STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING ______ B. WING ______	C 09/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 9/23/24 through 9/26/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #5ML411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 9/23/24 through 9/26/24. Event ID# 5ML411. The following intakes were investigated NC00222062, NC00221162, NC00219969, NC00216997, NC00214565, NC00213923, NC213313, and NC00211836. 1 of the 15 complaint allegations resulted in deficiency.	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care.	F 553		10/24/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/18/2024

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

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F 553	Continued From page 1 (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview, the facility failed to hold a care plan meeting or invite the resident to participate in the care planning process for 1 of 22 residents whose care plans were reviewed (Resident #62). The findings included: Resident #62 was admitted to the facility on 5/21/21. Review of the Multidisciplinary Care Conference Assessment dated 9/05/23 revealed a quarterly care plan meeting was conducted for Resident #62. Review of the Multidisciplinary Care Conference Assessment dated 11/28/23 revealed a quarterly care plan meeting was conducted for Resident #62. Review of the Multidisciplinary Care Conference Assessment dated 7/02/24 revealed a quarterly	F 553	F553 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/8/2024, a care plan meeting was held with Resident #62, the Interdisciplinary Care Team, resident representative #1 present and resident representative #2 via telephone conference. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 9/30/2024, the MDS Coordinator audited 100% of the resident medical records to identify any other residents who needed to have a care plan meeting and or invite a resident(s) to participate in the	

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Continued From page 2

care plan meeting was conducted for Resident #62.

The Minimum Data Set (MDS) quarterly assessment dated 7/11/24 revealed Resident #62 had moderate cognitive impairment. Resident #62 was coded for active participation in the assessment and goal setting.

Review of Resident #62's electronic medical record revealed no documentation that a care plan meeting was held or that Resident #62 was invited to participate in a care plan meeting during the time between the 11/28/23 and 7/02/24 care plan meetings.

During an interview with Resident #62 on 9/23/24 at 10:16 am, Resident #62 reported she was unable to recall the last time she had a care plan meeting, but she wanted to be involved with her care plan meetings.

An interview was conducted on 9/24/24 at 1:05 pm with the Director of Social Services who revealed she was responsible to invite the resident and/or the Responsible Party (RP) to participate in the quarterly care plan meetings. She stated she personally invited the residents to participate in the quarterly care plan meetings when they were scheduled. The Director of Social Services reported she was unable to locate any documentation that a care plan meeting was held for Resident #62 between the 11/28/23 and 7/02/24 care plan meetings but she stated there should have been one held during that time frame.

An interview was conducted with MDS Nurse #2 on 9/24/24 at 1:14 pm who revealed the

F 553

care planning process.

The measures the facility will take to ensure the problem will be corrected and will not reoccur:

On 9/30/2024, the Nursing Home Administrator educated the Social Services Director, Social Service Assistant and both MDSC that each resident needed to have a care plan meeting and invite the resident to participate in the care planning process.

Monthly for three months, Minimum Data Set Coordinator #2 will randomly audit the Resident Assessment Instrument Schedule and care plan meetings held to validate five care plan meetings were scheduled and completed to include resident and resident representative invitation to participate in the care planning process. If it is noted that a care plan meeting was not held or that a resident or resident representative was not invited to participate in the care plan process, the Nursing Home Administrator will be immediately notified, an Ad Hoc QAPI meeting will be held, a care plan meeting will be scheduled within the next 72 hours, and re-education for the Social Services Department and Minimum Data Set Coordinators will be completed by the Nursing Home Administrator.

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

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F 553	Continued From page 3 long-term resident care plan meetings were held quarterly (every 3 months). MDS Nurse #2 stated MDS Nurse #1 created a care plan meeting calendar and would give the calendar to the Director of Social Services to schedule the resident care plan meeting. MDS Nurse #2 stated Resident #62 should have had a care plan meeting between the 11/28/23 and 7/02/24 care plan meetings but she was unable to locate any documentation that the meeting was scheduled or completed. During an interview on 9/26/24 at 10:32 am with MDS Nurse #1 she revealed she was responsible to create a care plan meeting calendar based on the resident assessment dates which were every 3 months for long-term care residents. She stated she created the care plan meeting calendar that noted the residents that required a care plan meeting to be scheduled for a particular month. MDS Nurse #1 stated she gave the calendar of residents that required a care plan meeting to the Director of Social Services to schedule and invite the resident to the care plan meeting. MDS Nurse #1 stated Resident #62 should have been on the calendar to have a care plan meeting sometime around the March 2024 time frame for her next care plan meeting after the 11/28/23 care plan meeting. MDS Nurse #1 was unable to locate the care plan meeting calendar to confirm Resident #62 was listed to have the meeting scheduled, but she stated she thought Resident #62's name was listed. A follow-up interview was conducted on 9/26/24 at 12:21 pm with the Director of Social Services who revealed if Resident #62 was listed on the care plan meeting calendar created by MDS Nurse #1 she would have scheduled a care plan	F 553	Minimum Data Set Coordinator #2 will present the audits to the facility's Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	

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F 553	Continued From page 4 meeting to be held. The Director of Social Services stated Resident #62 should have had a care plan meeting scheduled sometime between the end of February 2024 through early March 2024 based on the last care plan meeting date, but she must not have been on the care plan calendar list provided by MDS Nurse #1. An interview was conducted on 9/26/24 at 12:43 pm with the Administrator who revealed MDS Nurse #1 was responsible to ensure the care plan meeting calendar was completed accurately and communicated appropriately to the Director of Social Services to create the schedule.	F 553		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of a pressure reducing surface for pressure ulcer (Resident #7) and the use of a continuous positive airway pressure (CPAP) machine (Resident #95) for 2 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #7 was admitted to the facility on 3/24/23. Resident #7 had an active physician order dated	F 641	F641 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #7 quarterly assessment regarding pressure reducing surface was modified on 9/24/2024. Resident #95 quarterly assessment completed on 8/30/24 was modified on 9/24/2024 to reflect the use of the continuous positive airway pressure device. Address how the facility will identify other	10/24/24

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F 641	Continued From page 5 4/19/24 for a standard pressure ulcer redistribution mattress. The Minimum Data Set (MDS) quarterly assessment dated 7/22/24 revealed Resident #7 had moderate cognitive impairment and was coded for an unhealed, unstageable (due to coverage of the wound bed by slough and/or eschar) pressure ulcer. Resident # 7 was not coded for a pressure reducing surface for bed. An interview was conducted on 9/24/24 at 3:19 pm with MDS Nurse #2 who completed Resident #7's MDS quarterly assessment. MDS Nurse #2 confirmed Resident #7 had a physician order for the standard pressure ulcer redistribution mattress and stated Resident #7's mattress was a pressure reducing surface for the bed. MDS Nurse #2 stated she should have coded the mattress as a pressure reducing surface for bed for Resident #7's quarterly assessment. During an interview on 09/26/24 at 12:38 pm with the Administrator she revealed the MDS Nurse was responsible to code Resident #7's MDS assessment accurately. 2. Resident #95 was admitted to the facility on 6/21/23 with diagnoses which included obstructive sleep apnea and acute respiratory failure with hypoxia. Resident #95 was noted to be discharged to the hospital on 8/19/24 and returned to the facility on 8/26/24. Resident #95 had a care plan initiated on 2/02/24 for oxygen therapy related to continuous positive airway pressure (CPAP) related to obstructive sleep apnea with an intervention to encourage to wear the CPAP as ordered by the physician.	F 641	residents having the potential to be affected by the same deficient practice: On 10/17/2024, Minimum Data Set Coordinator #1 conducted a 100% audit on residents with physician□s orders for pressure reducing surfaces and continuous positive airway pressure devices to validate coding accuracy of the MDS per the Resident Assessment Instrument (RAI) Manual. Any resident with physician's order for pressure reducing surfaces and continuous positive airway pressure device that is identified as requiring a modification will be modified and transmitted by 10/17/2024. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: MDS Coordinators were educated on 10/17/2024 by the RAC-CT Clinical Reimbursement Specialist on MDS coding of sections M1200 B and O0110 G3 per the RAI Manual. Monthly for three months the Director of Nursing (DON) will audit five Minimum Data Sets to validate coding per the RAI Manual for sections M1200 B and O0110 G3 for residents with physicians□ orders for specialty surfaces or continuous positive airway pressure devices. Any areas of concern identified will be reviewed by the DON with the MDS Coordinators, Nursing Home Administrator, and RAC-CT Clinical Reimbursement Specialist with modifications completed as needed and	

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Continued From page 6

Resident #95 had an active physician order dated 8/26/24 for CPAP machine to apply at bedtime and remove when awake for sleep apnea.

Review of the medication administration record for the month of August 2024 revealed Resident #95 used the CPAP machine as ordered with the exception of 8/28/24 which was noted as refused.

The Minimum Data Set (MDS) quarterly assessment dated 8/30/24 revealed Resident #95 was cognitively intact and was not coded for use of a CPAP machine.

An observation and interview were conducted on 9/23/24 at 10:24 am with Resident #95 who had a CPAP machine located on the bedside table. Resident #95 revealed she had the CPAP machine for a long time and did use it at night while sleeping.

An interview was conducted on 9/24/24 at 1:31 pm with MDS Nurse #1 who revealed if Resident #95 used the CPAP it should have been coded on the assessment. MDS Nurse #1 stated she reviewed the MDS assessment, and she did not have the option to answer the question regarding Resident #95's CPAP use.

A follow-up interview was conducted with MDS Nurse #1 on 9/24/24 at 3:10 pm who revealed she reviewed the Resident Assessment Instrument (manual used for completing the MDS assessments) and she found that in order to code Resident #95's CPAP she had to choose yes to mechanical ventilation first. MDS Nurse #1 stated she was not aware she had to answer the mechanical ventilation area first in order to

F 641

an Ad Hoc QAPI Meeting held if indicated, and re-education will be conducted with the MDS Coordinators by the RAC-CT Clinical Reimbursement Specialist.

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

Results of the audits will be presented by the DON in the monthly Quality Assurance and Performance Improvement (QAPI) Meeting monthly for three months. The QAPI Committee will review the audits and make recommendations to assure compliance is sustained ongoing.

Date of Compliance:
10/24/2024

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F 641	Continued From page 7 accurately code Resident #95 for use of the CPAP. During an interview on 09/26/24 at 12:38 pm with the Administrator she revealed the MDS Nurse was responsible to code Resident #95's MDS assessment accurately.	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657		10/24/24

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F 657	Continued From page 8 by: Based on record review, staff interviews, and resident interview, the facility failed to revise the care plan in the area of antipsychotic medication use (Resident #62) and risk for pain (Resident #101) for 2 of 22 residents reviewed for care plan revision. The findings included: 1. Resident #62 was admitted to the facility on 5/21/21 with diagnoses which included Alzheimer's Disease, major depressive disorder, and cognitive communication deficit. Review of the Psychiatric Provider visit note dated 12/11/23 revealed Resident #62 was recommended to start olanzapine (an antipsychotic medication) 2.5 milligrams (mg) tablet at bedtime for mood instability related to dementia. Resident #62 had an active physician order dated 12/14/23 for olanzapine 2.5 mg at bedtime for mood instability related to dementia. The Minimum Data Set (MDS) quarterly assessment dated 7/11/24 revealed Resident #62 had moderate cognitive impairment and was coded for rejection of care for 1-3 days during the 7-day look back period. Resident #62 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident #62's care plan last reviewed on 8/13/24 revealed no care plan in place for use of an antipsychotic medication. An interview was conducted on 9/26/24 at 10:08	F 657	F657 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/24/2024, Resident #62 care plan was updated by Minimum Data Set Coordinator #2 (MDSC #2) to reflect the use of antipsychotic medication. On 9/26/2024, Resident #101 care plan was updated by Minimum Data Set Coordinator #2 (MDSC #2) to reflect the potential for pain related to chronic pain and use of non-steroidal medication for pain. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/17/2024, MDSC #2 audited 100% of the residents with physician's orders for antipsychotics to validate antipsychotic care plans are in place. Any updates and or revisions needed were completed by MDSC #2 at that time. On 10/17/2024, MDSC #2 audited 100% of the residents with physician's orders for analgesics and nonsteroidal medication for chronic pain to validate potential for pain or pain management care plans are in place. Any updates and or revisions needed were completed by MDSC #2 at that time. The measures the facility will take to	

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F 657	Continued From page 9 am with the Interim Director of Nursing (DON) who revealed care plan revisions were completed by the MDS Nurse. During an interview on 9/26/24 at 10:20 am MDS Nurse #2 revealed the MDS Nurses were responsible to update resident care plans. MDS Nurse #2 stated the normal process was the new medication would be discussed in the clinical meeting by nursing and she would revise the care plan during the meeting. MDS Nurse #2 stated had the new medication been discussed at the clinical meeting by nursing she would have revised Resident #62's care plan, but she did not recall the new medication being discussed. An interview was conducted on 9/26/24 at 10:35 am with MDS Nurse #1 who revealed Resident #62's antipsychotic medication required a care plan. MDS Nurse #1 stated she normally did not revise resident care plans because it was MDS Nurse #2's responsibility. MDS Nurse #1 stated the care plan should have been revised by MDS Nurse #2 when Resident #62's antipsychotic medication was started. An interview with the Administrator was conducted on 9/26/24 at 12:46 pm who revealed she expected resident care plans to be revised as needed. 2. Resident #101 was admitted to the facility on 1/23/24 with diagnoses which included Parkinsonism (clinical syndrome characterized by tremor, slow movement, and rigidity). Resident #101 had an active physician order dated 3/02/24 for meloxicam (a nonsteroidal medication used to treat arthritis) tablet 7.5	F 657	ensure the problem will be corrected and will not reoccur: On 9/30/2024, the Nursing Home Administrator educated MDSC #2 and the Interdisciplinary Care Team on updating resident care plans as needed for use of antipsychotic medication and pain management. Monthly for three months, Minimum Data Set Coordinator #1 will randomly audit five residents with physician's orders for antipsychotic medication and or residents with physician's orders for nonsteroidal medication or analgesics for chronic pain to validate MDSC #2 and the Interdisciplinary Care Team (IDCT) have updated and revised care plans as needed. If it is noted that a care plan was not updated, the DON, the Nursing Home Administrator will be immediately notified, an Ad Hoc QAPI meeting will be held, and the care plan will be updated at that time. Re-education for MDSC#2 and the IDCT will be completed by the Nursing Home Administrator on an as needed basis. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Minimum Data Set Coordinator #1 will present the audits to the facility's Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audit and make	

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F 657	Continued From page 10 milligram (mg) one time a day for chronic pain. The Minimum Data Set (MDS) quarterly assessment dated 7/15/24 revealed Resident #101 had moderate cognitive impairment and was coded for a stage 3 pressure ulcer. Resident #101 was coded for use of scheduled pain medication. Review of Resident #101's care plan last reviewed on 7/24/24 revealed no care plan was in place for pain management. Review of the medication administration record (MAR) for August 2024 through September 2024 revealed Resident #101 was administered the meloxicam medication as ordered. An interview was conducted with Resident #101 on 9/23/24 at 12:39 pm who reported she often had aching pain to her right arm. Resident #101 stated she did report the pain when it starts to the nurses, but she was not sure if they gave her pain medication. An interview was conducted with Nurse #2 on 9/24/24 at 2:03 pm who revealed Resident #101 was on a scheduled pain medication that was administered every morning, and she had not reported right arm pain to her in the past. An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed the MDS Nurses were responsible for resident care plans. During an interview on 9/26/24 at 10:15 am with MDS Nurse #2 she revealed Resident #101 was not taking a lot of pain medication and did not	F 657	recommendations to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	

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F 657	Continued From page 11 report a pain presence when she completed her assessment, so she did start a pain management care plan. MDS Nurse #2 stated she could have entered a risk for pain care plan, but she did not revise Resident #101's care plan when the meloxicam medication was ordered. An interview was conducted on 9/26/24 at 10:35 am with MDS Nurse #1 who revealed Resident #101 should have had a care plan in place for pain related to her scheduled pain medication and the stage 3 pressure ulcer. MDS Nurse #1 stated she normally did not revise resident care plans because it was MDS Nurse #2's responsibility. MDS Nurse #1 stated the care plan should have been revised by MDS Nurse #2 when Resident #101's pain medication was started. An interview with the Administrator was conducted on 9/26/24 at 12:46 pm who revealed she expected resident care plans to be revised as needed.	F 657		
F 727 SS=F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve	F 727		10/24/24

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F 727	Continued From page 12 as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to designate a full-time Director of Nursing (DON) for the Skilled Nursing Facility (SNF) when the current DON went out on family medical leave. The findings included: During an interview with the Administrator on 9/23/24 at 9:53 AM, the Administrator explained that the Director of Nursing (DON) was out due to having surgery. She stated the DON had been available by phone when unable to physically be in the building due to these issues. The Administrator stated on 9/16/24 the DON had planned surgery and took medical leave at that time. The Administrator stated that the Staff Development Coordinator who was a registered nurse (RN) was the contact person for nursing-related questions. During an interview with the Staff Development Coordinator (SDC) on 9/24/24 at 2:48 PM, she stated she shared on call duty with the Wound nurse. The SDC reported staff would call her with nursing related questions after hours during her on call day. The Staff Development Coordinator stated she had not been informed that she was the DON designee. During a follow up interview with the Administrator on 9/26/24 at 9:17 AM, she stated she did not appoint an interim DON when the DON went out for surgery on 9/16/24. The Administrator stated on 9/25/24 the SDC was appointed as the interim	F 727	F727 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 09/24/24 the Nursing Home Administrator received the Family and Medical Leave Act (FMLA) documentation for the Director of Nursing, as a result on 09/25/24 the Nursing Home Administrator appointed an interim Director of Nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have been identified as having the potential to be affected by the practice. On 09/25/24 the Nursing Home Administrator appointed an interim Director of Nursing. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 9/27/2024 the Regional Vice President of Clinical Services provided education to the Nursing Home Administrator advising the nursing home administrator that the director of nursing does not need to be officially on medical leave with FMLA documentation prior to appointing an	

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F 727	Continued From page 13 DON.	F 727	interim director of nursing as well as the requirement for notification of change in Director of Nursing. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Monthly for three months the NHA will update the QAPI Committee, to include the Medical Director, when changes in reportable positions need to be made. The Regional Vice President of Clinical Services will review the change of director of nursing notifications to validate timely submission and assure sustained compliance ongoing. Date of Compliance: 10/24/2024	
F 744 SS=B	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan that addressed dementia care for 1 of 3 residents reviewed for comprehensive care plans (Resident #39). The findings included:	F 744	F744 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 9/24/2024 Resident #39 care plan was	10/24/24

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F 744	Continued From page 14 Resident #39 was admitted to the facility on 8/26/2021 with diagnoses that included Dementia and Insomnia. Review of Resident #39's care plan updated on 8/7/2024 revealed a focus area for dementia was not reflected in the care plan. A review of Resident #39's Nursing progress note dated 9/21/2024 at 11:18 P.M. revealed the resident refused the previous shift nurse to complete wound care. In an interview with Nurse #12 on 9/25/2024 at 12:03 P.M. she revealed Resident #39 had behaviors which included refusing wound care and medications or forcing his way to the smoking area outside smoking times. During an interview with MDS Nurse #2 on 9/24/2024 at 12:10 P.M. she revealed it was her responsibility to ensure the diagnosis of Dementia was care planned. She further revealed the error of not updating the care plan was an oversite on her part. An interview was conducted with the Administrator on 9/25/2024 at 9:19 A.M. She revealed it was the responsibility of the Director of Nursing to ensure the care plans accurately reflected the resident's condition and diagnosis.	F 744	updated by MDSC #2 to reflect the diagnosis of dementia. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/17/2024, MDSC #2 audited 100% of the residents with diagnosis of dementia to validate dementia care plans are in place. Any updates and or revisions needed were completed by MDSC #2 at that time. The measures the facility will take to ensure the problem will be corrected and will not reoccur: On 9/30/2024, the Nursing Home Administrator educated MDSC #2 and the Interdisciplinary Care Team on updating resident care plans as needed for the diagnosis of dementia. Monthly for three months, Minimum Data Set Coordinator #1 will randomly audit five residents with diagnosis of dementia to validate MDSC #2 and the Interdisciplinary Care Team (IDCT) have updated and revised care plans as needed. If it is noted that a care plan was not updated, the DON, the Nursing Home Administrator will be immediately notified, an Ad Hoc QAPI meeting will be held, and the care plan will be updated at that time. Re-education for MDSC#2 and the IDCT will be completed by the Nursing Home Administrator on an as needed basis. Indicate how the facility plans to monitor	

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F 744	Continued From page 15	F 744	its performance to make sure that solutions are sustained: Minimum Data Set Coordinator #1 will present the audits to the facility's Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and the Performance Improvement Committee will review the audit and make recommendations to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 756		10/24/24

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F 756	Continued From page 16 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and Consultant Pharmacist interview, the Pharmacist failed to identify and report a medication irregularity when an Abnormal Involuntary Movement Scale (AIMS) assessment was not initiated for Olanzapine (antipsychotic medication used to regulate behaviors) or 1 of 4 residents reviewed for unnecessary medications (Resident #57). The findings included: Resident #57 was admitted on 1/17/23 with diagnoses that included anxiety disorder and dementia with behavioral disturbance. A review of the physician's orders revealed an order for Olanzapine 10 MG (milligrams) (an antipsychotic medication used to regulate behaviors)- Give 1 tablet by mouth at bedtime for	F 756	F756 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 10/15/2024, Resident #57 Abnormal Involuntary Movement Scale (AIMS) Assessment was completed by Interim Director of Nursing. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/11/2024 the interim Director of Nursing (DON) audited 100% of the residents with orders for antipsychotic medication to validate completion and	

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mood instability and hallucinations dated 1/17/23.

Review of the most recent quarterly Minimum Data Set (MDS) dated 7/10/24 revealed Resident #57 was cognitively intact and was not coded for behaviors. Resident #57 was coded for antipsychotic medications for 7 of the 7 days during the assessment period.

Review of Resident #57's electronic medical record from 8/10/23 to 9/26/24 revealed no documentation regarding the completion of an AIMS assessment.

Review of the Monthly Medication Regimen (MRR) for Resident #57 revealed the Pharmacy Consultant reviews were completed on the following days: 9/17/23, 10/17/23, 11/8/23, 12/18/23, 1/22/24, 2/25/24, 3/24/24, 4/23/24, 5/22/24, 6/16/24, 7/23/24, and 8/22/24. There were no recommendations made by the Consultant Pharmacist for completion of an AIMS assessment.

Review of the care plan last reviewed on 7/10/24 revealed Resident #57 used psychotropic medications due to hallucinations. The interventions included administering psychotropic medications as ordered by physician and monitoring for side effects.

Further review of the care plan revealed Resident #57 exhibited behaviors of pulling off clothes, making inappropriate remarks to staff, and loud yelling. The interventions included approach/speak to resident in a calm manner, divert attention, and intervene as necessary to protect the rights and safety of others.

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routine scheduling of AIMS assessments. Any updates and or revisions needed were completed by the Interim Director of Nursing at that time.

The measures the facility will take to ensure the problem will be corrected and will not reoccur:

On 10/16/2024, the Nursing Home Administrator educated the Pharmacist on reviewing for AIMS assessments when completing review on antipsychotic medication and alerting the Director of Nursing when an AIMS Assessment needs to be completed. Director of Nursing will complete AIMS Assessment for resident with antipsychotic medication at that time.

On 9/30/2024, the Nursing Home Administrator educated the Minimum Data Set Coordinators (MDSC) on reviewing for AIMS assessments when coding the Minimum Data Set for residents with physician□s orders for antipsychotic medication. The MDSCs will alert the Director of Nursing when there is not a current AIMS Assessment for a resident who requires AIMS Assessments. Director of Nursing will complete AIMS Assessment for resident with antipsychotic medication at that time.

Monthly for three months, MDS Coordinator #1 will randomly audit five residents with physician□s orders for antipsychotics to validate updated AIMS Assessment. If it is noted that an AIMS

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F 756	Continued From page 18 A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated Resident #57 had been overlooked and the facility was responsible for completing the AIMS assessment once Resident #57 was started on the antipsychotic medication. An interview was conducted with the Senior Vice President of Clinical Operations on 09/26/24 at 11:09 AM. The Senior VP stated AIMS should be completed every 6 months for residents who are on antipsychotic medications. She further stated the AIMS assessments were to be reviewed during the at-risk meetings which involved the interdisciplinary team. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication.	F 756	needs to be completed or updated, the DON will be immediately notified, an AIMS will be completed and an Ad Hoc QAPI meeting will be held at that time, and re-education for the Pharmacist and Minimum Data Set Coordinators (MDSC) will be completed by the Nursing Home Administrator. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: Minimum Data Set Coordinator #1 will present the audits to the facility□s Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and Performance Improvement Committee will review the audit and make recommendations to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		10/24/24

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Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on record review, staff interviews, and

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Consultant Pharmacist interview, the facility failed to complete an Abnormal Involuntary Movement Scale (AIMS) assessment for residents receiving an antipsychotic medication, which is used for medication monitoring of side effects of antipsychotic medication for 3 of 5 residents reviewed for unnecessary medications (Resident #7, Resident #62, and Resident #57).

The findings included:

1. Resident #7 was admitted to the facility on 3/24/23 with diagnoses which included dementia with behaviors.

Resident #7 had an active physician order dated 4/20/24 for quetiapine fumarate oral tablet (an antipsychotic medication) 25 milligrams (mg) give one tablet by mouth one time a day for dementia with behaviors.

Resident #7 had an active physician order dated 4/22/24 for quetiapine fumarate oral tablet 50 mg at bedtime for behaviors.

The Minimum Data Set (MDS) quarterly assessment dated 7/22/24 revealed Resident #7 had moderate cognitive impairment and was not coded for behaviors. Resident #7 was coded for antipsychotic medications for 7 of the 7 days during the assessment period.

Resident #7 had a care plan last reviewed on 7/26/24 for use of psychotropic mediations related to dementia and behavior management with interventions to administer psychotropic medication as ordered by the physician, and to monitor for adverse reactions.

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

On 10/14/2024 Resident #7, on 10/15/2024 Residents #57, and on 10/17/2024 Resident #62 Abnormal Involuntary Movement Scale (AIMS) Assessments were completed by Interim Director of Nursing.

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

On 10/11/2024, the Interim Director of Nursing (DON) audited 100% of the residents with orders for antipsychotic medication to validate completion and routine scheduling of AIMS assessments. Any updates and or revisions needed were completed by the Interim Director of Nursing at that time.

The measures the facility will take to ensure the problem will be corrected and will not reoccur:

On 10/16/2024, the Nursing Home Administrator educated the Pharmacist on reviewing for AIMS assessments when completing review on antipsychotic medication and alerting the Director of Nursing when an AIMS Assessment needs to be completed. Director of Nursing will complete AIMS Assessment for resident with antipsychotic medication

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A review of Resident #7's electronic medical record from 4/20/24 through 9/25/24 revealed no documentation regarding the completion of an AIMS assessment since the antipsychotic medication had been started. The AIMS assessment was utilized to detect Tardive Dyskinesia (involuntary repetitive movements which occurs following treatment with medication) in residents prescribed antipsychotic medications.

A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated the facility was responsible to ensure the AIMS assessment was completed as required for Resident #7 when the antipsychotic medication was started.

An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed Resident #7 was required to have an AIMS assessment for the antipsychotic medication when it was started. The Interim DON stated the medication orders were reviewed in the daily clinical meeting and the need for Resident #7's initial baseline AIMS assessment should have been identified during those meetings.

During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication.

2. Resident #62 was admitted to the facility on

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at that time.

On 9/30/2024, the Nursing Home Administrator educated the Minimum Data Set Coordinators (MDSC) on reviewing for AIMS assessments when coding the Minimum Data Set for residents with physicians order for antipsychotic medication. The MDSCs will alert the Director of Nursing when there is not a current AIMS Assessment for a resident who requires AIMS Assessments. Director of Nursing will complete AIMS Assessment for resident with antipsychotic medication at that time.

Monthly for three months, MDS Coordinator #1 will randomly audit five residents with physicians orders for antipsychotics to validate updated AIMS Assessment. If it is noted that an AIMS needs to be completed or updated, the DON will be immediately notified, an AIMS will be completed and an Ad Hoc QAPI meeting will be held at that time, and re-education with the Pharmacist and Minimum Data Set Coordinators (MDSC) will be completed by the Nursing Home Administrator.

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

Minimum Data Set Coordinator #1 will present the audits to the facility Quality Assurance and Performance Improvement Committee monthly for three months. The Quality Assurance and

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ACCORDIUS HEALTH AT CREEKSIDE CARE	604 STOKES STREET EAST AHOSKIE, NC 27910

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F 758	Continued From page 22 5/21/21 with diagnoses which included Alzheimer's Disease with early onset and major depressive disorder. Review of the Psychiatric Provider visit note dated 12/11/23 revealed Resident #62 was recommended to start olanzapine (an antipsychotic medication) 2.5 milligrams (mg) tablet at bedtime for mood instability related to dementia. Resident #62 had an active physician order dated 12/14/23 for olanzapine 2.5 mg at bedtime for mood instability related to dementia. Review of Resident #62's electronic medical record revealed an AIMS assessment was completed on 1/25/24 for the start of the olanzapine medication. The AIMS assessment was utilized to detect Tardive Dyskinesia (involuntary repetitive movements which occurs following treatment with medication) in residents prescribed antipsychotic medications. Further review of Resident #62's electronic medical record 2/01/24 through 9/25/24 revealed no documentation regarding the completion of an AIMS assessment since the baseline AIMS assessment was completed for the antipsychotic medication on 1/25/24. The Minimum Data Set (MDS) quarterly assessment dated 7/11/24 revealed Resident #62 had moderate cognitive impairment and was coded for rejection of care for 1-3 days during the 7-day look back period. Resident #62 was coded for antipsychotic medications for 7 of the 7 days during the assessment period.	F 758	Performance Improvement Committee will review the audit and make recommendations to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	

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F 758	Continued From page 23 Review of Resident #62's care plan last reviewed on 8/13/24 revealed no care plan in place for use of an antipsychotic medication. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months thereafter. The Consultant Pharmacist stated he would have expected for the facility to have completed another AIMS assessment for Resident #62's antipsychotic medication within 6 months of the initial assessment. An interview was conducted on 9/26/24 at 10:08 am with the Interim Director of Nursing (DON) who revealed an AIMS assessment for the antipsychotic medication was required when the medication was started and then quarterly thereafter. The Interim DON stated the AIMS assessments were reviewed in the daily clinical meeting and the need for Resident #62's next AIMS assessment should have been identified during those meetings. The Interim DON was unable to recall if Resident #62's AIMS assessments due dates were discussed during the meetings. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication. 3. Resident #57 was admitted on 1/17/23 with diagnoses that included anxiety disorder and dementia with behavioral disturbance.	F 758		

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F 758	Continued From page 24 A review of the physician's orders revealed an order for Olanzapine10 (milligrams) MG (an antipsychotic medication used to regulate behaviors)-Give 1 tablet by mouth at bedtime for mood instability and hallucinations dated 1/17/23. Review of the most recent quarterly Minimum Data Set (MDS) dated 7/10/24 revealed Resident #57 was cognitively intact and was not coded for behaviors. Resident #57 was coded for antipsychotic medications for 7 of the 7 days during the assessment period. Review of Resident # 57's electronic medical record from 8/10/23 to 9/26/24 revealed no documentation regarding the completion of an AIMS assessment. Review of the care plan last reviewed on 7/10/24 revealed Resident #57 used psychotropic medications due to hallucinations. The interventions included administering psychotropic medications as ordered by physician and monitoring for side effects. Further review of the care plan revealed Resident #57 exhibited behaviors of pulling off clothes, making inappropriate remarks to staff, and loud yelling. The interventions included approach/speak to resident in a calm manner, divert attention, and intervene as necessary to protect the rights and safety of others. A telephone interview was conducted on 9/25/24 at 12:33 pm with the Consultant Pharmacist who revealed the facility was required to complete an AIMS assessment on all residents that were prescribed an antipsychotic medication upon initiation of the medication and every 6 months	F 758		

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F 758	Continued From page 25 thereafter. The Consultant Pharmacist stated Resident #57 had been overlooked and the facility was responsible for completing the AIMS assessment once Resident #57 was started on the antipsychotic medication. An interview was conducted with the Senior Vice President of Clinical Operations on 09/26/24 at 11:09 AM. The Senior VP stated AIMS should be completed every 6 months for residents who are on antipsychotic medications. She further stated the AIMS assessments were to be reviewed during the at-risk meetings which involved the interdisciplinary team. During an interview on 9/26/24 at 12:20 pm the Administrator stated the AIMS assessment was missed due to a breakdown in their process and communication.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and Medical Director interview, the facility failed to hold a blood pressure medication as ordered by the physician when the blood pressure was above the parameter for 1 of 1 resident reviewed for a significant medication error (Resident #101). The findings included: Resident #101 was admitted to the facility on 1/23/24 with diagnoses which included	F 760	F760 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #101 is currently receiving medication per physician's order. Address how the facility will identify other	10/24/24

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hypertension, heart failure, and atrial fibrillation.

A physician order dated 3/18/24 for midodrine (a medication used to treat low blood pressure) 5 milligram (mg) tablet by mouth three times a day for hypotension (low blood pressure). Hold for systolic blood pressure (SBP) greater than 120 millimeters of mercury (mmHg).

Review of the Medication Administration Record for July 2024 revealed Resident #101 was administered midodrine 15 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings:

7/1/24 at 8:00 am SBP was 134 mmHg and was administered by Nurse #1.
7/1/24 at 12 pm SBP was 142 mmHg and was administered by Nurse #1.
7/1/24 at 4:00 pm SBP was 138 mmHg and was administered by Nurse #1.
7/2/24 at 8:00 am SBP was 138 mmHg and was administered by Nurse #7.
7/2/24 at 12 pm SBP was 138 mmHg and was administered by Nurse #7.
7/2/24 at 4:00 pm SBP was 133 mmHg and was administered by Nurse #7.
7/6/24 at 4:00 pm SBP was 130 mmHg and was administered by Nurse #6.
7/11/24 at 8:00 am SBP was 124 mmHg and was administered by Nurse #4.
7/11/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #4.
7/18/24 at 12:00 pm SBP was 128 mmHg and was administered by Nurse #8.
7/22/24 at 8:00 am SBP was 139 mmHg and was administered by Nurse #8.
7/27/24 at 4:00 pm SBP was 122 mmHg and was

F 760

residents having the potential to be affected by the same deficient practice:

On 10/10/2024, Interim Director of Nursing conducted a 100% audit on residents who have physicians' orders for medication to be administered within specific parameters have been identified as having the potential to be affected.

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

On 10/10/2024 the Director of Nursing, Nursing Home Administrator, or Regional Vice President of Clinical Services provided education to each Licensed Nurse and Certified Medication Aid on following physician's orders for medication administration with special emphasis on medications with specific parameters. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 10/24/2024 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 10/24/2024 without receiving the education.

Any newly hired License Nurse, newly contracted agency nurse, or newly hired Certified Medication Aid will receive the education from the Director of Nursing, Nurse Practitioner, NHA, or Nurse Supervisor in Charge on medication

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administered by Nurse #1.
7/28/24 at 8:00 am SBP was 142 mmHg and was administered by Nurse #1.
7/28/24 at 12:00 pm SBP was 136 mmHg and was administered by Nurse #1.
7/28/24 at 4:00 pm SBP was 124 mmHg and was administered by Nurse #1.

Review of the Medication Administration Record for August 2024 revealed Resident #101 was administered midodrine 5 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings:

8/9/24 at 4:00 pm SBP was 128 mmHg and was administered by Nurse #5.
8/10/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5.
8/12/24 at12:00 pm SBP was 127 mmHg and was administered by Nurse #5.
8/20/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5.
8/23/24 at 12:00 pm SBP was 124 mmHg and was administered by Nurse #5.

Review of the nursing progress notes from July 2024 through August 2024 revealed no identified concerns related to the midodrine being administered to Resident #101 outside of the physician order parameters.

An attempt to conduct a telephone interview with Nurse #8 on 9/25/24 at 1:15 pm was unsuccessful.

An attempt to conduct a telephone interview with Nurse #7 on 9/25/24 at 1:59 pm was unsuccessful.

F 760

administration with special emphasis on medications with specific parameters during their classroom orientation, prior to provision of care.
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Twice a week for twelve weeks during the Clinical Morning Meeting, the Director of Nursing or Nurse Supervisor in Charge will randomly audit five residents' medication administration records to validate residents with specific parameters were followed for medication administration. During the auditing, if it is noted that the parameters were not followed, the Licensed Nurse or Medication Aide will be removed from patient care and a one-to-one educational in-service will be provided by the Director of Nursing, Nurse Practitioner, NHA, or RN Supervisor.

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

The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing.

Date of Compliance:
10/24/2024

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During a telephone interview on 9/25/24 at 2:06 pm with Nurse #5 confirmed she worked at the facility on the dates the medication was signed out on the MAR. She revealed she normally checked Resident #101's blood pressure before she gave her midodrine and she recalled Resident #101's SBP normally being lower than order parameter. Nurse #5 reported the medication should have been held based on the SBP that was documented. Nurse #5 stated she cannot say what happened and why the medication was given.

An attempt to conduct a telephone interview with Nurse #6 on 9/25/24 at 2:15 pm was unsuccessful.

A telephone interview was conducted on 9/25/24 at 2:23 pm with Nurse #4 who revealed when a blood pressure medication had a parameter to hold a blood pressure was supposed to be obtained prior to administration of the medication. Nurse #4 stated she did not recall the particular dates she was assigned to Resident #101, but she stated the midodrine should have been held if the SBP was greater than 120 mmHg. Nurse #4 could not say why she gave the medication.

A telephone interview was conducted on 9/25/24 at 6:00 pm with Nurse #1 who revealed she did not recall Resident #101or the specific dates to respond to the questions. Nurse #1 stated that in general if a blood pressure medication had a parameter, she would have obtained the blood pressure prior to giving the medication and documented the blood pressure when she signed out the medication. Nurse #1 stated if she documented that she administered the

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medication she would not be able to say what happened and why she would have given the medication.

An interview was conducted on 9/25/24 at 1:01 pm with the Nurse Practitioner who revealed she had only been at the facility for a few weeks and was unable to answer the questions regarding Resident #101.

An attempt to conduct a telephone interview with the Medical Doctor who was assigned to Resident #101 on 9/26/24 at 11:39 am was unsuccessful.

A telephone interview was conducted on 9/26/24 at 1:50 pm with the Medical Director who revealed Resident #101's midodrine was ordered with a parameter to keep the blood pressure from going too low. The Medical Director stated the risk associated with the midodrine being administered outside of the SBP parameter could have increased her blood pressure to an unsafe level which is why a parameter was placed on specific orders. The Medical Director stated Resident #101's midodrine should not have been administered when the SBP was greater than 120 mmHg.

An interview was conducted on 9/26/24 at 9:58 am with the Interim Director of Nursing (DON) who revealed nurses were educated regarding medication administration including to hold medications when outside of an order parameter. The Interim DON stated nurses were to check the blood pressure prior to the medication being administered. The Interim DON stated the Nurses should not have administered Resident #101's midodrine when the SBP was greater than

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F 760	Continued From page 30 the parameter of the physician order.	F 760		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews with resident, Speech Language Pathologist, Registered Dietitian, and staff, the facility failed to honor food preferences for 1 of 4 residents reviewed for preferences (Resident #66). The findings included: Resident #66 was readmitted to the facility on 9/5/24. Diagnoses included severe protein calorie malnutrition, failure to thrive, diabetes, and dysphagia. An admission Minimum Data Set (MDS) assessment dated 9/9/24 assessed Resident #66 with adequate hearing/vision, understood, understands, clear speech, severely impaired cognition. A diet order for Resident #66 dated 9/15/23 recorded a regular diet with mechanical soft	F 806	F806 Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #66 food preference is currently being honored. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: Residents who receive nutrients from the dietary department have been identified as having the potential to be affected. These identified residents have had their food preferences reviewed and updated by the Nutritional Services Manager on or before 9/26/2024	10/24/24

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ground meat texture on a sectioned plate with thin liquids, and double portions.

Review of Diet Order and Communication form dated 9/15/24 for Resident #66 revealed a new diet order that included mechanically altered level 2, thin liquids, and double portions on a sectioned plate.

A Nutritional Review dated 9/20/24, completed by the Registered Dietitian (RD), recorded Resident #66 for a regular, mechanical soft, ground meat texture; double portions diet order. Her intake varied from 25-75% consumption of meals. She had a wound noted to the right buttocks. The current diet order met nutritional requirements, but Resident #66 had variable intake. Wound healing interventions needed.

Resident #66 was interviewed on 9/24/24 at 8:36 AM. She stated that she was supposed to receive double portions at meals but had yet to receive.

During an observation on 9/25/24 at 8:52 AM, Resident #66 did not receive double portions of food items on breakfast meal tray, including eggs and oatmeal. The meal ticket did not include the details of double portions.

During an observation on 9/25/24 at 12:58 PM, Resident #66 did not receive double portions of food items on the lunch meal tray, including ground meat, rice, and creamed corn. The meal ticket did not include the details of double portions.

The Dietary Manager (DM) was interviewed on 9/25/24 at 1:05 PM. She revealed that all diet order changes were communicated with a Diet

F 806

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

On 9/26/2024, the Nursing Home Administrator re-educated the Nutritional Service Manager. On 9/30/2024, the Nursing Home Administrator educated the Interdisciplinary Care Team on communication of food preferences via the Diet Order and Communication Form.

The Director of Nursing, Nursing Home Administrator, or Regional Vice President of Clinical Services provided education to Licensed Nurse on the Diet Order and Communication Form initiated on 10/10/2024. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 10/24/2024 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift.

The Nursing Home Administrator, Registered Dietician, or Nutritional Services Manager provided education to each dietary employee on honoring food preferences and execution of the Diet Order and Communication Form on 10/14/2024. Any Dietary Employee who did not receive the education by 10/24/2024 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift.

The Nursing Home Administrator or Director of Rehab Services provided

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F 806	Continued From page 32 Order and Communication form from the nurse on duty. She stated she was not notified that the order change on 9/15/24 included double portions. The DM indicated that Resident #66 ate a lot of snacks/cookies and drank fluids, but she did not eat most of her meals. During an interview with the Speech Language Pathologist (SLP) on 9/25/24 at 2:13 PM, she revealed that if she initiated a diet change for a resident, a copy would be given to the Director of Rehab, the RD, and the nurse on duty. The SLP stated that Resident #66 asked for double portions on 9/15/24 because she was still hungry after meals. So, the SLP gave the Diet Order and Communication form to kitchen staff (names unknown) and the nurse on duty assigned to Resident #66. An interview was conducted with the RD on 9/25/24 at 2:47 PM. She revealed that she was aware of Resident #66's double portions diet order, but the description seemed vague and left a lot of room for interpretation. The RD indicated she needed to clarify the double portions order with the SLP as to double protein or double entrees. The interview further reveaked if Resident #66 requested more food and was included in the diet order, then she should receive double portions. Nurse #10 was interviewed on 9/25/24 at 3:32 PM. She revealed that when she was given a Diet Order and Communication form, she would take it to the kitchen. Nurse #10 stated she could not recall if she was given a Diet Order and Communication form from the SLP on 9/15/24. During an interview with the Senior Vice	F 806	education to each Speech Language Pathologist (SLP) on the Diet Order and Communication Form on 10/17/2024. Any SLP who did not receive the education by 10/24/2024 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift. Any newly hired License Nurse, newly contracted agency nurse, any newly hired dietary employee and any newly hired or contracted SLP will receive the education from the Director of Nursing, NHA, Director of Rehab Services, Nutritional Services Manager, or Nurse Supervisor in Charge on the Diet Order and Communication Form. Weekly for twelve weeks the Nutritional Services Manager (NSM) will randomly interview three alert and oriented residents to validate resident food preferences are correctly updated. During the auditing, if it is noted that the food preferences were not updated, they will be updated at that time and additional follow-up will be conducted. Results of the audits will be presented by the NSM to the QAPI Committee for review. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The audits will be presented by the NSM to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 806	Continued From page 33 President of Operations on 9/25/24 at 3:25 PM, she revealed that the RD told her Resident #66's request for double portions was considered a preference. If the DM was not in the building when a food preference/dietary change was made, then there needed to be a process in place to ensure clear communication. She stated she would expect any changes to a dietary order or food preference to be fulfilled and carried out. The Administrator was interviewed on 9/26/24 at 8:49 AM. She revealed that Resident #66 asked for double portions, and dietary staff should have been alerted to the change and provided her preference at meals.	F 806	Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		10/24/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345359	A. BUILDING ______ B. WING ______	C 09/26/2024

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F 842	Continued From page 34 §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842

Continued From page 35

determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews, the facility failed to accurately document the administration of 14 doses of blood pressure medication in the medical record for 1 of 1 resident reviewed for a significant medication error (Resident #101).

The findings included:

Resident #101 was admitted to the facility on 1/23/24 with diagnoses which included hypertension, heart failure, and atrial fibrillation.

A physician order dated 3/18/24 for midodrine (a medication used to treat low blood pressure) 5 milligram (mg) tablet by mouth three times a day for hypotension (low blood pressure). Hold for systolic blood pressure (SBP) greater than 120 millimeters of mercury (mmHg).

Review of the Medication Administration Record for July 2024 revealed Resident #101's midodrine was documented as administered 2 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings:
7/4/24 at 4:00 pm SBP was 132 mmHg and was documented as administered by Nurse #3.
7/10/24 at 4:00 pm SBP was 128 mmHg and was documented as administered by Nurse #3.

Review of the Medication Administration Record

F 842

F842

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

Resident #101 is currently receiving medication per physician's order. Resident #101 medication administration is being documented per policy.

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

On 10/10/2024, Interim Director of Nursing conducted a 100% audit on residents who have physicians' orders for medication to be administered within specific parameters have been identified as having the potential to be affected.

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

On 10/10/2024 the Director of Nursing, Nurse Practitioner, Physician, RN Supervisor, Nursing Home Administrator, or Regional Vice President of Clinical

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F 842 Continued From page 36

for August 2024 revealed Resident #101's midodrine was documented as administered 8 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings:
8/2/24 at 12:00 pm SBP was 128 mmHg and was documented as administered by Nurse #3.
8/8/24 at 12:00 pm SBP was 132 mmHg and was documented as administered by Nurse #2.
8/14/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2.
8/17/24 at 12:00 pm SBP was 124 mmHg and was documented as administered by Nurse #2.
8/21/24 at 8:00 am SBP was 132 mmHg and was documented as administered by Nurse #2.
8/22/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2.
8/28/24 at 8:00 am SBP was 122 mmHg and was documented as administered by Nurse #2.
8/31/24 at 4:00 pm SBP was 124 mmHg and was documented as administered by Nurse #2.

Review of the Medication Administration Record for September 2024 revealed Resident #101's midodrine was documented as administered 4 times with the SBP greater than 120 mmHg. The MAR report revealed the following dates, times, and blood pressure readings:
9/1/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2.
9/11/24 at 4:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2.
9/15/24 at 12:00 pm SBP was 122 mmHg and was documented as administered by Nurse #2.
9/19/24 at 4:00 pm SBP was 121 mmHg and was documented as administered by Nurse #2.

An interview was conducted on 9/25/24 at 1:01 pm with Nurse #2 who revealed when a physician

F 842

Services provided education to each Licensed Nurse and Certified Medication Aid on following physician’s orders for medication administration with special emphasis on medications with specific parameters and documentation of medication administration. Any Licensed Nurse or Certified Medication Aid who did not receive the education by 10/24/2024 will not be permitted to work without first receiving the education prior to the start of their next scheduled shift. No Licensed Nurse or Certified Medication Aid will be permitted to work after 10/24/2024 without receiving the education.

Any newly hired License Nurse, newly contracted agency nurse, or newly hired Certified Medication Aid will receive the education from the Director of Nursing, Nurse Practitioner, NHA, or Nurse Supervisor in Charge of medication administration with special emphasis on medications with specific parameters and documentation of medication administration during their classroom orientation, prior to provision of care.
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Twice a week for twelve weeks during the Clinical Morning Meeting, the Director of Nursing or Nurse Supervisor in Charge will randomly audit five residents’ medication administration records to validate residents with specific parameters for medication administration were followed and accurately documented. Three random interviews per week for twelve weeks with Licensed Nurses or Medication Aides will be

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F 842	Continued From page 37 order had a parameter to hold the medication the order required a blood pressure to be obtained and documented on the Medication Administration Record (MAR). Nurse #2 stated she did not believe she administered the midodrine medication to Resident #101 on the dates noted because she always paid attention to the medication order. Nurse #2 stated does not think she gave the medication outside the parameter because she knows Resident #101 well. An interview was conducted on 9/25/24 at 1:09 pm with Nurse # 3 who revealed she checked Resident #101's blood pressure prior to administering the midodrine medication and would enter the blood pressure when she documented the medication as administered. Nurse #3 stated it may have been a documentation mistake, but she did not think she would have administered Resident #101's midodrine medication outside of the parameter. An interview was conducted with the Interim Director of Nursing (DON) on 9/26/24 at 9:58 am who revealed all nursing staff were provided education during orientation and random medication pass observations throughout the year to ensure medications were being administered correctly. The Interim DON stated the education included documentation of the medications administered.	F 842	conducted by the DON or Nurse Supervisor in Charge to validate accuracy of medication administration for medications with parameters. Results of the audits and interviews will be presented by the Director of Nursing to the QAPI Committee monthly for three months. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained: The audits will be presented by the Director of Nursing to the facility's Quality Assurance and Performance Improvement Committee for review monthly for three months. The facility's Quality Assurance and Performance Improvement Committee will make recommendations as needed to assure compliance is sustained ongoing. Date of Compliance: 10/24/2024	