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	345534	A. BUILDING _____ B. WING _____	C 02/08/2021

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E 000	Initial Comments An unannounced COVID-19 Focused Survey was conducted on 1/20/2021 through 1/22/2021. The survey was conducted onsite on 1/20/2021 and 1/22/2021 and remotely on 1/21/2021. The facility was found to be in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# VQCJ11	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey and complaint investigation were conducted on 1/20/2021 through 1/22/2021. The survey was conducted onsite on 1/20/2021 and 1/22/2021 and remotely on 1/21/2021. Validation of the credible allegation was completed on 2/8/21, therefore the exit date was changed to 2/8/21. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 7 of 13 allegations were substantiated resulting in deficiencies. Immediate jeopardy was identified at: CFR483.45 at tag F760 at a scope and severity J. F760 constituted Substandard Quality of Care. An extended survey was conducted on 2/8/21. Immediate jeopardy began on 1/8/21 and was removed on 1/23/21.	F 000		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		2/22/21

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

Electronically Signed | 02/18/2021

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F 689	Continued From page 1 §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure resident bed remote control cords were in good repair to prevent resident injury for 4 of 7 resident beds (beds for Resident #12, #15, and #16; and bed in Room 132 B) reviewed for accident hazards. The findings included: On 1/22/21 at 9:15 AM the bed in room 132 B was observed. The bed remote control was connected by a coiled cord and this cord was in disrepair. There were multiple areas of the cord where the exterior covering was missing and the internal wires were exposed. There was no resident in room 132B at the time of this observation. On 1/22/21 at 9:18 AM Resident #16 ' s bed was observed with the Maintenance Manager (MM). The bed remote control was connected by a coiled cord and this cord was in disrepair. There were multiple areas of the cord where the exterior covering was missing and the internal wires were exposed. Resident #16 was in bed at the time of this observation. The MM stated that he had not been informed of the condition of this cord and	F 689	The bed remote in 132B was replaced on 1/22/21. Maintenance Director replaced the bed remotes for resident #12 replaced 1/22, #15 part ordered and replaced 2/2, and #16 replaced 1/22. 100% audit of all bed remotes, for exposed coiled cords, wires, or missing exterior coverings was conducted by the Maintenance Director completed on 1/29/21 and any deficient cords were replaced. On 2/22/21 The Maintenance Director was in-serviced by the Administrator in regard to monitoring, removing, and reporting any bed remotes with exposed coiled cords, wires or missing exterior coverings, and the process of tag out/remove from service. By 2/22/21 Staff Development will complete an 100% in-service of monitoring, removing, and reporting any bed remotes that are found with exposed coiled cords, wires or missing exterior coverings and the process of tag out/remove from service. Staff will be educated to place a tag on defected equipment, notify Receptionist to	

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F 689	Continued From page 2 that he would have it replaced today. On 1/22/21 at 9:50 AM Resident #12 ' s bed was observed with Nursing Assistant (NA #1). The bed remote control was connected by a coiled cord and this cord was in disrepair. There were multiple areas of the cord where the exterior covering was missing and the internal wires were exposed. Resident #12 was in bed at the time of this observation. NA #1 stated that she had not noticed the condition of this cord prior to this observation. On 1/22/21 at 9:51 AM Resident #15 ' s bed was observed with NA #1. The bed remote control was connected by a coiled cord and this cord was in disrepair. There were multiple areas of the cord where the exterior covering was missing and the internal wires were exposed. Resident #15 was in bed at the time of this observation. During an interview with NA #1 on 1/22/21 at 9:52 AM she stated that the normal process for filing a maintenance request was to inform the front desk staff and they completed the request electronically. She reported that if she had noticed the condition of the bed remote control cords in Resident #12 and #15 ' s rooms she would have followed this process and put in a maintenance request. NA #1 explained that she had been very busy with her tasks and had not noticed the condition of the cords. She further explained that she was not always assigned to the same rooms so she wasn ' t seeing these cords every time she worked. An interview was conducted with NA #2 on 1/22/21 at 1:20 PM. NA #2 confirmed she was assigned to Resident #16. She revealed she had	F 689	place work order, and after-hours complete maintenance work order form and place in maintenance box. Emergency concerns will be reported immediately to chain of command. The Administrator and/or the Maintenance Director will complete a 10% bed remote audit weekly for 3 months to ensure they are free from exposed coiled cords. Wires or missing exterior coverings. Any damaged cords will be removed and replaced immediately. Results of the audits will be presented to the facility's Quality Assurance Committee Maintenance Director for review and recommendations monthly for 3 months and thereafter if necessary.	

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F 689	Continued From page 3	F 689		

not noticed the bed remote control cord had multiple areas where the exterior covering was missing and the internal wires were exposed. NA #2 explained that she had been very busy with her tasks and had not noticed the condition of the cords. She further explained that she was not always assigned to the same rooms so she wasn ' t seeing this cord every time she worked.

During an interview on 1/22/21 at 9:20 AM the MM spoke about the process of making a maintenance request. He stated that all maintenance requests were placed through an electronic application (app) and he received notification instantly on his phone and his email when a request was filed. He indicated that during normal business hours the nursing staff notified the front desk staff of any maintenance issues and the front desk staff input the information into the app. The MM reported that after normal business hours the staff were to leave him a hard copy note of any maintenance issues either at the drop box outside of his office or in his mailbox in the main office and he added the request into the app the next morning when he arrived at work. He stated that he kept a supply of bed remote controls with cords in stock and if he had received a request related to a cord in need of repair he would have replaced the entire bed remote control and cord the same day the request was filed. The maintenance log from 12/1/20 through present (1/22/21) was reviewed and revealed only 1 maintenance request related to a damaged bed remote control cord (room 408B). This was filed on 12/30/20 and the bed remote control with cord was replaced. The MM indicated that in terms of safety, the bed remote control cords were low voltage, but they still had

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F 689	Continued From page 4 the potential to cause injury. He added that this also presented the risk of skin tears if a resident had fragile skin and rubbed against the exposed internal wires. The MM stated that he had no routine monitoring system of bed remote control cords in place. He reported that beds and their remote controls were often moved with the residents to new rooms and there were many room changes over the past several months related to COVID-19 procedures. He explained that his routine monitoring rounds were normally conducted by halls with one hall completed per week. He further explained that in order to routinely monitor the bed remote control cords it would require all of them being observed on the same day, otherwise there was no guarantee every bed would be observed as some beds may be moved to a different room and/or unit by the next week ' s monitoring round. The MM stated that he tells the staff that they are his and ears and that it was pertinent to inform him of any maintenance issues so he could attend to them. An interview was conducted with the Director of Nursing (DON) on 1/22/21 at 1:55 PM. He stated that his expectation was for staff to complete maintenance requests anytime they saw an issue that needed repaired. He indicated that he expected bed remote control cords to be in good repair as they created the potential for injury that was avoidable if the cords had been repaired/replaced.	F 689		
F 760 SS=J	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.	F 760		2/22/21

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F 760	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review, Physician, Physician Assistant (PA), Nurse Practitioner (NP), Pharmacist and staff interviews, the facility failed to prevent significant medication errors by not administering a medication as ordered, not entering verbal order, not verifying medication orders and not transcribing physician's prescribed medications to the Medication Administration Record (MAR) which resulted in prescribed medications not administered as ordered for 3 of 3 sampled residents reviewed for medication administration (Residents #5, #11 & #12). Resident #5 was prescribed intravenous (IV) Cefazolin (an antibiotic drug) for bacteremia (presence of bacteria in the bloodstream) on 1/8/21. Cefazolin was not verified and transcribed to the MAR until 1/11/21 and he missed 5 doses. In addition, Resident #5 was prescribed Levofloxacin capsule (an antibiotic drug) for pneumonia on 1/8/21. The verbal order for the Levofloxacin was not entered in the computer until 1/10/21 and Resident #5 missed 5 doses. Resident #5 was sent to the emergency room (ER) on 1/11/21 due to shortness of breath and he tested positive for COVID-19. On 1/12/21, Resident #5 was transferred to another hospital for the need of intensive care unit (ICU) bed. Immediate jeopardy began on 1/8/21 when the facility failed to verify and to transcribe the order for the IV Cefazolin and failed to enter the verbal order for the Levofloxacin for Resident #5. Resident #5 was sent to ER due to shortness of breath on 1/11/21. Immediate jeopardy was removed on 1/23/21 when the facility provided and implemented an acceptable credible allegation for immediate jeopardy removal. The	F 760	Order for IV Cefazolin was verified on 1/11/21 for Resident #5. IV Cefazolin was administered at 8:00 am on 1/11/21. Resident #5 received Levaquin on 1/11/21. Physician notified on 1/11/21 and no new orders. On 1/22/21 Physician notified of missed medication for Resident #11 (Lorazepam) and Resident #12 (Amoxicillin) and no new orders. Chart audits were completed by Regional Nurse on 1/23/21 for all current residents that were admitted after January 1, 2021 to ensure accurate transcription of admission orders. On 1/23/21 Physician was notified of any errors and new orders. Licensed nursing staff were in-serviced by the Director of Nursing on accurate transcription of orders, verifying orders, at the beginning and end of each shift, and admission checklist. All Licensed Nursing Staff including Full Time, Part Time, PRN, and Agency will be in-service on accurate transcription of orders, verifying orders, at the beginning and end of each shift, and admission checklist by Director of Nursing/ Staff Development by 2/22/21. Staff will not be allowed to work until in-service is completed. All new licensed staff will be trained upon orientation. Admission Checklist and Verification Report will be reviewed daily times two weeks during the clinical meeting and will be monitored on the weekend remotely or in the facility by the Director of Nursing	

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F 760	Continued From page 6 facility remains out of compliance at a lower scope and severity of "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) due to examples #2 and #3 to ensure monitoring systems put into place are effective. Findings included: 1. Resident # 5 was admitted to the facility on 1/7/21 with multiple diagnoses including sepsis, end stage renal disease (ESRD), status post kidney transplant (1992) and Methicillin susceptible staphylococcus aureus (MSSA). a. Review of the hospital discharge summary dated 1/7/21 revealed under discharge plan to continue IV Cefazolin for staphylococcus aureus bacteremia until 1/13/21. The progress note written by the PA on 1/8/21 revealed under assessment and plan: MSSA bacteremia - to continue IV Cefazolin 1 gram (gm) every 12 hours with end date of 1/14/21. The electronic doctor's orders for Resident #5 were reviewed. On 1/8/21 at 12:39 PM, there was a prescription order for Cefazolin 1 gm IV every 12 hours (8 AM & 8 PM) with the end date of 1/14/21. The order was entered in the computer by the PA. Review of Resident #5's January 2021 MAR revealed that the Cefazolin was not administered on 1/8/21 (8 PM dose), on 1/9/21 (8 AM & 8 PM doses), and on 1/10/21 (8AM & 8 PM doses), a total of 5 missed doses. Review of the progress note dated 1/11/21 at	F 760	and/or Nurse Supervisors per rotating schedule by 1/22/21. Then will be reviewed 5 times a week for two weeks; then weekly times two week, then monthly times two months. Results of the Admission Checklist audit will be presented by Director of Nursing to the facility's Quality Assurance Committee monthly for 3 months and thereafter if necessary.	

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10:12 PM written by the Physician revealed that she was contacted by the facility staff and was informed that Resident #5's lungs sounded a little bit wet and the family was adamant about sending the resident to ER.

Review of Resident #5's nurse's note dated 1/12/21 at 7:03 PM revealed that on 1/11/21 at 9:15 PM, Nurse #2 had received a call from Resident #5's family wanting the resident sent to the hospital. The Nurse assessed the resident and had notified the Physician. The Physician had given an order to send the resident to the hospital for evaluation and treatment. Resident #5's blood pressure (B/P) was 110/60, respiration rate (RR) of 16, temperature of 98.6 degrees Fahrenheit (F) and oxygen saturation of 96% on 2 liters (L) per minute oxygen.

The hospital ER note dated 1/11/21 at 10:58 PM revealed that Resident #5 presented in ER with worsening shortness of breath (RR 30), hypotensive (B/P 87/54), and bradycardic (HR 59). He was stuporous and minimally responsive to painful stimuli with opening of his eyes. The assessment and plan included acute kidney injury due to COVID -19 and pneumonia due to COVID - 19 virus, renal transplant failure and rejection, septic shock, metabolic acidosis and hyperkalemia. The note further indicated that the decision was made to transfer the resident to another hospital due to need for intensive care unit (ICU) bed. On 1/12/21, the resident was transferred to another hospital.

On 1/20/21 at 11:05 AM, the Unit Manager (UM) was interviewed. She stated that the medication error for Resident #5 was identified and investigated by the facility and a plan of correction

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was put into place. The UM revealed that the order for the IV Cefazolin was entered in the computer by the PA on 1/8/21 and Nurse #1 who was assigned to Resident #5 failed to verify the order for the IV Cefazolin and therefore the medication was not transcribed to the MAR until 1/11/21. She added that on 1/11/21, she was informed by a nurse (didn't remember the name) that she needed to verify the order for the IV Cefazolin and that was when she identified the medication error. The UM indicated that Nurse #1 should have checked the computer during her shift for new orders and verify the orders if any.

On 1/20/21 at 12:45 PM, the PA was interviewed. She stated that she was new to the facility and she started end of November 2020. She revealed that she had seen Resident #5 on 1/8/21 and reviewed his hospital records. Resident #5 was admitted to the facility on 1/7/21 with multiple diagnoses including bacteremia, ESRD, status post kidney transplant. She entered an order in the computer on 1/8/21 for IV Cefazolin 1 gm every 12 hours for bacteremia. She was not aware until 1/11/21 that the IV antibiotic was not administered due to transcription error. On 1/11/21, Resident #5 was sent to the ER and the ER notes revealed that the resident was having worsening shortness of breath, and he tested positive for COVID in ER. The PA indicated that missing doses of the antibiotics could have contributed to the resident's decline in condition but also had to consider that he had multiple medical history/comorbidities being immunocompromised (s/p kidney transplant) and tested positive for COVID.

On 1/20/21 at 3:40 PM, Nurse #1 was interviewed. She verified that she worked day

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shift and was assigned to Resident #5 on 1/8/21. On 1/12/21, she was informed by the UM that the PA had entered an order in the computer for IV Cefazolin for Resident #5 on 1/8/21. She was told that the order was not verified in the computer and was not transcribed to the MAR. Nurse #1 stated that she was not in-serviced on this new system of verifying orders in the computer. She was not aware that a new order was written for Resident #5 on 1/8/21. Nurse #1 revealed that on 1/12/21, she was educated by the Corporate Nurse on how to verify orders. She must check the computer so often during her shift to see if any new orders. If there were new orders, she must verify those orders, and once the orders were verified, the medications would appear on the MAR.

On 1/20/21 at 3:59 PM, the Physician was interviewed. She stated that she had seen Resident #5 on 1/11/21 (not sure morning or evening). The resident had decreased breath sounds but had no complaints. At around 10 PM, she received a call from the facility that the resident was having trouble breathing and the family wanted to send him to the hospital. The Physician further stated that she was made aware on 1/11/21 that Resident #5 did not receive the IV antibiotic ordered on 1/8/21. She indicated that the use of the antibiotic could have helped with the infections especially with the pneumonia but could not tell if that was the cause of his decline or hospitalization given his medical history and he tested positive for COVID in ER.

On 1/21/21 at 9:05 AM, Nurse #3 was interviewed. She stated that she worked at the facility for less than a year on night shift. Nurse #3 indicated that she was not in-serviced on how to

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verify orders in the computer until this week (unable to remember exact date). She was in-serviced by the UM that she must check the computer several times a day during her shift to check for new orders and to verify if any. Once the order was verified, the medication would appear on the MAR.

On 1/21/21 at 9:18 AM, Nurse #8 was interviewed. She stated that she didn't receive any training on how to carry out orders in the computer nor how to verify orders in the computer.

On 1/21/21 at 9:28 AM, Nurse #2 was interviewed. She was assigned to Resident #5 on 1/11/21 on night shift when the resident was transferred to ER. Nurse #2 stated that the resident's oxygen saturation was around 95% on room air and he was a little bit short of breath, so she started him on 2 L/min oxygen. At around 9 PM, Resident #5's family member had called wanting the resident transferred to the ER. She called the doctor and the doctor ordered to send him out. Nurse #2 further indicated that the resident's vital signs were within normal limits before the discharge. Nurse #2 also revealed that she was not in-serviced on how to verify orders in the computer until 1/21/21 when the Director of Nursing (DON) had called and educated her on how to verify new orders.

On 1/21/21 at 3:50 PM, the Pharmacist was interviewed. He stated that there were no records in their system dated 1/8/21 for IV Cefazolin for Resident #5. On 1/11/21, there was a prescription order for Cefazolin 1 gm IV twice a day but that was discontinued on 1/11/21. The Pharmacist indicated that he was not familiar with

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the facility's system in transcribing orders.

On 1/22/21 at 1:41 PM, the DON was interviewed. He stated that he was made aware of the medication error on Resident #5. An order for IV Cefazolin was entered by the PA in the computer on 1/8/21 and Nurse #1 failed to verify the order. The system was Physician/PA enters the order in the computer, the nurse must verify the order. After the order was verified, the medication would appear on the MAR and the pharmacy dispense the medication to the facility. The order for the Cefazolin was later verified by the UM on 1/11/21 and the medication was administered to the resident. The DON further indicated that he expected the nurses to check the computer several times a day during their shift to check for new orders and to verify the orders timely. The DON confirmed Resident #5's Cefazolin was not administered on 1/8/21 (8 PM dose), on 1/9/21 (8AM & 8 PM doses), and on 1/10/21 (8AM & 8 PM doses), for a total of 5 missed doses.

b. A nurse's note (written by Nurse #1) dated 1/8/21 at 8:26 AM (recorded as late entry on 1/10/21 at 8:32 AM) was reviewed. The note revealed that the PA was informed of the resident's fall and his lung fields sounded a little diminished bilaterally. The PA had ordered for chest x-ray and the report came back pneumonia. The DON and responsible party (RP) were made aware of the fall and the need for antibiotic.

Interview with Nurse #1 on 1/20/21 at 3:40 PM was conducted. Nurse #1 verified that she was assigned to Resident #5 on 1/8/21 on day shift. The resident had a fall that day (1/8/21) and his

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lungs sounds were diminished. She called and informed the PA of the fall and the diminished lung sounds and the PA ordered chest x-ray. The x-ray result came back with pneumonia and the PA had given a verbal order to start Levofloxacin 500 milligrams (mgs) by mouth for 7 days for the pneumonia. Nurse #1 revealed that she was overwhelmed that day and she forgot to enter the order for the Levofloxacin in the computer. She remembered and entered the order for Levofloxacin on 1/10/21 and the medication was started on 1/11/21.

The chest x-ray result dated 1/8/21 "bilateral lower lobe infiltrates and effusions".

The January 2021 MAR revealed that Resident #5 had received Levofloxacin 500 mgs tablet on 1/11/21 at 8 AM dose. Resident #5 did not receive the Levofloxacin on 1/8/21 (8 PM dose), 1/9/21 (8AM & 8 PM doses) and 1/10/21 (8AM & 8 PM doses), a total of 5 missed doses.

On 1/20/21 at 2:58 PM, the Unit Manager (UM) was interviewed. She stated that the medication error for Resident #5 was identified and investigated by the facility and a plan of correction was put into place. The UM revealed that the PA had given Nurse #1 a verbal order on 1/8/21 for Levofloxacin 500 milligrams (mgs) by mouth twice a day (8 AM & 8 PM) for 7 day for pneumonia. Nurse #1 who was assigned to Resident #5 on 1/8/21 failed to enter the order for Levofloxacin in the computer until 1/10/21 and the medication was not started until 1/11/21.

On 1/20/21 at 3:55 PM, the PA was interviewed. She stated that Nurse #1 had called on 1/8/21 and informed her that Resident #5 had a fall and

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with diminished lungs sounds. Chest x-ray was ordered, and the result came back positive for pneumonia. A verbal order was given to Nurse #1 on 1/8/21 to start Levofloxacin 500 mgs by mouth twice a day for 7 days for pneumonia. On 1/11/21, she was notified that the order for Levofloxacin was not transcribed and was not administered until 1/11/21. The PA indicated that missing doses of the antibiotics could have contributed to the resident's decline in condition but also had to consider that he had multiple medical history/comorbidities being immunocompromised (s/p kidney transplant) and tested positive for COVID.

On 1/21/21 at 3:50 PM, the Pharmacist was interviewed. He stated that there were no records in their system dated 1/8/21 for Levofloxacin for Resident #5. The Pharmacist indicated that he was not familiar with the facility's system in transcribing orders.

On 1/22/21 at 1:41 PM, the DON was interviewed. He stated that he was made aware of the medication error on Resident #5. A verbal order for Levofloxacin was given to Nurse #1 on 1/8/21. The Nurse forgot to enter the order in the computer timely and the medication was not transcribed and administered timely. Nurse #1 entered the order on 1/10/21 and the medication was administered on 1/11/21. The DON indicated that he expected the nurses to enter orders in the computer and to administer ordered medications timely and as ordered. The DON confirmed that Resident #5 did not receive the Levofloxacin on 1/8/21 (8 PM dose), 1/9/21 (8AM & 8 PM doses) and 1/10/21 (8AM & 8 PM doses), a total of 5 missed doses.

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The Administrator and the Director of Clinical Resources were notified of the immediate jeopardy on 2/3/21 at 8:27 AM.

The facility provided an acceptable credible allegation for immediate jeopardy removal on 2/4/21 that read:

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

Resident # 5 was admitted to the facility on 1/7/21 with Methicillin Susceptible Staphylococcus aureus bacteremia. Upon admission, orders were transcribed, not to include the IV Cefazolin due to the discharge summary did not give a dose or frequency. On 1/8/21, the Physician Assistant (PA) entered an order for IV Cefazolin 1 gram every 12 hours with an end date of 1/14/21. The medication order was not verified by the Nurse #1 in the computer system until 1/11/21, resulting in the medication not being delivered, added to the Medication Administration Record or the administration of the medication. The IV Cefazolin was administered to Resident #5 on 1/11/21 at 8:00am. Due to failure to verify the order, Resident #5 missed 5 doses of the IV Medication.

On 1/8/21, chest x-ray results reporting pneumonia was called to the PA. The PA gave a verbal order to Nurse #1 Levofloxacin 500 mg by mouth for 7 days for the pneumonia. The order was not entered until 1/10/21 to start 1/11/21 at 0800. The failure of the Nurse #1 to transcribe the PA order resulted in Resident #5 not receiving the administration of the medication. Resident #5 did receive the oral Levaquin 1/11/21 at 8:00AM.

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Due to failure to transcribe the order, Resident #5 missed 5 doses of the oral medication.

Resident #5 was sent out the ER per the family request on 1/11/21 at approximately 2115. The assessment of Resident #5 vital signs was blood pressure 110/60, respiration rate 16, temperature of 98.6, and oxygen saturation 96% on 2 liters of oxygen. Resident #5 was a little short of breath, hence the oxygen. Resident #5 was seen by the PA earlier in the day on 1/11/21, with decreased breath sounds, but had no other complaints. Resident tested positive for COVID-19 in the Emergency Room (ER). The ER assessment and plan included acute kidney injury due to COVID -19 and pneumonia due to COVID - 19 virus, renal transplant failure and rejection, septic shock, metabolic acidosis and hyperkalemia. On 1/12/21, the resident was transferred to another hospital for the need of ICU bed

Immediately upon acknowledgement of the unverified orders for Resident # 5 on 1/11/21, a report was pulled from the Matrix Care system, to assess for any open and unverified orders by the Unit Manager (UM) on 1/11/21. At the time of the report, there were no orders left unverified. The acknowledgement of the failure to transcribe a PA order, all nurses notes were reviewed by the Director of Nursing (DON) on 1/11/21 for the previous week (7 days) to assess for a change in condition, notification to the PA, or potential order needs. Progress notes reviewed, did not show any other resident to be affected by the failure to transcribe a verbal PA or physician order.

2. Specify the action the entity will take to alter the process or system failure to prevent a serious

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adverse outcome from occurring or recurring, and when the action will be complete.

An In-service was provided to the Nurse #1 who did not verify the PA order and did not transcribe the PA order given on 1/8/21 by the Regional Clinical Manager on 1/12/21. This in service included verification and transcription of orders and entering orders given verbally by a Physician, Physician Assistant or Nurse Practitioner.

An in Service was initiated by the Director of Nursing (DON) on 1/12/21 via an electronic system to all Nurses for the process of verifying orders in Matrix and transcribing verbal orders. Nurses who received the electronic in service responded with a thumbs up, or response to the notification system. Agency nurses were educated prior to the start of the following working shifts. The DON was responsible for verifying the education had been completed on all licensed nurses. On this in service, two licensed nurses did not receive the required education, resulting in additional education on the new plan 1-19-21.

On 1/19/21, the Director of Clinical Resources provided additional In- Servicing to the Director of Nursing, on the use of the Admission Documentation Checklist, of which was updated from a previous version to add orders, to check admission orders were accurately transcribed, verified and clarified, verifying orders in the Matrix system, reading progress notes daily to evaluate for changes in condition related to medication or order changes. Verification report follow up reeducated to the DON during this in service.

Additional in-servicing was initiated by the Director of Nursing to the Nurse Supervisors and

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Staff Development Coordinator (SDC) on 1/19/21 to encompass all areas of verification of orders, Admission Documentation Checklist, Verification Report, transcription of orders to include verbal orders, reading progress notes to evaluate for changes of condition related to medication or order changes. During this in service they were also educated that the Admission Checklist and Verification Report would be reviewed daily during the clinical meeting and would be monitored on the weekend remotely or in the facility, by the DON, SDC , and/or the Nurse Supervisors per rotating schedule.

The Director of Nurses, Nurse Supervisors and Staff Development Coordinator, on 1/20/21 in-serviced all nurses on the proper protocol (comparing orders from admission paperwork to what has been entered into the Matrix system) for checking orders, to include the verification of orders (To be checked at the beginning and end of shift) and entering orders to include verbal orders (upon receipt) into Matrix. In addition to the in-service education, the DON spoke to each licensed staff member individually by phone and/or in person to go over the expectations of transcribing and verifying all orders to include verbal orders. Agency staff attended the in-service meeting and individual meetings with the DON. Any agency staff that work will be in serviced prior to the start of his/her shift by the DON, Nurse Supervisor or SDC. All nurses including agency staff received training by 1/23/21, any nurse that had not received the training, was not allowed to work until the training was completed (due to work schedules, prn staff or agency staff that had not worked. The DON will keep a training tracker of the nurses to ensure that no nurse has been missed in the in servicing.

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Any staff hired after 1/23/21, received and will receive this training during orientation.

IJ Removal Date: 1/23/2021

On 2/8/21 at 10:30 AM, the facility's credible allegation for immediate jeopardy removal was validated by the following:
- review of the one on one education with Nurse #1 on verifying, processing of orders timely and verification of orders
- review of the in-service records on medication verification/transcription, admission documentation checklist and entering of orders and the signed in sheets for the licensed nurses and administrative staff
-review of their daily monitoring and the "admission documentation checklist" to verify orders were entered, verified and transcribed
- interview with the nursing staff to verify they had received the in-service on verifying, transcribing and entering of orders.
- review of the records of 3 new admit/readmit residents to verify the admission orders were entered, verified and transcribed.

The facility's date of immediate jeopardy removal of 1/23/21 was validated.

2. Resident # 12 was admitted to the facility on 1/8/21 with multiple diagnoses including urinary tract infection (UTI). The admission Minimum Data Set (MDS) assessment dated 1/12/21 indicated that Resident #12 had impaired cognition and had received 2 days of antibiotic medication during the last 7 days.

The hospital discharge summary dated 1/8/21

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listed the discharge medications which included Amoxicillin (an antibiotic drug) 875-125 milligrams (mgs) by mouth every 12 hours for urinary tract infection (UTI).

The admission orders at the facility dated 1/8/21 for Resident #12 included Amoxicillin 875-125 mgs po twice a day (8AM & 8 PM) for UTI.

The January 2021 Medication Administration Record (MAR) revealed that Resident #12 did not receive Amoxicillin on 1/8/21 (8 PM dose), 1/9/21 (8 AM & 8 PM doses), 1/10/21 (8 AM & 8 PM doses) and 1/11/21 (8 AM dose), a total of 6 missed doses.

On 1/20/21 at 2:58 PM, the Unit Manager (UM) was interviewed. She verified that she received the order for the Amoxicillin for Resident #12 on 1/8/21 from the Physician. She verified the order in the computer on the same day 1/8/21 and didn't know why the medication did not appear on the MAR to be administered until 1/11/21.

On 1/21/21 at 9:28 AM, Nurse #2 was interviewed. She stated that she was assigned to Resident #12 on 1/10/21. She indicated that she didn't see an order for the Amoxicillin on the MAR on 1/10/21.

On 1/21/21 at 3:50 PM, the Pharmacist was interviewed. He stated that the pharmacy had received the order for Resident #12's Amoxicillin and the medication was dispensed on 1/8/21 at 6:15 PM.

On 1/22/21 at 1:35 PM, Nurse #4 was interviewed. She was assigned to Resident #12 on 1/9/21 and 1/11/21. She stated that she didn't

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see an order for Amoxicillin on the MAR on 1/9/21 and 1/11/21 during the morning medication pass.

On 1/22/21 at 1:41 PM, the DON was interviewed. He stated that it looked like the order for the Amoxicillin was entered in the computer on 1/8/21 but was not verified until 1/11/21 and so it was not showing on the MAR from 1/8/21 through 1/10/21. The DON stated that he expected the nurses to verify orders timely. The DON confirmed Resident #12 did not receive Amoxicillin as ordered on 1/8/21 (8 PM dose), 1/9/21 (8 AM & 8 PM doses), 1/10/21 (8 AM & 8 PM doses) and 1/11/21 (8 AM dose), for a total of 6 missed doses.

On 2/2/21 at 12:50 PM, the PA was interviewed. The PA stated that she was notified by the staff that the prescribed Amoxicillin for Resident #12 on 1/8/21 was not administered until 1/11/21. She added that she could not remember if there was a negative outcome to the resident for missing 6 doses of Amoxicillin, and she added that it was not good for the resident to miss doses of prescribed antibiotic.

On 2/2/21 at 1:05 PM, the Physician was interviewed. She stated that she was informed by the PA that Resident #12's prescribed antibiotic was not administered on 1/8/21 as ordered. The Physician revealed that the resident had missed 6 doses however there were no negative effects on the resident. She added that it was not good for the resident to miss doses of the prescribed antibiotic.

3. Resident # 11 was admitted to the facility on 1/3/20 with multiple diagnoses including mood

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disorder. The quarterly Minimum Data Set (MDS) assessment dated 1/13/21 indicated that Resident #11 had moderate cognitive impairment and had not received an antianxiety medication during the last 7 days.

Review of the electronic records revealed that Resident #11 was receiving psychiatric (psych) services.

On 12/29/20 at 4:41 PM, the psych Nurse Practitioner (NP) had entered an order in the computer for Lorazepam (an antianxiety drug) 0.5 milligrams (mgs) by mouth every 6 hours (12 MN, 6 AM, 12 Noon and 6 PM) for mood disorder with the end date of 1/11/21.

Review of the December 2020 and January 2021 Medication Administration Records (MARs) revealed that Resident #11 did not receive Lorazepam on 12/29/20 (6 PM dose), 12/30/20 (12 MN, 6 AM, 12 Noon and 6 PM doses), 12/31/20 (12 MN, 12 Noon and 6 PM doses), and on 1/1/21 (12 MN, 6 AM, 12 Noon doses), a total of 11 missed doses.

On 1/22/21 at 11:11 AM, interview with the Medication Aide (MA) #1 assigned to Resident #11 on 1/1/21 revealed that she didn't administer the Lorazepam on 1/1/21 since it was not available. The MA indicated that she should have informed the nurse, but she did not.

On 1/22/21 at 1:25 PM, Nurse #5 who was assigned to Resident # 11 on 12/29/20 was interviewed. Nurse #5 stated that she was not aware that there was an order entered on 12/29/20 for Resident #11. The order for the Lorazepam was entered by the psych NP on

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12/29/20 and was not verified until 12/30/20. Nurse #5 indicated that she didn't administer the Lorazepam on 12/30/20 since the medication was not available.

Attempts made to interview the nurses assigned to Resident #11 on 12/31/20 but were unsuccessful.

On 1/22/21 at 1:35 PM, Nurse #4 who was assigned to Resident #11 on 1/2/21 and 1/3/21 was interviewed. She stated that the Lorazepam for Resident #11 was not available on 1/2/21. She went to get the medication from the pyxis (a medication dispensing cabinet) and administered it to the resident. On 1/3/21, the Lorazepam was still not available, and she thought that the pharmacy might need a hard script before dispensing the medication since it is a controlled drug. Nurse #4 called the psych NP for the hard script and the NP gave an order to discontinue the Lorazepam since the resident was already stable and was not anxious anymore.

On 1/22/21 at 1:41 PM, the Director of Nursing (DON) was interviewed. The DON stated that the order for the Lorazepam on 12/29/20 for Resident #11 was not verified until 12/30/20. The pharmacy did not dispense the medication since it was a controlled drug and it needs a hard script from the doctor. The DON stated that Lorazepam was available in the pyxis and he expected the nurses to use the pyxis if the medication was not available. He added that when a medication was taken from the pyxis that would alert him to check as to why the pharmacy did not send the medication. The DON confirmed Resident #11 did not receive Lorazepam on 12/29/20 (6 PM dose), 12/30/20 (12 MN, 6 AM, 12 Noon and 6 PM

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F 760	Continued From page 23 doses), 12/31/20 (12 MN, 12 Noon and 6 PM doses), and on 1/1/21 (12 MN, 6 AM, 12 Noon doses), a total of 11 missed doses.	F 760		
F 761 SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on review of facility's policy on medication storage and discard dates, observation and staff interview, the facility failed to discard expired medications and to label medications with open date on 3 of 3 medication carts observed (	F 761	Director of Nursing/ Nursing Supervisors on 1/22/21 completed 100% medication cart audit and all opened/undated medications found were discarded and reordered from the pharmacy.	2/22/21

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F 761	Continued From page 24 medication cart #1 (rooms 101-106 &122), medication cart #2 (rooms 121-134 & 310-315) and medication cart #3 (rooms 201-212 & 301-309)) and on 1 of 2 medication rooms observed (100 hall medication room). Findings included: The facility's policy on medication storage and discard dates (undated) was reviewed. The policy indicated to date and to initial the insulin vials/pens when opened. The policy also indicated to discard insulin (used to treat diabetes mellitus) vials including Humulin, Humalog, Lantus, Novolin, Novolog and Levemir 28 days after opening. The policy also indicated to discard insulin pens including Lantus pens 28 days after opening, Humalog mix (75/25) kwikpen 14 days after opening and Levemir flex pen 42 days after opening. Under inhaled medication, the policy indicated to discard Advair (used to treat asthma and chronic obstructive pulmonary disease (COPD) 30 days after opening, and Symbicort (used to treat asthma and COPD) 3 months after the foil pouch is opened. The Purified Protein Derivatives (PPD) (used to diagnoses tuberculosis) is to be discarded 30 days after opening. The manufacturer's specification for Spiriva Respimat and Stiolto Respimat (used to treat asthma and COPD) revealed to discard 3 months after insertion of the cartridge into the inhaler and for Fluticasone Furoate inhaler (steroid inhaler which help control the symptoms of asthma and COPD) to be discarded 6 weeks after opening the moisture protective foil tray or when the counter reads "0" whichever comes first. The Prostat (a protein supplement) bottle read "to discard 3	F 761	All Medication Aides, Licensed Nursing Staff including Full Time, Part Time, PRN, and Agency will be in-service on proper storage and dating of open medication by Director of Nursing/ Staff Development by 2/22/21. Staff will not be allowed to work until in-service is completed. All new med aides and licensed staff will be trained upon orientation. The Director of Nursing and/or Nurse Supervisors will audit all medication carts for proper storage and dating opened medications daily times one week, then twice a week times three weeks, then monthly for two months. Results of the medication cart audits will be presented to the facility's Quality Assurance Committee by Director of Nursing for review and recommendation monthly for 3 months and thereafter if necessary.	

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F 761	Continued From page 25	F 761		

months after opening".

1. On 1/22/21 at 9:05 AM, medication cart #1 was observed with Nurse #6. The following were observed:

Humulin N vial - opened and undated
Lantus vial (3 vials) - opened and undated
Lantus pen - opened and undated
Novolog vial - opened and undated
Novolin R vial - opened and undated
Humalog mix 75/25 kwikpen - opened and undated
Advair discus - opened and undated
Spiriva Respimat - opened and undated
Symbicort inhaler - opened and undated
Prostat liquid - opened and undated.

On 1/22/21 at 9:30 AM, Nurse #6 observed and verified the identified medications/derivative to be opened and undated. The Nurse stated that a pharmacy staff was responsible for checking the medication carts for expired and undated medications. Nurse #6 further indicated that the pharmacy staff comes once a month. He also revealed that multi dose medications including insulin, Advair, Spiriva, Symbicort and Prostat should be dated when opened. He added that he always referred to the facility's policy and or manufacturer's specification for the medications expiration/discard dates.

2. On 1/22/21 at 9:45 AM, medication cart #2 was observed with Medication Aide (MA) # 2. The following were observed:

Levemir vial - opened and dated 11/17/20 -

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expired
Novolog vial - opened and undated
Lantus vial - opened and undated
Admelog or Humalog vial - opened and undated
Prostat liquid - opened and undated

On 1/22/21 at 10:05 AM, MA #2 was interviewed. She stated that she didn't know who was responsible for checking the medication carts for expired and undated medications. She added that she was new and just started as MA this January 2021.

On 1/22/21 at 10:07 AM, the Director of Nursing (DON) observed and verified the identified insulin and Prostat to be opened, undated and expired.

3. On 1/22/21 at 11:17 AM, medication cart #3 was observed with Nurse # 7. The following were observed:

Stiolto Respimat inhaler (used to treat COPD) - opened and undated
Advair 500/50 micrograms (mcg) diskus - opened and undated
Fluticasone Furoate inhaler (the counter reads "5")- opened and undated

On 1/22/21 at 11:19 AM, Nurse # 7 was interviewed. She observed the identified inhalers and verified that they were opened and undated. Nurse #7 stated that all nurses were responsible for checking the medication carts for expired and undated medications. She also stated that the nurse who opened the inhaler should have dated it.

4. On 1/22/21 at 9:55 AM, the medication room

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on 100 hall was observed with Nurse #6. In the refrigerator, there was an opened Purified Protein Derivative (PPD) vial that was opened and with open date of 6/20/20.

On 1/22/21 at 9:57 PM, Nurse #6 observed and verified the opened PPD bottle as expired. He indicated that PPD was good for 30 days after opening.

On 1/21/21 at 4:30 PM, a phone interview was conducted with Nurse #2. She indicated that she worked nights shift as an agency nurse. She stated that she didn't know who was responsible for checking the medication carts and the medication rooms for expired and undated medications. She added that multi dose medication should be dated when opened.

On 1/21/21 at 4:35 PM, a phone interview was conducted with Nurse #3. Nurse #3 indicated that she worked at the facility on night shift. She stated that she didn't know who was responsible for checking the medication carts and the medication rooms for expired and undated medications. Nurse #3 further indicated that multi dose medications including insulin and inhalers should have been dated when opened.

On 1/22/21 at 1:41 PM, the Director of Nursing (DON) was interviewed. The DON indicated that night shift nurses were responsible for checking the medication carts and medication rooms every night for expired and undated medications. He also indicated that a pharmacy staff also comes once a month to check the medication carts. The DON revealed that his expectation was for all nurses to follow the facility's policy on medication storage and discard dates including the labeling

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F 761	Continued From page 28 of the medication with date and initial when first opened.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, and staff interviews, the facility failed to label, date, and discard expired foods in the nourishment room refrigerators and also failed to ensure refrigerator drawers were free from food spills for 2 of 2 nourishment rooms observed. The findings included: 1. An observation of the nourishment room at the nurses ' station located at the intersection of the 100 hall and 300 hall was completed on 1/22/21	F 812	The bowl of grapes and oranges, circular black plastic storage container with plastic lid (containing rice and meat), and the 2 black plastic containers with clear lid (containing white thick substance) where discarded on 1/22/21 by the Dietary Manager. On 1-22-21, 2 of 2 nourishment rooms in the facility were deep cleaned by the Housekeeping Manager. Refrigerators were cleaned by the Housekeeping	2/22/21

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F 812	Continued From page 29 at 9:50 AM. A sign located on the exterior of the nourishment room refrigerator indicated that no personal items were to be kept in the refrigerator and that resident items needed to be labeled with the date and the resident ' s room number. The refrigerator contained, in part, the following items: a. A bowl of grapes and oranges place inside of a black garbage bag. The exterior of the garbage bag had a yellow label with a resident ' s name (Resident #17). There was no date on the label. b. A circular black plastic storage container with a clear plastic lid, approximately 8 inches in diameter, containing rice and meat was placed inside of a plastic grocery bag. There was no label or date. c. 2 black plastic storage containers with clear plastic lids, approximately 2.5 inches in diameter, filled with an off white thick substance had no label or date. An interview was conducted with the Dietary Manager (DM) on 1/22/21 at 10:40 AM. She stated that all foods in the nourishment room refrigerators should be labeled and dated per the facility ' s food storage policy. She indicated that dietary staff replenished the nourishment room refrigerators twice daily and that during this time they were to discard any items that were expired and/or not properly labeled. The DM revealed that the garbage bag with a bowl of grapes and oranges, the circular round storage container with rice and meat, and the 2 storage containers with pudding (off white thick creamy thick substance) should have been discarded as they were not properly labeled.	F 812	manager on 1-22-21. The Dietary Manager and Housekeeping Manager were in-serviced by the Administrator in regarding proper food storage and cleanliness of the nourishment rooms on 1-22-21. The Dietary Manager and Housekeeping Director in-serviced their respective staff regarding the same on 1-22-21. No staff were allowed to work beyond 1-22-21 without having been in-serviced. All Staff including Full Time, Part Time, PRN, and Agency will be in-service on proper food storage and cleaning of spills by Staff Development by 2/22/21. Staff will not be allowed to work until in-service is completed. All new staff will be trained upon orientation. All staff placing items in the nourishment refrigerator are responsible for ensuring proper labeling, and dating have occurred, and for ensuring any spills are properly cleaned. The Dietary manager and dietary staff will monitor the dating and labeling of items located in the nourishment refrigerators daily. Any spills will be cleaned out and items not dated and labeled will be removed daily. The housekeeping staff will deep clean the refrigerator in the nourishment rooms weekly. Cleanliness, dating and labeling audits for both nourishment rooms will be conducted by the Administrator, Dietary Manager, dietary aides, housekeeping staff and/ or	

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F 812	Continued From page 30 During an interview with the Administrator on 1/22/21 at 10:52 AM she indicated she expected all foods located in the nourishment room refrigerators to be labeled, dated, and discarded in accordance with the facility ' s food storage policy. 2. An observation of the nourishment room at the nurses ' station located at the intersection of the 100 hall "short" (101 - 106) and 100 hall "long" (107 - 120) was completed on 1/22/21 at 9:50 AM with Nursing Assistant (NA) #1. A sign located on the exterior of the nourishment room refrigerator indicated that no personal items were to be kept in the refrigerator and that resident items needed to be labeled with the date and the resident ' s room number. The refrigerator contained, in part, the following items: a. The left pull out drawer contained 5 sandwiches each in an individual sandwich bag labeled 1/7/21 with a different resident name on each bag. The sandwiches were hard to the touch. b. The bottom of the left pull out drawer contained a sticky substance that was purplish-pink in color. A sandwich stored in a plastic sandwich bag was stuck to the substance. NA #1 was interview on 1/22/21 at 9:50 AM. NA #1 indicated that the 5 sandwiches in the sandwich bags dated 1/7/21 should have been thrown away by dietary staff. She explained that these sandwiches were resident snacks and if the resident refused the snack that it was placed back in the refrigerator by nursing staff and the dietary staff were to check the refrigerator for	F 812	Housekeeping Director daily times two weeks, then weekly times two weeks, then monthly for two months. Results of cleanliness, dating and labeling audits will be presented to the facility's Quality Assurance Committee by the Dietary Manager for review and recommendations monthly for 3 months and thereafter if necessary.	

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F 812	Continued From page 31	F 812		

unused foods when they replenished it daily. NA #1 further revealed that this process had not always occurred and that there were times she went through the refrigerator herself and discarded items that were unused/stale/expired. She was asked who was responsible for cleaning the refrigerators on the nursing units and she indicated she believed it was housekeeping staff.

An interview was conducted with the Dietary Manager (DM) on 1/22/21 at 10:40 AM. She stated that all foods in the nourishment room refrigerators should be labeled and dated per the facility ' s food storage policy. She indicated that dietary staff replenished the nourishment room refrigerators twice daily and that during this time they were to discard any items that were expired and/or not properly labeled. The observation of 5 sandwiches in sandwich bags dated 1/7/21 was reviewed with the DM. The DM stated any food item prepared in the facility kitchen was to be discarded after 7 days. She revealed these 5 sandwiches should have been discarded over a week ago. The observation of the sticky substance in the left drawer of the refrigerator was reviewed with the DM. She reported that the housekeeping staff were responsible for cleaning the nourishment room refrigerators.

An interview was conducted with the Housekeeping Manager on 1/22/21 at 10:50 AM. She reported that Housekeeping staff cleaned the inside of the nourishment room refrigerators once per week. She indicated that this was normally done on Wednesdays. She reported that this cleaning including pulling out the drawers inside of the refrigerator and removing any items necessary to clean the entirety of the drawers. She stated that she also checked these

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F 812	Continued From page 32 refrigerators once per week to ensure housekeeping staff were completing their tasks. The Housekeeping Manager stated that she checked the nourishment room refrigerator located at the intersection of 100 hall "short" (101 - 106) and 100 hall "long" (107 - 120) on 1/20/21 and she had not noticed a sticky substance in the bottom of the left pull out drawer. During an interview with the Administrator on 1/22/21 at 10:52 AM she indicated she expected all foods located in the nourishment room refrigerators to be labeled, dated, and discarded in accordance with the facility ' s food storage policy. She further indicated that she expected the refrigerators to be thoroughly cleaned once per week and spot cleaned when spills were identified.	F 812		
F 842 SS=C	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented;	F 842		2/22/21

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(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services

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F 842	Continued From page 34 provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain accurate medical records for the documentation of administered insulin for 3 of 3 sampled residents reviewed for medication administration (Residents # 11, #13 & #14). Findings included: 1. Resident # 14 was admitted to the facility on 3/19/13 with multiple diagnoses including Type 2 diabetes mellitus (DM). a. Resident #14 had a doctor's order dated 3/21/19 for Humalog insulin sliding scale for Type 2 DM before meals (6:00 AM, 11:30 AM, and 4:30 PM) and at bedtime (9:00 PM). Review of Resident #14's December 2020 Medication Administration Records (MARs) revealed that Medication Aide (MA) #1 had signed off the MARs indicating that she had administered the Humalog on 12/1/20 at 9:00 PM, 12/13/20 at 11:30 AM and at 4:30 PM, 12/26/20 at 11:30 AM and 4:30 PM, 12/27/20 at 11:30 AM, 12/30/20 at 11:30 AM and 12/31/20 at 9:00 PM. Further review of the Resident #14's December 2020 MARs revealed that MA #2 had signed off the MARs indicating that she had administered	F 842	By 1/25/21 the Director of Nursing completed written counseling for Medication Aide #1, #2, #3 regarding the legality and consequences of signing the Medication Administration Record for medications they did not administer. On 1/22/21 Resident #11, #13, #14 Physician notified of errors and no new orders. Chart audits were completed by Regional Nurse on 2/17/21 for all current residents that received accu-checks, insulin, medication by enternal tube to ensure that no other Medication Aide had signed for medications that HE/SHE had not administered. On 2/17/21 Physician was notified of any errors and no new orders. All Medication Aides, Licensed Nursing Staff including Full Time, Part Time, PRN, and Agency will be in-service on Medication Aides not performing accu-checks, administration of insulin, and administering medication via enternal tube by Director of Nursing/ Staff Development by 2/22/21. Staff will not be allowed to work until in-service is completed. All new med aides and licensed staff will be trained upon orientation.	

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SANFORD HEALTH & REHABILITATION CO	2702 FARRELL ROAD SANFORD, NC 27330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 35 the Humalog insulin on 12/7/20 at 9:00 PM, 12/10/20 at 4:30 PM and 12/29/20 at 9:00 PM. b. Resident #14 had a doctor's order dated 3/21/19 for Humalog 8 units subcutaneous (SQ) before meals (7:30 AM, 11:30 AM and 4:30 PM) for Type 2 DM. Review of Resident #14's December 2020 and January 2021 MARs revealed that MA #1 had signed off the MARs indicating the she had administered the Humalog on 12/2/20 at 7:30 AM, 12/13/20 at 7:30 AM and 11:30 AM, 12/26/20 at 7:30 AM, 11:30 AM and 4:30 PM, 12/27/20 at 7:30 AM, 11:30 AM and 4:30 PM, 12/30/20 at 7:30 AM, 11:30 AM and 4:30 PM and on 1/9/21 at 11:30 AM and 4:30 PM. c. Resident #14 had a doctor's order dated 4/20/20 for Lantus 35 units SQ daily (9:00 AM). Review of Resident #14's December 2020 and January 2021 MARs revealed that MA #1 had signed off the MARs indicating the she had administered the Lantus on 12/2/20, 12/13/20, 12/26/20, 12/27/20, 12/30/20 and 1/9/21. 2. Resident # 13 was admitted to the facility on 11/6/16 with multiple diagnoses including Type 2 Diabetes Mellitus (DM). a. Resident #13 had a doctor's order dated 7/28/20 for Lantus subcutaneous (SQ) at bedtime (9:00 PM). Review of Resident #13's December 2020 and January 2021 MARs revealed that MA #3 had signed off the MARs indicating the she had	F 842	The Director of Nursing and/or Nurse Supervisor will audit Medication Administration Record of residents receiving injections and /or medications via enternal tube for appropriate initials five times a week for two weeks, then weekly times two weeks, then monthly for two months. Results of Medication Administration Record Audits will be presented to the facility's Quality Assurance Committee by Director of Nursing for review and recommendations monthly for 3 months and thereafter if necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345534	A. BUILDING _____ B. WING _____	C 02/08/2021

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administered the Lantus on 12/14/20, 12/15/20, 1/12/21, 1/13/21, 1/14/21 and 1/17/21.

b. Resident #13 had a doctor's order dated 8/10/20 for Novolog SQ sliding scale before meals (6:00 AM, 11:30 AM and 4:30 PM) for Type 2 DM.

Review of Resident #13's December 2020 and the January 2021 MARs revealed that MA #1 had signed off the MARs indicating the she had administered the Novolog on 12/3/20 at 11:30 AM, and 4:30 PM, 12/9/20 at 6:00 AM, 12/21/20 at 11:30 AM, 12/22/20 at 4:30 PM and 12/28/20 at 4:30 PM.

3. Resident # 11 was admitted to the facility on 12/7/20 with multiple diagnoses including Type 2 Diabetes Mellitus (DM).

Resident #11 had a doctor's order dated 12/7/20 for Humulin N 10 units subcutaneous (SQ) once a day (7:30 AM) and 8 units SQ at bedtime (9:00 PM) for Type 2 DM.

Review of Resident #11's January 2021 MARs revealed that MA #1 had signed off the MARs indicating the she had administered the Humulin on 1/7/21 at 9:00 PM and on 1/8/21 at 7:30 AM. MA #3 had signed off the MARs on 1/14/21 at 9:00 PM and on 1/17/21 at 9:00 PM.

On 1/21/21 at 2:53 PM, a phone interview was conducted with MA #3. She stated that she was not supposed to administer injections including insulin and medications via tubes. She indicated that nurses were responsible for administering insulin to residents. When asked about her

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initials on the MARs for the insulin, she responded that she was just signing it off for the nurses. MA #3 indicated that she didn't know that she was not supposed to sign off on the medication that she did not administer.

On 1/22/21 at 11:11 AM, a phone interview with MA#1 was conducted. MA #1 stated that she could administer all medications by mouth. She indicated that she could not give injections including insulin and medications through the gastrostomy (G) tube. She revealed that nurses were responsible for administering insulin and all the medications of residents on G-tube. When questioned about her initials on the MARs for the insulin, she acknowledged that she had signed off for the insulin on the MARs, but the nurses administered the insulin. MA #1 stated that she was not aware that she was not allowed to sign off on the medication that she did not administer.

On 1/22/21 at 1:41 PM, the Director of Nursing (DON) was interviewed. The DON indicated that the initials of the nurses and MAs on the MARs indicated that they administered the medication. He stated that whoever administer the medication should be the one to sign off or put their initial on the box. The DON revealed that he was just informed that MAs were signing off for the nurses for the insulin administration and this was not acceptable.