STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345148	A. BUILDING _____ B. WING _____	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS HOMES AT GUILFORD	925 NEW GARDEN ROAD GREENSBORO, NC 27410

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E 000	Initial Comments An unannounced recertification survey was conducted on 10/21/24 through 10/24/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # B11Q11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 10/21/24-10/24/24. Event ID #B11Q11.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide a safe transfer resulting in the resident falling to the floor. The resident sustained no injuries. This was for 1 of 3 (Resident #25) residents reviewed for accidents. The findings included: Resident #25 was admitted to the facility on 04/12/21 with diagnoses of dementia, unsteadiness on feet, muscle weakness, localized edema, and cognitive communication deficit. Review of Resident #25's quarterly Minimum	F 689	Preparation and/or execution of this Plan of Correction does not constitute admission by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Law. F689 Corrective action: Resident #25 was assessed by Nurse #1 on 10/17/24 and reassessed by the	11/21/24

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

Electronically Signed | 11/07/2024

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F 689	Continued From page 1 Data Set (MDS) dated 08/22/24 revealed the resident was severely cognitively impaired and required substantial/maximal assistance with toileting and transfers. Review of the Resident #25's care plan revised on 09/17/24 revealed the resident required assistance with mobility due to weakness, unsteadiness on feet, and gate problem. The goal was staff would continue to assist Resident #25 in her current mobility status while she maintained comfort and safety. Interventions included Resident #25 required at times 2 person assist with transfers from sit to stand and to utilize the toilet grab bar for toilet transfer due to Resident #25's right knee giving out. Review of Resident #25's care guide as of 10/17/24 revealed Resident #25 required extensive assistance with toilet transfer and toileting care with toileting hygiene. The care guide further revealed Resident #25 was to utilize toilet grab bar for transfer and required extensive assist due to her right knee could give out. Review of progress note dated 10/17/24 completed by Nurse #1 revealed Resident #25 had a witnessed fall in the resident's bathroom where staff assisted the resident to the floor. The note further revealed Resident #25 was alert, vitals were taken, and skin was intact. Review of an incident report dated 10/17/24 and completed by Nurse #1 revealed Resident #25 had a witnessed fall with Nurse Aide #1. It further revealed Nurse #1 was called to Resident #25's room and observed Resident #25 sitting upright against the toilet with legs outstretched. Nurse Aide #1 had assisted Resident #25 with toileting	F 689	Director of Nursing on 10/23/24 to ensure there were no injuries. Resident #25 was found to be without bruising, pain, or other signs of injury. Immediate re-education to Nurse Aide #1 was conducted by Nurse #1 on 10/23/24 regarding identifying all resident transfer needs. prior to transferring any resident. Identification of other residents who may be involved in this practice: Since all residents that are at risk for falls or require assistance for transfers have the potential to be impacted, A 100% audit was completed from 10/31/24-11/5/24 to ensure all resident fall risk and transfer needs were reviewed. The fall risk and transfer needs were addressed in the resident care plan and reflected in the care guide. Fall risk and transfer/lift assessments will be completed on 100% of Residents, with care plan and Kardex updated to reflect current resident status by 11/21/24. Systemic changes: Re-education conducted from 11/7/24 □ 11/21/24 with to all nursing staff to check Kardex at the beginning of their shift and prior to assisting a resident with transfers and that not following the care guide would lead to disciplinary action, up to an including termination. Nursing staff were educated on monitoring resident transfers to ensure unlicensed assistive personnel followed care plans when delivering care.	

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F 689	Continued From page 2 and the resident lost balance and was assisted to the floor with NA #1. Resident #25 was unable to tell what had happened but was assessed and obtained no injuries. A phone interview conducted with Nurse Aide (NA) #1 on 10/23/24 at 11:30 AM revealed on 10/17/24 during third shift she assisted Resident #25 to the toilet. NA #1 further revealed she assisted Resident #25 up from the wheelchair and when the resident went to pivot to sit on the toilet the resident became weak and started to fall to the ground. NA #1 indicated she assisted Resident #25 to the ground and sat her up so she could retrieve the Nurse. NA #1 stated Resident #25 did not express or show any signs of pain or injury. NA #1 indicated she had worked with the resident for 2 months consistently and was educated by a nurse to have two people to assist with transfers for Resident #25. NA #1 indicated she had also been educated to check the residents' care guide for assist information. NA #1 revealed it was a busy day and she failed to retrieve another staff member to assist her when she took Resident #25 to the restroom. A phone interview conducted with Nurse #1 on 10/23/24 at 11:05 AM revealed she was the assigned Nurse for Resident #25 on 10/17/24. Nurse #1 further revealed NA #1 retrieved her and went to Resident #25's room and found her sitting up against the toilet in her restroom. Nurse #1 indicated she completed an assessment, and the resident did not show any signs of pain and did not obtain any injuries. Nurse #1 revealed Resident #25 often had weak legs and was unable to hold her weight. Nurse #1 stated Resident #1 required two people for transfers and NA #1 should have had another person with her	F 689	Monitoring: Observational audits to ensure residents who require extensive or mechanical assistance for transfers are transferred according to the care guide will be conducted by the Director of Nursing, Nurse Mentors, and/or the Household Coordinator. This audit will be conducted on random shifts for five residents. The frequency of the audit is five times per week, for 2 weeks, then three times per week for 10 weeks for 5 Residents. The results of these audits will be brought to and discussed by the Director of Nursing at the monthly Quality Assurance/ Performance Improvement (QAPI) Committee meeting. Any issues identified will be immediately addressed and corrected along with immediate re-education of staff upon discovery. Any trends or changes needed to the plan will be addressed with the IDT team, Medical Director, and QAPI team and the plan will be updated to ensure continued compliance.	

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F 689	Continued From page 3 to assist the resident. Nurse #1 reported she verbally educated NA #1. Nurse #1 revealed staff had been educated to look at the resident's care guide and care plan. Nurse #1 stated she educated staff that Resident #25 was a two-person assist for transfers due to having a decline and being weaker. Nurse #1 indicated NA #1 knew Resident #25 was a two person assist before the incident on 10/17/24. An interview conducted with Nurse #2 on 10/23/24 at 2:00 PM revealed she had cared for and assisted Resident #25 since April 2024 and the resident had always been a two person assist. Nurse #2 further revealed Resident #25 often was weak and unable to hold herself up. Nurse #2 indicated staff had been educated to look at the resident's care guide and care plan. Nurse #2 stated she had educated the aides she worked with that Resident #25 was a two person assist due to her muscle weakness and unable to hold her own weight. An interview conducted with the Director of Nursing on 10/24/24 at 9:00 AM revealed Resident #25's incident occurred during third shift on 10/17/24. It was further revealed Resident #1 often had fluid and edema in her legs which caused muscle weakness. The DON indicated she expected for nursing staff to follow the assistance that the resident is coded for the residents in the care plan and care guides.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		11/21/24

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F 758	Continued From page 4	F 758		

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

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

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

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

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

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

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F 758	Continued From page 5 §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 staff and consultant pharmacist interviews and record reviews, the facility failed to limit the duration of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) ordered on an as needed (PRN) basis to 14 days and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. This occurred for 1 of 5 residents whose medications were reviewed (Resident #59). The findings included: 1. Resident #59 was admitted to the facility on 6/27/24. Her cumulative diagnoses included dementia with mild anxiety. A review of the resident's electronic medical record (EMR) revealed the following medication orders were received for Ativan (an antianxiety medication). Ativan is a psychotropic medication and a controlled substance medication. -A physician's order was received on 8/8/24 for 0.5 milligram (mg) Ativan to be given as one tablet by mouth every 4 hours as needed (PRN) for anxiety. The resident's most recent Minimum Data Set (MDS) was a significant change assessment dated 8/18/24. Resident #59 was reported to	F 758	F758 Corrective action: Resident #59□s medication orders were reviewed by the Medical Director on 10/25/24. An order clarifying duration of Ativan for resident #59 was entered into the medical record with a stop date. Identification of other residents who may be involved in this practice: Since all residents with psychotropic medications are potentially impacted, an audit of all residents with orders for as needed (PRN) psychotropic medications was conducted to ensure they have appropriate stop dates and/or indicate the duration and rationale for the PRN order to be extended beyond 14 days, when appropriate. The Regional Clinical Manager with Neil Medical conducted a 100% audit of all active PRN psychotropic medication orders for current resident□s on 10/25/24. The findings were shared with the Director of Nursing. The Regional Clinical Manager, with Neil Medical Group provided in-service on regulations pertaining to psychotropic medication with Traci Burge, Pharm D consultant on 10/25/24. Any residents found to be	

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F 758	Continued From page 6	F 758		

have intact cognition with no behaviors nor rejection of care. The Medication section of the MDS revealed Resident #59 did not receive an antianxiety medication during the 7-day look back period.

Resident #59's EMR indicated the physician's order for the PRN Ativan (ordered on 8/8/24) as active orders up through the date of the review on 10/24/24. A review of Resident #59's Medication Administration Records (MARs) revealed 2 doses (8/8/24 and 9/1/24) of PRN Ativan were administered to Resident #59 from 8/8/24 through the date of the review 10/24/24. The last dose of PRN Ativan was documented as having been administered on 9/1/24.

Further review of Resident #59's EMR revealed no evidence of justification of the extended use of the PRN Ativan.

An interview was conducted on 10/24/24 at 11:52 AM with nurse practitioner (NP #1) and she indicated that she ordered the 0.5 mg of Ativan PRN on 8/8/24 but failed to include an end date of 14 days. She further revealed that this was an oversight, and the order should have included a stop date of 14 days and then be reviewed for further orders.

A telephone interview was conducted on 10/24/24 at 11:26 AM with the facility's consultant pharmacist. During the interview, the pharmacist reported she completed a medication regime review for Resident #59 on 9/5/24 but did not realize the PRN Ativan order that was started on 8/8/24 did not include a 14 day stop date.

An interview was conducted on 10/24/24 at 12:05

impacted had their orders reviewed by the Medical Director for updates.

Systemic changes:

The Director of Nursing re-educated licensed nursing staff and the Medical Director on 10/31/24 regarding the requirements for all PRN psychotropic medications to have a 14 day stop date. Education and training provided on 11/06/2024 to all nurses and medication aides by Traci Burge, Pharm D regarding the requirements for all PRN psychotropic medications to have a 14 day stop date.

Monitoring:

An audit of all new psychotropic medications will take place three times per week for four weeks then monthly for eight weeks to ensure any psychotropic medication has a 14 day stop date or a provider documented rationale for extension beyond the 14 days. A 100% audit of all active PRN psychotropic orders will be conducted monthly by the Regional Clinical Manager from November 2024 through January 2025 and periodically if deemed necessary by the QAPI team. The results of this audit will be brought to and discussed by the Director of Nursing and Consultant Pharmacist at the monthly Quality Assurance/ Performance Improvement (QAPI) Committee meeting. Any issues identified will be immediately addressed and corrected upon discovery. Any trends or changes needed to the plan will be

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F 758	Continued From page 7 PM with the facility's Director of Nursing (DON). During the interview, the DON reported that she was aware that orders for PRN psychotropic medications required a stop date, and that additional documentation was required to continue PRN psychotropic medications (other than antipsychotic medications) for an extended duration. She further revealed that Resident #59's PRN Ativan order should have been ordered with a 14 day stop date and that the consultant pharmacist should have caught the error during her September 2024 medication regimen review, and this was an oversight.	F 758	addressed to the IDT team, Medical Director, Attending Physicians or Extended Providers and QAPI team and the plan will be updated to ensure continued compliance.	