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	345113	A. BUILDING _____ B. WING _____	C 12/06/2024

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WILLOW CREEK NURSING AND REHABILITATION CENTER	2401 WAYNE MEMORIAL DRIVE GOLDSBORO, NC 27534

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/2/24 through 12/6/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #UZH411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 12/2/24 through 12/6/24. Event ID# UZH411. The following intakes were investigated NC00211859, NC00213729, NC00214490, NC00217227, NC00217471, NC00217564, NC00217908, and NC00219850. 6 of the 26 complaint allegations resulted in deficiency.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.	F 584		1/7/25

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

Electronically Signed | 12/23/2024

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F 584	Continued From page 1 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to replace a damaged bed mattress for 1 of 32 residents reviewed for environment (Resident #9). The findings included: Resident #9 was admitted on 6/25/24 with diagnoses that included right sided hemiplegia (paralysis), neuropathy (nerve pain), artificial knee joint, and osteoarthritis. The quarterly Minimum Data Set (MDS) assessment dated 11/07/24 revealed Resident #9 was cognitively intact. Work order # 9213 created on 11/15/24 revealed	F 584	F584 Safe/Clean/Comfortable/Homelike Environment On 12/3/24, the bed mattress for resident #9 was replaced by Central Supply. Resident #9 had no further complaints of bed mattress being uncomfortable. On 12/9/24, the Unit Managers initiated an audit of all bed mattresses to ensure they were in good repair without indentations. The Unit Managers will address all areas of concern identified during the audit to include replacement of mattress when indicated. The audit will be completed by 12/16/24. On 12/9/24, the Social Workers initiated questionnaires with alert and oriented residents regarding concerns with bed	

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F 584	Continued From page 2 a request had been entered by Med Aide (MA) #1 for Resident #9's current room for "mattress extremely uncomfortable, has a deep dip in it." The notes stated Resident #9 "is requesting a new mattress, it causes his back to hurt. He is out of bed right now if you can change it." The work order was assigned to the Maintenance Assistant, who referred the work order to central supply and set the status to completed. In an interview with MA #1 on 12/04/24 2:44 PM she stated on 11/15/24 Resident #9 told her he "felt like he was down in a hole" when he laid on his mattress. She stated she placed a work order, and the mattress had been replaced within about 15 minutes or so on 11/15/24. She stated the Central Supply Manager told her he replaced it with a new mattress, and the replacement mattress on 11/15/24 did not look worn to her. MA #1 stated Resident #9 told her that the replacement mattress was uncomfortable and he "felt like he was sitting in a hole again." She stated she told Resident #9 the Central Supply Manager told her it was new so it was not the mattress, and she told Resident #9 it might be because he was so tall that it felt like that. MA #1 stated that she did not assess the mattress herself to see if it had an indentation in it. During an interview with the Maintenance Assistant on 12/04/24 at 1:45 PM he stated he received a work order placed on 11/15/24 for Resident #9's bed mattress and took the work order to the Central Supply Manager so a new mattress could be ordered. After he assigned it to the Central Supply Manager on 11/15/24 he marked the work order as completed. During an interview with the Central Supply	F 584	mattresses to include mattresses with indentations. The Unit Managers will address all concerns identified during the questionnaires to include replacement of mattress when indicated. The questionnaires will be completed by 1/7/25. On 12/9/24, the Administrator completed an in-service with the Maintenance Director and maintenance staff regarding Maintaining a Homelike Environment with emphasis on inspection and timely replacement bed mattresses when worn or have indentions. The in-service also included notification of the Administrator for any concerns that cannot be addressed timely for additional recommendations/interventions. All newly hired maintenance staff will be educated during the orientation regarding Maintaining a Homelike Environment. The Unit Managers will audit 10 bed mattresses to include mattress for resident #9 weekly x 4 weeks then monthly x 1 month using the Mattress Audit Tool. This audit is to ensure the mattress is in good repair without indentations. The Unit Managers will notify the maintenance director, nurse supervisor and/or Administrator for all identified areas of concern. The Maintenance Director will address all work orders submitted for concerns identified to include but not limited to replacement of bed mattress when indicated. The Administrator will review the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed.	

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F 584	Continued From page 3 Manager on 12/04/24 at 2:26 PM he stated that he replaced old mattresses on beds and if the mattresses were still in good condition, he placed them on another bed. He further indicated that he had not replaced a mattress on Resident #9's bed on 11/15/24. The Central Supply Manager stated if a resident complained about a mattress, he just replaced it regardless of condition. An observation was conducted on 12/02/24 at 12:06 PM of Resident #9's bed mattress. The mattress was observed to be without bed linens and the mattress slanted down from the left side of the mattress toward the right side of the mattress. A 15-inch by 15-inch in diameter indentation was visible midway of the mattress towards the right side. The cover of the mattress was observed to have a faded, rough, cracked, worn appearance as compared to the remainder of the mattress cover. During an interview with Resident #9 on 12/02/24 at 12:06 PM he stated he moved from another room to his current room about a month ago and his first mattress was in "bad shape" and had a sag in it that was like the sag in the current mattress. He stated he told Medication Aide (MA) #1 the mattress was uncomfortable, and he received a replacement mattress about 3 weeks ago. He stated the mattress was replaced with the current mattress and the man (did not know his name or title) who put it on his bed told him it was a new mattress but, within a few days he could tell it was not new because it sagged worse than the first mattress. Resident #9 stated when he laid on the second mattress, he felt like his buttocks dipped in a hole and it caused him to have discomfort in his back. He stated he had back surgery about 3 years ago and it aggravated	F 584	The Administrator will present the findings of the Mattress Audit to the Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months to review the environmental rounds audit to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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his back. When asked if he had pain from laying on the mattress, he stated it felt like there was something pressing between his shoulder blades and it made him feel achy at times. Resident #9 stated a week ago he told another Nursing Assistant (NA) (could not recall her name) that the second mattress was uncomfortable, and she told him she talked to someone about it, but it never got changed.

During an observation and interview with Nurse # 1 on 12/02/24 at 12:21 PM she stated she was unaware of the condition of Resident #9's bed mattress but it should not sag like it did and should be replaced. She stated she would put in a work order immediately to have it replaced.

Housekeeper #1 assigned to Resident #9's hall was interviewed on 12/05/24 at 11:26 AM and stated she was responsible for inspecting the mattresses on her assigned hall when she deep cleaned the rooms, and if they were damaged or had sags in them, they would need to be replaced. Housekeeper #1 further indicated she had deep cleaned Resident #9's room before he moved in around 11/01/24. She stated she could not recall if the mattress had an indentation or damage and that she just wiped down the mattress.

In an interview with the Housekeeping Supervisor, on 12/04/24 at 2:05 PM he stated the housekeepers kept him informed when a mattress needed to be replaced related to poor condition. He stated he was not informed about a mattress in poor repair for Resident #9 on 11/15/24 and had not changed the mattress on that date. He stated the Central Supply Manager changed mattresses on beds when needed.

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In an interview with the Maintenance Director on 12/04/24 at 9:28 AM he stated he had received a work order for Resident #9's room on 11/15/24. He stated the request was related to Resident #9's bed mattress. He stated the work orders were assigned to the Maintenance Assistant who would have made a referral to Central Supply so a new mattress could be ordered.

In an interview with a family member of Resident #9 on 12/05/24 at 11:54 AM she stated she visited the resident sometime around 11/17/24. She stated that during her visit Resident #9's bed had been stripped of linen and the mattress was visible. The family member stated the mattress was "cracked and broken up, and had a saggy look to it in the middle" and stated she did not know another way to describe the appearance of the mattress. Resident #9's family member said no one should have to sleep on a mattress in that poor of a condition. She stated she told a NA (name unknown to her), and the NA told her she was new, and Resident #9 should not have had a mattress in that poor of a condition.

In an interview with Nurse Practitioner # 1 on 12/05/24 at 10:59 AM she stated laying on a mattress with an indentation would not cause long lasting effects for Resident #9 because he got out of the bed to a wheelchair during the day, but he had right sided hemiplegia and neuropathy and had pain in general and it could have added to his pain.

During a combined interview with the Administrator and the Central Supply Manager on 12/04/24 11:50 AM the Administrator stated if residents had a concern about a bed mattress the

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F 584	Continued From page 6 resident told the unit staff, and a work order would be placed and the Maintenance Director or the Administrator notified the Central Supply Manager so a new mattress could be ordered. The Central Supply Manager did not recall a replacement mattress being placed on Resident #9's bed on 11/15/24. He stated if a work order had been placed on 11/15/24 it would have been assigned to him to get a new mattress and he would have replaced the mattress. In interviews with the Administrator on 12/04/24 at 3:18 PM and 12/5/24 at 9:47 AM she shared she was unaware that Resident #9 had slept on a mattress in poor condition from 11/15/24 until 12/2/24, when it was observed by the surveyor. The Administrator stated a replacement mattress should be provided if a resident requested one. She further stated that if Resident #9 requested to have a mattress replaced because of discomfort, then it should have been replaced immediately.	F 584		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, pharmacist and physician interviews, the facility failed to protect a resident's right to be free from	F 602	Past noncompliance: no plan of correction required.	

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the misappropriation of medication for 2 of 2 residents (Resident #116, Resident #163) reviewed for misappropriation of resident property.

Findings included:

1. Resident #116 was admitted to the facility on 10/16/22. Her active diagnoses included diabetes mellitus.

Review of Resident #116's orders revealed on 1/16/24 she was ordered Ozempic inject 0.25 mg (milligrams) subcutaneously one time a day every Tuesday for diabetes mellitus.

A review of Resident #116's Medication Administration Record (MAR) revealed on 4/23/24 Nurse #8 documented Ozempic was not available to be administered.

During an interview on 12/4/24 at 2:49 PM Nurse #8 who documented Ozempic as unavailable and not administered to Resident #116 on 4/23/24 stated she did work with Resident #116 on night shifts in 4/2024. She further stated at that time Resident #116's Ozempic was being administered once a week at night on Tuesdays. She stated it was a long time ago, but she believed she gave the resident her Ozempic a few times prior to 4/23/24 with no issues. She stated she did not recall that night (4/23/24) very well. She stated this was her only experience with Ozempic not being available for her to administer the medication. She stated Resident #116's blood sugars were baseline and the resident did not display any negative side effects from the lack of the medication. She concluded had Resident #116 developed hyperglycemia they had faster

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acting insulin available in their e-kit and would have been able to provide coverage per physician orders had it been necessary which it was not.

A review of a pharmacy packing slip dated 4/24/24 revealed the facility received a pen containing 12 doses of Ozempic for Resident #116.

A review of Resident #116's MAR revealed on 4/30/24 Nurse #10 documented Ozempic was not available to be administered. On 5/7/24 Nurse #9 documented Ozempic was not available to be administered. On 5/14/24 Nurse #10 documented Ozempic was not available to be administered.

During a telephone interview on 12/5/24 at 9:53 AM Nurse #9 who documented Ozempic as unavailable and not administered to Resident #116 on 5/7/24 she stated she did not remember the incident as it was a long time ago. She reported that to her knowledge; Resident #116 did not have any negative side effect of not receiving Ozempic on her shift but she reiterated she did not remember the incident or that Resident #116 was on Ozempic but stated Resident #116 had always been stable when she worked with her.

Nurse #10 who documented not having available or administering Ozempic to Resident #116 on 4/30/24 and 5/14/24 was unavailable for interview.

During a telephone interview on 12/05/24 at 1:01 PM Pharmacist #2 stated the pharmacy dispensed a 3 milliliter Ozempic pen for Resident #116 on 4/24/24. This pen was reported as lost by the facility and was never returned by the facility. The facility was charged for the replacement

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which was dispensed on 5/15/24 and received by the facility.

A review of the facility's investigational summary dated 5/18/24 completed by the Director of Nursing revealed on 5/16/24 the facility noted a pattern of Ozempic being unavailable for Resident #116 and conducted a 100% audit of all residents receiving GLP1 (a class of drugs used to treat type 2 diabetes and obesity) medications. During this audit all GLP1 medications were counted, and control substance count sheets were placed in the narcotic books. On 5/18/24 the facility initiated an in-service with the Minimum Data Set (MDS) nurses as it related to pulling reports to capture the past 24 hours of medications not available and medications not given. On 5/18/24 the facility initiated an in-services with all nurses and medication aides related to counting GLP1 injectable pens during shift/break changes including adding control substance count sheets on arrival of new supplies.

During an interview on 12/3/24 at 8:20 AM Resident #116 stated sometime this year her Ozempic went missing, and she did not receive a few doses of it. She stated she gets the medication every Saturday currently. At the time, she was getting it every Tuesday. When the facility identified that her Ozempic was missing they changed the day it was being given to Saturday. They also reordered the medication. She had no issues since.

On 12/04/24 at 9:10 AM the Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON) were interviewed and stated during Inter-Disciplinary Team (IDT) morning

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meeting on 4/24/24 they noted Ozempic was documented as not available and not given to Resident #116 on 4/23/24 based on the report provided by the Minimum Data Set (MDS) nurses which was pulled each morning for the IDT morning meeting. This did not raise any concern at that time because upon review, the medication was to be delivered that evening on 4/24/24. Nurse Practitioner #1 was a part of this discussion and was following the resident for Diabetes Mellitus and blood sugars. They ensured they had coverage (medication to control blood sugar levels) for her blood sugars. The DON stated during morning IDT meeting on 5/1/24 it was noted that Resident #116's Ozempic was again not available and not given on 4/30/24. She then told the nurse to reorder it through the computer from the pharmacy. She stated at that time she believed it was due to pharmacy delivery error and did not think there would be any reason for someone to take the medication. The medication was not given and not available on 5/7/24 but this was not captured in the IDT morning meeting on 5/8/24 due to an error in the way the MDS nurses were pulling the report. They were unaware of this at that time and assumed the medication had come in and was being given correctly. The next dose was to be given on 5/14/24 and it was not available and not given. This time it did show up on the MDS report and was flagged. The IDT team noted it was not available and not given to Resident #116 on 4/23/24, 4/30/24, 5/7/24, and 5/14/24. This caused them to do a more in-depth review of the medication and try to discover what was going on. The ADON stated she went to the unit refrigerator and looked for the medication for Resident #116 and was unable to find it. All unit managers went and checked all of the facility carts and unit

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refrigerators to ensure the medication had not been misplaced in the facility. They were unable to find the medication. She then called the pharmacy and pulled the packing slip which came with the medication when it was delivered. The packing slip was found with a delivery date of 4/24/24 and one pen with 12 doses was delivered to the facility. When the nurse had reordered the medication via the computer on 5/1/24 the pharmacy had not sent the medication because it was too soon to refill. She then called the pharmacy, and the pharmacy told her it was not time for the medication to be reordered and if they wanted another delivery of a pen with 12 doses the facility would have to pay out of pocket for the medication. She stated she then went to the Administrator to get permission to reorder the medication from the pharmacy out of the facility's pocket. The medication was ordered and filled on 5/16/24 and arrived that night.

On 12/4/24 at 1:27 PM the interview with the Administrator, DON, and ADON continued and the ADON stated at that point they felt the pen had been thrown away in error or misplaced. However, the next day they pulled a report on all residents that were prescribed antidiabetic medications and highlighted the residents prescribed GLP1 medications. Then they pulled the MAR for all those residents for the time range they were prescribed a GLP1. They then pulled all the packing slips from the pharmacy showing the amount and when the GLP1s were delivered to the facility for all residents identified as receiving GLP1 medications. They then compared the packing slip delivery quantities to the MARs to account for every dose that was received by the facility for the length of each GLP1 prescribed. They then checked all the

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medications currently in the facility to ensure what was in the facility was accurate compared to the delivery slips and what should be in the facility according to the packing slips. During this investigation it was also found that another resident (Resident #163) also had missing doses. These discrepancies were not captured by the MDS report for the IDT morning meetings the next day due to a mistake in how MDS pulled the records. At this point they felt this was not a pharmacy error or the pens were simply misplaced and initiated sign-in and out count sheets for all GLP1 medications currently in the facility and ensured locks were on the medication storage refrigerators. The nursing and medication aide staff were in-serviced on the use of the count sheets for GLP1 medications. The MDS nurses were educated on how to pull all missing medications to be reviewed in the morning IDT meetings. They implemented the process of signing in and out the countdown sheets for GLP1 medications and implemented a monitoring tool to check the medications daily. She stated from the point where they implemented the new count down sheet process and the monitoring tool, they had not had any discrepancies with GLP1 medications. She stated on 5/17/24 the police, Department of Health and Human Services, and Adult Protective Services were notified of the misappropriation of resident property.

During a telephone interview on 12/5/24 at 1:58 PM Physician #1 stated he was made aware of the incident when the Ozempic pens were missing. He further stated he was notified by the nurses on the hall when the medication was not available to be given. He explained that Ozempic was not a medication that controlled blood sugars

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on a day-to-day basis, but it helped stabilize hemoglobin A1C (a blood test that measures your average blood sugar level over the past three months) over the course of multiple months. He stated he had no concerns about any negative outcomes due to the lack of the Ozempic in the facility and was monitoring Resident #115's bloods sugars and the resident had coverage available. They had no negative out comes because of the lack of Ozempic.

During a follow up interview on 12/5/24 at 9:01 AM the Administrator stated following the investigation they concluded the facility was unable to substantiate the misappropriation of resident property because they were unable to determine the location of the Ozempic pens after they were last known to have been received by the facility from the pharmacy. The pens were replaced at no cost for both residents and the facility paid for the replacement pens.

2. Resident #163 was admitted to the facility on 4/9/24. Her active diagnoses included diabetes mellitus.

Review of Resident #163's orders revealed on 4/10/24 she was ordered Ozempic inject 2 mg (milligrams) subcutaneously one time a day every 7 days for diabetes mellitus.

A review of a pharmacy packing slip dated 4/10/24 revealed the facility received a pen containing 4 doses of Ozempic for Resident #163.

A review of Resident #163's Medication Administration Record (MAR) revealed on 4/24/24 and 5/15/24 Nurse #12 documented

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Ozempic was not available to be administered. On 5/1/24 Nurse #11 documented Ozempic was not available to be administered. On 5/8/24 Nurse #13 documented Ozempic was not available to be administered.

During a telephone interview on 12/5/24 at 8:39 AM Nurse #12 who documented Ozempic as not available and not administered to Resident #163 on 4/24/24 and 5/15/24 stated she did not remember the incident or the resident. She indicated she did not know of any negative outcomes for Resident #163 due to not having Ozempic available.

During a telephone interview on 12/5/24 at 8:17 AM Nurse #11 who documented Ozempic as not available and not administered to Resident #163 on 5/1/24 stated she did not remember that Resident #163 was on Ozempic. She further stated she did not recall specifically not having Ozempic for Resident #163. She stated Resident #163's bloods sugars never went out of baseline for the resident as far as she could recall, and she did have insulin coverage (medication to control blood sugar levels) if her blood sugars were elevated, and the resident did not have any negative outcomes due to Ozempic not being available.

Nurse #13 who documented Ozempic as not available and not administered to Resident #163 on 5/8/24 was not available for interview.

During a telephone interview on 12/05/24 at 1:01 PM Pharmacist #2 stated an 8mg Ozempic pen was dispensed on 4/10/24 for Resident #163 and arrived at the facility. This pen should have lasted 28 days per dosing. The pen was not returned.

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On 5/16/24 this pen was refilled, and the facility reported the 4/10/24 pen as lost and paid for the pen dispensed on 4/10/24.

A review of the facility's investigational summary dated 5/18/24 completed by the Director of Nursing revealed on 5/16/24 the facility noted a pattern of Ozempic being unavailable for another resident (Resident #116) and conducted a 100% audit of all residents receiving GLP1 (a class of drugs used to treat type 2 diabetes and obesity) medications. During this audit all GLP1 medications were counted, and control substance count sheets were placed in the narcotic books. The audit identified Resident #163 had not had available or received her Ozempic on 4/24/24, 5/1/24, 5/8/24, and 5/15/24. On 5/18/24 the facility initiated an in-service with the Minimum Data Set (MDS) nurses as it related to pulling reports to capture the past 24 hours of medications not available and medications not given. On 5/18/24 the facility initiated an in-services with all nurses and medication aides related to counting GLP1 injectable pens during shift/break changes including adding control substance count sheets on arrival of new supplies.

During an interview on 12/4/24 at 1:27 PM the Assistant Director of Nursing stated another resident had triggered concerns that GLP1 medications were not available and administered. On 5/16/24 they pulled a report on all residents that were prescribed antidiabetic medications and highlighted the residents prescribed GLP1 medications. Then they pulled the MAR for all those residents for the time range they were prescribed a GLP1. They then pulled all the packing slips from the pharmacy showing the

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amount and when the GLP1s were delivered to the facility for all residents identified as receiving GLP1 medications. They then compared the packing slip delivery quantities to the MARs to account for every dose that was received by the facility for the length of each GLP1 prescribed. They then checked all the medications currently in the facility to ensure what was in the facility was accurate compared to the delivery slips and what should be in the facility according to the packing slips. During this investigation it was also found Resident #163 had not had available or received her dose of Ozempic on 4/24/24, 5/1/24, 5/8/24, and 5/15/24. These discrepancies were not captured by the MDS report for the IDT morning meetings the next day due to a mistake in how MDS pulled the records. At this point they felt this was not a pharmacy error or the pens were simply misplaced and initiated sign-in and out count sheets for all GLP1 medications currently in the facility and ensured locks were on the medication storage refrigerators. The nursing and medication aide staff were in-serviced on the use of the count sheets for GLP1 medications. The MDS nurses were educated on how to pull all missing medications to be reviewed in the morning IDT meetings. They implemented the process of signing in and out the countdown sheets for GLP1 medications and implemented a monitoring tool to check the medications daily. She stated from the point where they implemented the new count down sheet process and the monitoring tool, they had not had any discrepancies with GLP1 medications. She stated on 5/17/24 the police, Department of Health and Human Services, and Adult Protective Services were notified of the misappropriation of resident property.

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During a telephone interview on 12/5/24 at 1:58 PM Physician #1 stated he was made aware of the incident when the Ozempic pens were missing. He further stated he was notified by the nurses on the hall when the medication was not available to be given. He explained that Ozempic was not a medication that controlled blood sugars on a day-to-day basis, but it helped stabilize hemoglobin A1C (a blood test that measures your average blood sugar level over the past three months) over the course of multiple months. He stated he had no concerns about any negative outcomes due to the lack of the Ozempic in the facility and was monitoring Resident #163's bloods sugars and the resident had coverage available. They had no negative out comes because of the lack of Ozempic.

During a follow up interview on 12/5/24 at 9:01 AM the Administrator stated following the investigation they concluded the facility was unable to substantiate the misappropriation of resident property because they were unable to determine the location of the Ozempic pens after they were last known to have been received by the facility from the pharmacy. The pens were replaced at no cost for both residents and the facility paid for the replacement pens.

The facility provided the following corrective action plan.

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

On 4/23/2024, scheduled Ozempic pen was not available to administer to Resident #116 per physician order. On 4/24/24, the facility received

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3ml (2mg/ml) Ozempic pen via pharmacy courier. On 4/30/24, the scheduled dose of Ozempic for resident #116 was noted as not available to administer per nursing documentation. On 5/1/24, the Assistant Director of Nursing (ADON) was notified of Resident #116 scheduled Ozempic medication was not available to administer. The ADON submitted a refill request via the computer. On 5/7/24 and 5/15/24, the scheduled dose of Ozempic medication for Resident #116 was documented as not available to administer per nursing documentation. The ADON notified the pharmacy for a refill of the medication at the cost of the facility. The medication arrived on 5/16/24. On 5/17/24, the physician was notified of scheduled Ozempic medication not available to administer on 4/23/24, 4/30/24, 5/7/24 and 5/14/24 with new order to resume medication on 5/18/24. On 5/18/24, Resident #116 was administered Ozempic per physician order.

On 4/10/24, the scheduled Ozempic pen for Resident #163 was documented as not available to administer per nursing documentation. The assigned nurse notified the pharmacy for refill request. On 4/10/24, 3ml Ozempic (8mg/ml) pen were delivered to the facility via pharmacy courier. On 4/17/24, Resident #163 received Ozempic per physician order. On 4/24/24, Resident #163 was moved from station 4 to station 2. The nurse documents that the scheduled Ozempic dose as not available to administer. The assigned nurse requested a refill via the electronic record. On 5/16/24, the administrative nurse identified during the audit of residents receiving Ozempic that the resident had not received scheduled doses due to the drug not available to administer. The ADON notified the

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pharmacy for a refill of the medication at the cost of the facility. The medication arrived on 5/16/24. On 5/17/24, the physician was notified of scheduled Ozempic medication not available to administer on 4/10/24, 4/17/24, 4/24/24, 5/1/24 and 5/8/24 with new order to resume medication on 5/18/24. On 5/18/24, Resident #163 was administered Ozempic per physician order.

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

On 5/16/2024 Facility conducted an audit of all residents receiving (glucagon-like peptide 1 (GLP1) medications (Ozempic/Semaglutide and Trulicity/Dulaglutide). This audit was to ensure medications were administered per physician order and/or the physician notified for further recommendations. The Administrative nurses addressed all concerns identified during the audit to include ordering medication not available to administer, notification of the physician for further recommendations and/or education of the nurse. During this audit all GLP1 Medications (Ozempic/Semaglutide and Trulicity/Dulaglutide) were counted, and the facility proactively initiated Control Substance Count sheets and placed in the appropriate Narcotic Books.

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

On 5/18/2024 the Facility completed an in-service with the Minimum Data Set (MDS) nurses as it relates to pulling reports to capture the past 24 hours of medications documented as "Not

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Available" or Medications Not Given for review by the Interdisciplinary team (IDT).

On 5/18/2024 the Staff Development Coordination initiated an in-service with all nurses and medication aides regarding (1) Counting GLP1 Injectables Pens during shift/break changes, including adding Control Substance Count Sheets on arrival of new Supplies (2) documentation on electronic medication record (eMAR) Administration note to include in detail reason the medication was not given or not available and (3) Misappropriation to include misappropriation or medications.
In-services were completed by 5/18/2024. After 5/18/2024 any Nurse/Medication Aide to include agency nurses, agency medication aides, who have not worked nor received the in-service will review/sign prior to next scheduled shift. All newly hired staff members to include agency nurses, agency medication aids will be in-serviced during orientation by the SDC regarding Counting GLP1 Medications, documentation on eMAR when meds not available to administer and Misappropriation of Residents Property

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

On 5/17/24, the Administrator and Director of Nursing made the decision to monitor resident's receiving GLP1 medications and to ensure they were administered per physicians' order.

The Unit Managers will audit all residents receiving GLP 1 medications to include Resident #116 and Resident #163 utilizing the GLP 1 Audit Tool 5 times a week x 4 weeks to ensure

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F 602	Continued From page 21 medication was administered per physician orders and/or the provider notified for further recommendations. Any identified areas of concern will be addressed with the Director of Nursing. The Director of Nursing will forward the results of the GLP 1 Audit tool to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 1 month. The QAPI Committee will meet monthly x 1 month and review the GLP1 Audit tool to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring. Completion date 5/19/24 Onsite validation of the facility's corrective action plan was completed on 12/6/24. The initial audit results were reviewed. The in-service education record dated 5/18/24 were reviewed. Interviews with nurses and medication aides indicated they attended and/or received in-service training on misappropriation of resident property including medications and handling of GLP1 medications to include count sheets and reconciliation. The monitoring results were reviewed. The QA meeting minutes were reviewed. The facility's completion date of 5/19/24 was validated.	F 602		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered	F 656		1/7/25

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care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
§483.21(b)(3) The services provided or arranged

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F 656	Continued From page 23 by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to develop a comprehensive care plan in the area of fall risk for 1 of 3 residents reviewed for accidents (Resident #81). The findings included: Resident #81 was admitted to the facility on 10/23/24 with diagnoses that included unspecified fracture of lower end of left radius, unspecified dementia and history of falling. A review of Resident #81's Minimum Data Set (MDS) dated 10/28/24 revealed he was coded as having had a fall in the previous 30 days. A review of Resident #81's comprehensive care plan did not reveal a care plan in the area of falls risk. In an interview with the Minimum Data Set (MDS) nurse on 12/5/24 at 8:04 AM she looked for Resident #81's falls risk care plan in his record and stated he did not have one. She stated the MDS nurse is responsible for completing the comprehensive care plan and the missing falls risk care plan was an oversight. An interview with the Director of Nursing (DON) on 12/5/24 at 10:45 AM revealed the MDS nurse was ultimately responsible for developing comprehensive care plans. She was unaware Resident #81 did not have a care plan to address his risk for falls.	F 656	F 656 Develop/Implement Comprehensive Care Plan On 12/05/2024, the Minimum Data Set Nurse (MDS) updated the care plan for resident #81 to accurately reflect falls risk/interventions. On 12/23/2024, the Director of Nursing (DON) initiated an audit of all residents at risk for falls to ensure the resident is care planned for falls risks/interventions, the care plan is person centered with measurable objectives and timeframes to meet the resident's needs. The DON/Assistant Director of Nursing (ADON) will address all concerns identified during the audit to include updating the care plan when indicated and/or education of staff. The audit will be completed by 1/7/2025. On 12/23/2024, the Staff Development Coordinator (SDC) initiated an in-service with all nurses regarding Care Plans with emphasis on the responsibility of the nurse to ensure care plan is person centered for all aspects of care with measurable objectives and timeframes to meet the resident's medical, nursing, and mental/psychosocial needs to include but not limited to residents at risk for falls. In-service will be completed by 1/7/2025. After 1/7/2025, any nurse who has not completed the in-service will be in-service prior to the next scheduled work shift. All	

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F 656	Continued From page 24 An interview with the Administrator was conducted on 12/5/24 at 10:45 AM where she stated she was not aware Resident #81 did not have a falls risk care plan.	F 656	newly hired nurses will be in-service during orientation regarding Care Plans. The Assistant Director of Nursing/Quality Assurance Nurse will review all newly identified residents at risk for falls weekly x 4 weeks then monthly x 1 month using the Care Plan Audit Tool. This audit is to ensure the resident is care planned for falls risks/interventions, the care plan is person centered with measurable objectives and timeframes to meet the resident's needs. The Assistant Director of Nursing/Quality Assurance Nurse will address all concerns identified during the audit to include updating the care plan when indicated and/or re-training of staff. The Director of Nursing (DON) will review the Care Plan Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Director of Nursing will forward the results of Care Plan Audit Tool to the Quality Assurance Performance Improvement Committee (QAPI) monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 658		1/7/25

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F 658	Continued From page 25 by: Based on record review, and staff, physician, and pharmacist interviews, the facility failed to ensure two residents received Ozempic subcutaneous injections as ordered for 2 of 7 residents reviewed for medication errors. (Resident #116 and Resident #163) Findings included: 1. Resident #116 was admitted to the facility on 10/16/22. Her active diagnoses included diabetes mellitus. Review of Resident #116's orders revealed on 1/16/24 she was ordered Ozempic inject 0.25 mg (milligrams) subcutaneously one time a day every Tuesday for diabetes mellitus. A review of Resident #116's Medication Administration Record (MAR) revealed on 4/30/24 Nurse #10 documented Ozempic was not available to be administered. On 5/7/24 Nurse #9 documented Ozempic was not available to be administered. On 5/14/24 Nurse #10 documented Ozempic was not available to be administered. During a telephone interview on 12/5/24 at 9:53 AM Nurse #9 who documented Ozempic as unavailable and not administered to Resident #116 on 5/7/24 stated she did not remember the incident as it was a long time ago. She further stated she if she did not have a medication available that was scheduled, she would call the physician to get a hold order or follow whatever orders he provided after being made aware as well as letting her supervisor know. She stated she would also call the pharmacy to check on the medication or reorder it. She concluded to her	F 658	F658 Services Provided Meet Professional Standards The physician was previously notified that resident #116 did not receive Ozempic medication per physician order on 4/30/24, 5/7/24 and 5/14/24 with no new recommendations. The medication was obtained from the pharmacy on 5/16/24 and administered per physician order. On 12/3/24, the review the DON reviewed the electronic medication record (eMAR) for resident #116 to ensure Ozempic was currently being administered per physician order. There were no additional concerns identified. The physician was previously notified that resident #163 did not receive Ozempic medication per physician order on 4/24/24, 5/1/24, 5/8/24 and 5/15/24 with no new recommendations. The medication was obtained from the pharmacy on 5/16/24 and administered per physician order. On 5/17/24, the DON reviewed electronic medication record (eMAR) for resident #163 to ensure Ozempic was currently being administered per physician order. There were no additional concerns identified. The resident was discharged from the facility on 7/11/24. On 12/23/24, the Unit Managers initiated an audit of all residents eMAR from 12/1/24-12/22/24. This audit is to ensure medications to include Ozempic were administered per physician order and/or the physician was notified if medication was not available to administer for further recommendations with documentation in	

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F 658	Continued From page 26	F 658		

knowledge; Resident #116 did not have any negative side effect of not receiving a medication including Ozempic on her shift but she reiterated she did not remember the incident or that Resident #116 was on Ozempic but Resident #116 had always had stable blood sugars.

During a telephone interview on 12/05/24 at 1:01 PM Pharmacist #2 stated the pharmacy dispensed a 3 milliliter Ozempic pen for Resident #116 on 4/24/24. This pen was reported as lost by the facility and was never returned by the facility. The facility was charged for the replacement which was dispensed on 5/15/24 and received by the facility. This pen would have lasted 12 weeks per dosing, however, per the manufacturer it would only be good for 56 days after opening.

During a telephone interview on 12/5/24 at 1:58 PM Physician #1 stated he was made aware of the incident when the Ozempic pens were missing. He further stated he was notified by the nurses on the hall when the medication was not available to be given. It was not a medication that controlled blood sugars on a day-to-day basis, but it helped stabilize hemoglobin A1C (a blood test that measures your average blood sugar level over the past three months) over the course of multiple months. He stated he had no concerns about any negative outcomes due to the lack of the Ozempic in the facility and was monitoring Resident #163's bloods sugars and the resident had coverage available. They had no negative out comes because of the lack of Ozempic. He concluded he expected medications to be given as ordered.

During an interview on 12/5/24 at 8:13 AM the Director of Nursing stated medications should be

the electronic record. The Unit Managers will address all concerns identified during the audit to include but not limited to assessment of the resident, obtaining medications from pharmacy, notification of the physician for further recommendations if medications not available and/or education of staff. The audit will be completed by 1/7/2025.
On 12/23/24, the Assistant Director of Nursing (ADON) completed an audit of all medication carts to resident eMARs to ensure all Glucagon-Like Peptide-1 (GLP1) medications to include Ozempic are available to administer per physician order. The ADON will address all concerns identified during the audit to include obtaining medications from the pharmacy or back up pharmacy when indicated, notification of the physician when medication is not available to administer for further recommendations and/or education of staff. The audit will be completed by 1/7/2025.
On 12/23/24, the Staff Development Coordinator (SDC) initiated Medication Pass Audits with all nurses and medication aides. This audit is to ensure the nurse and/or medication aide administered medications per the physician's order or the nurse/medication aide notified the physician when medication was not available to administered for further recommendations with documentation in the electronic record. The SDC will address all concerns identified during the audit to include obtaining medications from pharmacy, notification of the physician for further

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F 658	Continued From page 27 given as prescribed. Nurse #10 who documented not having available or administering Ozempic to Resident #116 on 4/30/24 and 5/14/24 was unavailable for interview. 2. Resident #163 was admitted to the facility on 4/9/24. Her active diagnoses included diabetes mellitus. Review of Resident #163's orders revealed on 4/10/24 she was ordered Ozempic inject 2 mg (milligrams) subcutaneously one time a day every 7 days for diabetes mellitus. A review of Resident #163's Medication Administration Record (MAR) revealed on 4/24/24 and 5/15/24 Nurse #12 documented Ozempic was not available to be administered. On 5/1/24 Nurse #11 documented Ozempic was not available to be administered. On 5/8/24 Nurse #13 documented Ozempic was not available to be administered. During a telephone interview on 12/5/24 at 8:39 AM Nurse #12 who documented Ozempic as not available and not administered to Resident #163 on 4/24/24, and 5/15/24 stated she did not remember the incident or the resident. Stated if she was working and discovered a medication such as Ozempic was not available to be given and it was due, she would call the pharmacy to see if the medication was sent out or if it could be reordered. She stated she would let the physician or nurse practitioner know as well that it was not available to give. She concluded she did not know of any negative outcomes for Resident #163 due to not having Ozempic available.	F 658	recommendations if medications not available and/or education of staff. The audit will be completed by 1/7/2025. After 1/7/2025, any nurse or medication aide who has not worked or completed the medication pass audit will complete it upon the next scheduled work shift. On 12/23/24, the SDC initiated an in-service with all nurses and medication aides regarding the (1) Rights of Medication Administration with emphasis on ensuring the resident receives the right medication at the right time and (2) Following Physician Orders with emphasis on how to obtain medications when not available on the cart and/or notification of the physician when medications not available for further recommendations. The in-services will be completed by 1/7/2025. After 1/7/2025, any nurse or medication aide who has not worked or completed the education will complete prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the SDC during orientation regarding Rights of Medication Administration and Following Physician Orders, The Unit Managers/SDC will complete 5 Medication Pass Audits across all shifts with nurses and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurses and/or medication aides administered medications per the physician's order or the nurse/medication aide notified the physician when medication was not available to administered for further recommendations with documentation in	

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F 658	Continued From page 28 During a telephone interview on 12/5/24 at 8:17 AM Nurse #11 who documented Ozempic as not available and not administered to Resident #163 on 5/1/24 stated she did not remember that Resident #163 was on Ozempic. She further stated she did not recall specifically not having Ozempic for Resident #163 but whenever medication was not available when it was due, she would call the pharmacy to get it reordered and would check to see when it could be given, or she would get her manager to call the pharmacy. She stated she did not remember the incident but would notify the pharmacy and physician or nurse practitioner. She stated Resident #163's bloods sugars never went out of baseline for the resident as far as she could recall, and she did have insulin coverage if her blood sugars were elevated, and the resident did not have any negative outcomes due to Ozempic not being available. She stated she only worked with Resident #163 a short time and did not have concerns about not having the medication not being available regularly. During a telephone interview on 12/05/24 at 1:01 PM Pharmacist #2 stated an 8mg Ozempic pen was dispensed on 4/10/24 for Resident #163 and arrived at the facility. This pen should have lasted 28 days per dosing. The pen was not returned. On 5/16/24 this pen was refilled, and the facility reported the 4/10/24 pen as lost and paid for the pen dispensed on 4/10/24. During a telephone interview on 12/5/24 at 1:58 PM Physician #1 stated he was made aware of the incident when the Ozempic pens were missing. He further stated he was notified by the nurses on the hall when the medication was not	F 658	the electronic record. The Unit Managers/SDC will address all concerns identified during the audit to include obtaining medications from pharmacy, notification of the physician for further recommendations if medications not available and/or retraining of staff. The DON will review the Medication Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The DON/ADON will review medications not administered or not available 5 times a week x 4 weeks then weekly x 4 weeks utilizing the Meds not Administered Report. This audit is to identify any resident who did not receive or medications not available to administer per physician order. The DON/ADON will address all concerns identified during the audit to include but not limited to assessment of the resident, obtaining and administering medications per physician order, notification of the physician if medications not available for further recommendations with documentation in the electronic record and/or re-training of staff. The Director of Nursing or Assistant Director of Nursing will review the Meds not Administered Report 5 times a week x 4 weeks then weekly x 4 weeks to ensure all concerns are addressed. The Administrator/DON will forward the results of the Medication Pass Audits, and Meds Not Administered Report to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need	

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F 658	Continued From page 29 available to be given. It was not a medication that controlled blood sugars on a day-to-day basis, but it helped stabilize hemoglobin A1C (a blood test that measures your average blood sugar level over the past three months) over the course of multiple months. He stated he had no concerns about any negative outcomes due to the lack of the Ozempic in the facility and was monitoring Resident #163's bloods sugars and the resident had coverage available. They had no negative out comes because of the lack of Ozempic. He concluded he expected medications to be given as ordered. During an interview on 12/5/24 at 8:13 AM the Director of Nursing stated medications should be given as prescribed. Nurse #13 who documented Ozempic as not available and not administered to Resident #163 on 5/8/24 was not available for interview.	F 658	further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and Nurse Practitioner (NP) #1 interview the facility failed to follow professional standards of	F 695	F 695 Respiratory/ Tracheostomy Care and Suctioning	1/7/25

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F 695	Continued From page 30 practice and infection prevention measures when a nurse failed to perform hand hygiene between the removal of soiled gloves and the application of sterile gloves, when Nurse #4 touched the outside of the tracheostomy packaging with sterile gloves and did not change them and when she dropped a sterile q-tip onto the residents nightgown and proceeded to use it to clean the tracheostomy site. She further failed to keep sterile technique when she touched the new, sterile, inner cannula with contaminated sterile gloves that had touched the outside of the tracheostomy tray. This was for 1 of 1 resident (Resident #85) reviewed for respiratory care. Findings included: Resident #85 was admitted to the facility on 10/12/23 with diagnoses that included acute and chronic respiratory failure with hypoxia (low blood oxygen level), history of neoplasm (tumor) of nasal cavity and mid ear and chronic tracheostomy. Resident #85's Annual Minimum Data Set (MDS) dated 10/19/24 revealed he was cognitively intact and required complete assistance with all activities of daily living. He was documented to receive tracheostomy care in the facility. Resident #85's care plan revealed him to be at risk for ineffective breathing pattern related to having a tracheostomy. A continuous observation of tracheostomy care was observed on 12/4/24 at 10:00 AM with Nurse #4. At 10:10 AM she donned (put on) clean gloves and removed the residents soiled split gauze that rests between the skin and the	F 695	On 12/4/24, the Staff Development Coordinator (SDC) verbally educated nurse #4 regarding trach care, sterile technique and infection control with emphasis on handwashing and changing gloves. On 12/5/24 resident #85 was provided trach care by assigned hall nurse under the oversight of the Staff Development Coordinator to ensure appropriate sterile/clean technique was used to include handwashing/changing gloves or replace contaminated items when indicated. There were no concerns identified. On 12/4/24, the SDC initiated 15 random audits of staff currently working. This audit is to ensure staff utilized appropriate sterile/clean technique when providing care to include trach care, handwashing and changing gloves when indicated. The SDC will immediately address all concerns identified during the audit to include providing additional care utilizing the appropriate sterile/clean technique when indicated and education of staff. The audit will be completed by 1/7/2025. On 12/20/24, the SDC initiated an in-service with all nurses regarding (1) Trach Care with emphasis on sterile/clean technique when providing trach care to prevent infection to include maintaining a sterile field and replacing any item that accidently becomes contaminated during care and (2) Handwashing/Gloves Use with emphasis on washing hands	

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F 695	Continued From page 31 tracheostomy collar, and removed the residents used inner cannula and threw both away. She then doffed (removed) the soiled gloves and immediately donned (put on) sterile gloves without performing hand hygiene first in between. After donning the sterile gloves, she touched the outside of the tracheostomy care tray that held the sterile supplies needed for the care. At 10:23 AM, while wearing the same gloves, she picked up a sterile q-tip, dipped it into sterile water, dropped it onto the residents clothing covered chest, picked it up again and used it to clean around the tracheostomy stoma (entry into the windpipe from the outside). Wearing the same gloves she then opened the inner cannula package by touching the outside, removed the sterile inner cannula and inserted it into the residents outer cannula. In an interview with Nurse #4 on 12/4/24 at 10:47 AM she stated only sterile items should be touched with sterile gloves and the q-tip that she dropped should have been thrown away and a new one used. Nurse #4 indicated she should have performed hand hygiene between doffing soiled gloves and donning sterile gloves by washing her hands with soap and water. She further indicated she should have removed the sterile gloves after touching the outside of packaging, performed hand hygiene and donned new sterile gloves. An interview with the Staff Development Coordinator (SDC) on 12/5/24 at 8:45 AM revealed she trained all nurses who worked with Resident #85 on tracheostomy care. She stated she trained Nurse #4 on 12/4/24. In a follow-up interview on 12/6/24 at 8:32 AM the	F 695	before/after contact with residents and when removing/changing gloves. In-service also included changing gloves when visibly soiled or after contact with contaminated items if providing care requiring sterile technique. The in-services will include a return demonstration to validate staff knowledge and understanding of the education. In-services/return demonstrations will be completed by 1/7/2025. After 1/7/2025 any nurse who has not worked or completed the in-service/demonstration will complete it at the next scheduled work shift. Any nurse who cannot successfully complete the return demonstration after two attempts will not be allowed to work until re-training is completed. All newly hired nurses will be in-service during orientation. The SDC will observe trach care 2 times a week x 4 weeks then weekly x 4 weeks utilizing the Trach Care Observation. This audit is to ensure the nurse utilized appropriate sterile/clean technique and followed infection control guidelines regarding handwashing and glove use when providing trach care. The SDC will immediately address all concerns identified during the audit to include providing additional care utilizing the appropriate sterile/clean technique when indicated and re-training of staff. The Director of Nursing (DON) will review the Trach Care Observation weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed.	

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F 695	Continued From page 32 SDC stated she performed a hands-on demonstration with Nurse #4 on 12/4/24 at the beginning of the shift, before the investigation observation. In a follow-up telephone interview with Nurse #4 on 12/6/24 at 9:27 AM she stated she was not provided training on tracheostomy care by the SDC until the afternoon of 12/4/24, after the investigation observation of tracheostomy care. In an interview with the Director of Nursing (DON) and Administrator on 12/4/24 at 11:41 AM they stated if non-sterile items are touched with sterile gloves, the contaminated sterile gloves should be removed, hand hygiene performed and new sterile gloves donned. They indicated sterile items that become contaminated, such as the q-tip, should be discarded immediately, and hand washing with soap and water should be performed after doffing soiled gloves and before donning sterile ones. They further stated sterile technique in tracheostomy care is important to prevent bacteria from being introduced into the airway and causing respiratory illness. During an interview on 12/5/24 at 8:20 AM the infection preventionist (IP) stated Nurse #4 should have washed her hands with soap and water after removing the dirty gloves and before donning the sterile gloves. She further stated the outside of the tracheostomy care tray should not have been touched with sterile gloves as it is not sterile. Nurse #4 should have performed hand hygiene and donned new sterile gloves after touching the outside of the tracheostomy tray. The IP indicated the q-tip should have been thrown away and a new one should have been used after it fell on the residents clothing covered	F 695	The DON will forward the Trach Care Observations to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F 695	Continued From page 33 chest and hand hygiene should have been performed and new sterile gloves donned before getting a new sterile q-tip. She further indicated that bacteria could be introduced into the residents airway and this could lead to infection if sterile procedure is not followed. In an interview with NP #1 on 12/5/24 at 8:30 AM she stated that Resident #85 had a permanent tracheostomy and no current respiratory infection. NP #1 further stated it is important to follow infection control prevention procedures when performing tracheostomy care to avoid introducing bacteria into the residents airway and potentially causing an infection such as Pneumonia. NP #1 would have expected Nurse #1 to perform hand hygiene by washing her hands between doffing dirty gloves and donning sterile ones. She indicated that nonsterile items should not be touched with sterile gloves, and the sterile q-tip that was contaminated by falling onto the residents clothing should have been discarded and a new one should have been used after performing hand hygiene and donning new sterile gloves.	F 695		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		1/7/25

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F 726	Continued From page 34 accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure a Nurse was competent to provide tracheostomy care for 1 of 1 resident reviewed for tracheostomy (surgically created airway in the front of the neck) care (Resident #85). Findings include: A continuous observation of tracheostomy care was observed on 12/4/24 at 10:00 AM with Nurse #4 (agency). At 10:10 AM she donned (put on) clean gloves and removed the residents soiled split gauze that rests between the skin and the tracheostomy collar, and removed the residents used inner cannula and threw both away. She then doffed (removed) the soiled gloves and	F 726	F 726 Competent Nursing Staff On 12/4/24, the Staff Development verbally educated nurse #4 regarding trach care, sterile technique and infection control with emphasis on handwashing and changing gloves. On 12/5/24 resident #85 was provided trach care by assigned hall nurse under the oversight of the Staff Development Coordinator to ensure appropriate sterile/clean technique was used to include handwashing/changing gloves or replace contaminated items when indicated. There were no concerns identified.	

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F 726	Continued From page 35 immediately donned (put on) sterile gloves without performing hand hygiene first in between. After donning the sterile gloves, she touched the outside of the tracheostomy care tray that held the sterile supplies needed for the care. At 10:23 AM, while wearing the same gloves, she picked up a sterile q-tip, dipped it into sterile water, dropped it onto the residents clothing covered chest, picked it up again and used it to clean around the tracheostomy stoma (entry into the windpipe from the outside). Wearing the same gloves she then opened the inner cannula package by touching the outside, removed the sterile inner cannula and inserted it into the residents outer cannula. In an interview with Nurse #4 on 12/4/24 at 10:47 AM she stated only sterile items should be touched with sterile gloves and the q-tip that she dropped should have been thrown away and a new one used. Nurse #4 indicated she should have performed hand hygiene between doffing soiled gloves and donning sterile gloves by washing her hands with soap and water. She further indicated she should have removed the sterile gloves after touching the outside of packaging, performed hand hygiene and donned new sterile gloves. Nurse #4 revealed she worked for agency and had not had hands on training for tracheostomy care at the facility. An interview with the Staff Development Coordinator (SDC) on 12/5/24 at 8:45 AM revealed completed hands on tracheostomy training with all nurses who work with Resident #85 before they work with him. She stated she trained Nurse #4 on 12/4/24. In a follow-up interview on 12/6/24 at 8:32 AM the	F 726	On 12/23/24, the Staff Development Coordinator initiated an audit of all nurses to include agency nurse's education/skills checklist. This audit is to ensure the nurse was educated and completed a skills checklist with observation of skills to include but not limited to trach care, sterile technique and handwashing to validate staff knowledge and competency of skills during orientation and at least annually. The Staff Development Coordinator will address all concerns identified during the audit to include education of the nurse with the completion of the skills checklist/observation of skills to include but not limited to trach care, sterile technique and handwashing. The audit will be completed by 1/7/2025. On 12/23/24, the Administrator educated the Director of Nursing and Staff Development Nurse regarding the responsibility of ensuring all nurses to include agency nurses are educated and a skills checklist with observation of skills is completed during orientation and at least annually to validate staff knowledge and competency of skills to include but not limited to trach care, sterile technique and handwashing. All newly hired Director of Nursing and/or Staff Development Nurse will be educated during orientation regarding staff education/skills verification. On 12/23/24, the Staff Development Coordinator initiated an in-service with all nurses to include agency nurses	

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F 726	Continued From page 36 SDC stated she performed a hands-on demonstration with Nurse #4 on 12/4/24 at the beginning of the shift, before the investigation observation. In a follow-up telephone interview with Nurse #4 on 12/6/24 at 9:27 AM she stated she was not provided training on tracheostomy care by the SDC until the afternoon of 12/4/24, after the investigation observation of tracheostomy care. In an interview with the Director of Nursing (DON) and Administrator on 12/4/24 at 11:41 AM they stated new Nurses, including agency Nurses were trained on tracheostomy care before working with Resident #85. They indicated the SDC provided the education upon hire.	F 726	regarding (1) Trach Care with emphasis on sterile/clean technique when providing trach care to prevent infection to include maintaining a sterile field and replacing any item that accidently becomes contaminated during care and (2) Handwashing/Gloves Use with emphasis on washing hands before/after contact with residents and when removing/changing gloves. In-service also included changing gloves when visibly soiled or after contact with contaminated items if providing care requiring sterile technique. The in-services will include a return demonstration to validate staff knowledge and understanding of the education. The in-service/return demonstrations will be completed by 1/7/2025. After 1/7/2025 any nurse who has not worked or completed the in-service/demonstration will complete it at the next scheduled work shift. Any nurse who cannot successfully complete the return demonstration after two attempts will not be allowed to work until re-training is completed. All newly hired nurses, including agency nurses will be in-service during orientation. The Staff Development Coordinator will audit 10% of all nurses to include agency nurse's education/skills checklist weekly x 4 weeks then monthly x 1 month using the Education Audit Tool. This audit is to ensure the nurse was educated and completed a skills checklist with observation of skills to include but not limited to trach care, sterile technique and handwashing to validate staff knowledge	

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F 726	Continued From page 37	F 726	and competency of skills during orientation and at least annually. The Staff Development Coordinator will address all concerns identified during the audit to include education of the nurse with the completion of the skills checklist/observation of skills to include but not limited to trach care, sterile technique and handwashing. The Administrator will review the Education Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator will forward the Education Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, and resident, staff, physician, physician assistant, and pharmacist interviews the facility failed to ensure ear drop medication was administered via the correct route into the ears and not into the eyes. This was for 1 of 7 residents (Resident #2) reviewed for medication errors.	F 760	F760 Free of Significant Med Errors On 9/18/24, the DON notified the physician that resident #2 ear drops had potentially been administered into resident eyes. Resident #2 eyes were flushed with saline with no redness or irritation noted. Resident was seen by the provider with	1/7/25

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F 760	Continued From page 38 Findings included: Resident #2 was admitted to the facility on 7/11/24 with a diagnosis of left arm fracture. A review of Resident #2's admission Minimum Data Set (MDS) assessment dated 7/18/24 revealed she was cognitively intact. Her vision was impaired. She could see large print but not regular print in newspapers/books. She had functional limitation in range of motion in her upper and lower extremities on one side. She was independent with eating and personal hygiene. A review of Resident #2's comprehensive care plan revealed a focus area initiated on 7/23/24 of inability to read regular sized print without glasses. The goal was for Resident #2 to have no injuries and to feel safe and secure in her environment through the next review. An intervention was to use large print items for Resident #2. A review of a physician's order for Resident #2 revealed an order dated 8/8/24 for lubricant eye drops (carboxymethylcellulose sodium ophthalmic (eye) solution) instill one drop in both eyes two times a day for dry eyes. A review of a physician's order for Resident #2 revealed an order dated 9/17/24 for ciprofloxacin (an antibiotic medication) 0.3 percent-dexamethasone (a steroid medication) 0.1 percent instill 2 drops in left ear every 12 hours for 5 days for ear infection. A review of Resident #2's September 2024	F 760	new order for ophthalmology consult. On 9/18/24, nurse #5 was educated by Staff Development Coordinator regarding the Rights of Medication Administration with emphasis on ensuring the right medication is administered using the right route. On 9/23/24, resident #2 was seen by the Ophthalmologist with no negative findings related to eardrops potentially being administered into the resident's eyes. On 12/23/24, the Unit Managers completed an audit of all residents not able to report for acute changes to include eye redness/irritation potentially related to administration of medications with no negative findings. On 12/23/24, the Unit Managers initiated resident questionnaires regarding medication concerns to include receiving the right medication that has not previously been reported or addressed by staff. The Unit Managers will address all concerns identified during the audit to include assessment of the resident, notification of the physician when indicated for further recommendations and/or education of staff. The audit will be completed by 1/7/2025. On, 12/23/24 the Quality Assurance Nurse completed an audit of incident reports for the past 14 days. This audit was to identify any concerns related to not administering medications by the right route. There were no additional concerns identified. On 12/23/24, the initiated Medication Pass Audits Unit Managers (UM) all nurses and medication aides. This audit is to ensure	

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F 760	Continued From page 39 Medication Administration Record (MAR) revealed documentation indicating the ciprofloxacin -dexamethasone ear drops were administered to Resident #2 by Nurse #5 on 9/18/24 at 8:00 AM and by Nurse #7 on 9/18/24 at 8:00 PM. On 12/3/24 at 4:51 PM a telephone interview with Nurse #5 indicated although she could not recall the date, she had been orienting with Nurse #6 on the 7:00 AM to 7:00 PM shift. Nurse #5 stated Resident #2 had both eye drops and ear drops due and she brought both of these with her into Resident #2's room. She reported Nurse #6 told her that Resident #2 could give her eye drops to herself. She went on to say she had gone into Resident #2's room by herself, explained to Resident #2 that the bottle she was handing her was her ear drops, and she stood at Resident #2's bedside. Nurse #5 stated when Resident #2 started to put the drops into her eyes, she tried to stop Resident #2, but the medication had already gone into Resident #2's eyes. She reported she had immediately notified Nurse #6 what happened, and Nurse #6 reported it to the Director of Nursing (DON). Nurse #5 stated Physician #1 had been notified, and Resident #2's eyes had been flushed. She reported she received some education after the incident regarding ensuring the correct route for medications. On 12/4/24 at 9:59 AM a telephone interview with Nurse #6 indicated Nurse #5 had been on her second or third day of orientation (Nurse #6 could not recall the date) and he had asked Nurse #5 if she wanted to observe him administer medications, but she had said she was comfortable and could do this herself. Nurse #6	F 760	the nurse and/or medication aide administered medications per the physician's order and the Rights of Medication Administration with emphasis on administering the right medication by the right route. The SDC will address all concerns identified during the audit to include assessment of the resident, notification of the physician for further recommendations when indicated and/or education of staff. The audit will be completed by 1/7/2025. After 1/7/2025, any nurse or medication aide who has not worked or completed the medication pass audit will complete it upon the next scheduled work shift. On 12/20/24, the SDC initiated an in-service with all nurses and medication aides regarding the (1) Rights of Medication Administration with emphasis administering the right medication by the right route The in-service will be completed by 1/7/2025. After 1/7/2025, any nurse or medication aide who has not worked or completed the education will complete prior to the next scheduled work shift. All newly hired nurses and medication aides will be in-serviced by the SDC during orientation regarding Rights of Medication Administration. The Unit Managers/SDC will complete 5 Medication Pass Audits across all shifts with nurses and medication aides weekly x 4 weeks then monthly x 1 month. This audit is to ensure the nurse and/or medication aide administered medications per the physician's order and the Rights of Medication Administration with emphasis on administering the right medication by	

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F 760	Continued From page 40 stated Resident #2 had both eye drops, and ear drops to be administered that day. He reported he saw Nurse #5 knock on Resident #2's door, enter the room and introduce herself, and explain to Resident #2 that she had both eye drops and ear drops for her. Nurse #6 explained from where he was standing in Resident #2's room doorway, he could see Nurse #5 administer drops into Resident #2's eyes and set the bottle down on Resident #2's table, then administer ear drops to Resident #2 and set the bottle down. Nurse #6 stated as Nurse #5 picked the bottles up from Resident #2's table, he heard Resident #2 state, "You gave my ear drops in my eyes." He reported he entered Resident #2's room and reassured her he didn't think Nurse #5 had done this, but Resident #2 became upset and replied that she knew her medications and she wouldn't lie. He stated at that point he just went to notify the DON. Nurse #6 stated from where he had been standing in the doorway, he couldn't really tell which drops were which. On 12/4/24 at 8:56 AM an interview with the Staff Development Coordinator (SDC) indicated on 9/18/24 Resident #2 reported that Nurse #5 administered her ear drops into her eyes. She stated Nurse #5 had still been in her 90-day orientation period at that time, so she asked Nurse #5 to demonstrate to her which drops she administered in Resident #2's ear, and which drops she administered into Resident #2's eyes. The SDC reported she asked Nurse #5 to read the medication labels, and they discussed what optic (eye) versus otic (ear) meant with regards to routes of administration. She stated Nurse #5 indicated to her that she had administered the ear drops (ciprofloxacin-dexamethasone) into Resident #2's ear, and the eye drops	F 760	the right route. The SDC will address all concerns identified during the audit to include assessment of the resident, notification of the physician for further recommendations when indicated and/or retraining of staff. The Director of Nursing and/or Assistant Director of Nursing will review the Medication Pass Audits weekly x 4 weeks then monthly x 1 month to ensure all concerns are addressed. The Administrator/DON will forward the results of the Medication Pass Audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly x 2 months for review and to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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(carboxymethylcellulose sodium) into Resident #2's eyes. The SDC recalled Nurse #5 reported she had administered the medications to Resident #2, and denied having administered Resident #2's ear drops into her eyes. The SDC reported education had only been completed with Nurse #5 regarding this issue.

On 12/4/24 at 8:00 AM a telephone interview with Nurse #7 indicated she was assigned to care for Resident #2 on 9/18/24 on the 7:00 PM until 7:00 AM shift. She stated when she spoke with Resident #2 on that day, Resident #2 told her the nurse on the day shift that day put her ear drops into her eyes and she was very concerned about it. She went on to say she had gone to notify the DON, but the DON was already aware of this. Nurse #7 stated Resident #2 had not been complaining of any symptoms, and she had not observed any eye concerns.

On 12/2/24 at 11:57 AM in an interview Resident #2 stated on 9/18/24, the nurse assigned to care for her put the drops that were supposed to be for her ear into her eyes. She indicated she could not recall the name of this nurse, as it was this first time this nurse worked with her. She reported the nurse had not said anything to her, but she knew the nurse was about to put her eye drops in because of the motion the nurse made with the bottle. Resident #2 went on to say she had not paid much attention, because she trusted the nurse to do the right thing. She reported the drops that this nurse put into her eyes had been thicker than her eye drops usually were, and although she had not felt any pain at the time, her vision had been blurry since then. Resident #2 stated when the nurse set the bottle down on her table, she could see that it was the ear drops and

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not the eye drops bottle. She reported this nurse had been working with Nurse #6 that day, and she went out into the hallway to let Nurse #6 know what had happened. Resident #2 stated no one seemed to pay any attention when she reported this, and she felt everyone acted like it was nothing. Resident #2 indicated she had seen an eye doctor after the incident, and the doctor told her the blurry vision was not from the ear drops going into her eyes but was from age related changes. She stated she didn't believe this, because she had not had any blurry vision prior to the incident. Resident #2 went on to say she asked to see a second eye doctor and the second eye doctor had also told her having her ear drops administered into her eyes wouldn't cause any vision changes.

On 12/5/24 at 1:55 PM a telephone interview with Physician #1 indicated he had been notified that Resident #2's ear drops had potentially been administered into her eyes. He stated Resident #2's eyes were flushed with saline, and he had seen Resident #2 at the facility that same day. Physician #1 stated Resident #2 had not had any eye redness, or irritation. Physician #1 reported if a medication was ordered to be administered into a resident's ear, he would expect it to be administered into the resident's ear and not their eye.

A review of a physician's order for Resident #2 dated 9/18/24 revealed consultation for blurry vision at eye clinic.

A review of the eye clinic examination note for Resident #2 dated 12/23/24 written by Physician #2 revealed she was being seen due to having ear drops administered into her eyes. She did not

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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have any symptoms.

On 12/4/24 at 11:30 AM a telephone interview with Physician #2 indicated he examined Resident #2's eyes on 9/23/24. He stated Resident #2 was concerned after having ear drops administered into her eyes. He reported that the ciprofloxacin 0.3 percent-dexamethasone 0.1 percent designed to be administered into Resident #2's ear would not have caused any vision changes if it had been administered into Resident #2's eyes. He went on to say while it could cause mild transient irritation and burning, it would not cause any vision damage. Physician #2 stated it had been the right thing to flush Resident #2's eyes with saline as this would help prevent any irritation.

A review of a physician's order for Resident #2 dated 9/24/24 revealed to schedule a second opinion consultation at an eye clinic due to blurry vision.

A review of the eye clinic visit note for Resident #2 dated 10/2/24 written by Physician's Assistant (PA) #1 revealed Resident #2 was being seen for complaints of blurry vision. Resident #2 reported that a couple of weeks ago, a nurse administered her ear drops into her eyes. The impression from the examination was mild anterior basement membrane dystrophy (a genetic disorder of the cornea that causes recurrent erosions and blurred vision). PA #1 did not think ear drops caused Resident #2's current symptoms.

On 12/4/24 at 9:50 AM a telephone interview with PA #1 indicated she had seen Resident #2 in the eye clinic on 10/2/24 and examined her eyes. She stated Resident #2 was certain that having her

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	345113	A. BUILDING _____ B. WING _____	C 12/06/2024

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ear drops administered into her eyes was causing her to have blurry vision. PA #1 went on to say she had reassured Resident #2 that while this could cause mild temporary irritation, it would not cause her to have any vision changes or permanent damage to her eyes.

On 12/5/24 at 12:35 PM a telephone interview with the facility's consultant Pharmacist indicated she had been made aware that Resident #2 was reporting her ear drops were mistakenly administered into her eyes. She stated while ciprofloxacin 0.3 percent-dexamethasone 0.1 percent designed to be administered into Resident #2's ears could potentially cause a mild irritation if administered into her eyes, it would not cause any vision damage. The Pharmacist reported Resident #2 had been seen by an eye doctor, and no lasting ill effects had been confirmed.

On 12/4/24 at 8:42 AM an interview with the DON indicated on 9/18/24 she was notified that Resident #2 reported Nurse #5 put her ear drops into her eyes. She stated she immediately went to Resident #2's room, and Resident #2 was holding the ear drop medication package in her hand and was speaking with someone from the facility's consulting pharmacy. She reported after Resident #2 finished with her telephone call, she asked Resident #2 what happened, and how she knew it was the ear drops that went into her eyes. The DON stated Resident #2 told her she knew what her medications looked like, and which one was which. The DON reported Resident #2 had not been having any eye redness or irritation at the time, but she spoke with Resident #2's Physician (Physician #1) and was told to flush Resident #2's eyes with saline, which was done. She went on to

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say Resident #2's Physician #1 had seen her that same day. She reported Resident #2 had requested to see an eye doctor, so a consultation appointment was made. She went on to say Resident #2 had not been happy with the results of this eye consultation, so Resident #2 asked for a second opinion eye consultation which was also done.

On 12/5/24 at 1:20 PM an interview with the Administrator indicated Nurse #5 had denied putting Resident #2's ear drops into Resident #2's eyes during the facility's investigation of the incident. She stated Nurse #5 had been in her orientation period at the time of the incident and had denied this occurred. She reported the SDC had completed education with Nurse #5 regarding the proper routes of medication administration. The Administrator stated incorrect routes of ear drop administration had not been a trend at the facility.