was cited for failing to prevent a significant medication error by administering insulin to the wrong resident resulting in hospitalization for the treatment of hypoglycemia. In an interview with the Administrator on 3/15/24 at 5:30 pm she indicated she was not working at the facility at the time of the previous citation for F760.	F 867		