STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345429	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	**801 PINEHURST AVENUE CARTHAGE, NC 28327**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 04/05/21 through 04/08/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #Q4L811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/05/21 through 04/08/21. Event ID# Q4L811. 7 of the 17 complaint allegations were substantiated resulting in deficiencies. Immediate Jeopardy was identified at: CFR 483.25 at tag F689 at a scope and severity (J) CFR 483.15 at tag F624 at a scope and severity (J) Immediate Jeopardy tag F689 began on 3/9/21 and was removed on 4/8/21. Immediate Jeopardy tag F624 began on 3/11/21 and was removed on 4/8/21. The tag F689 constituted Substandard Quality of Care. An extended survey was conducted on 4/8/21.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.	F 554		4/26/21

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

Electronically Signed | 04/23/2021

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F 554	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation, staff interviews and resident and Medical Director interview, the facility failed to assess and obtain a physician's order for the self-administration of an inhaler found in Resident #71's possession and failed to assess for the self-administration of an ointment for Resident #71. This was for 1 of 1 residents reviewed for self-administration of medications. The findings included: 1a) Resident #71 was originally admitted to the facility on 10/12/18. Her cumulative diagnoses included chronic obstructive pulmonary disease (COPD). The quarterly Minimum Data Set (MDS) assessment dated 2/15/21, indicated Resident #71 was cognitively intact. She required setup assistance for eating, limited assistance for transfers, dressing and toileting, extensive assistance for bed mobility, and personal hygiene and was dependent on staff for bathing. She displayed no shortness of breath and received oxygen therapy. A review of Resident #71's care plan last reviewed/revised on 3/8/21 did not address the self-administration of medications. Resident #71's current physician orders included a medication order for Ventolin (albuterol sulfate) 90 micrograms (mcg) 2 puffs inhaled every 6 hours as needed for wheezing, that was initiated on 11/12/20. The current physician orders did not include an order for the resident to self-administer	F 554	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F554 Affected Residents Resident #71 had a Peak Self Administration of Medication Observation completed on 4-9-21 by the Director of Nursing (DON). This assessment determined that Resident #71 was able to self-administer her medications. A physician□s order to self-administer Albuterol inhaler was written on 4-8-21 by Medical Director (MD). A care plan was added for resident to self-administer medications as ordered by the physician. The resident was not adversely affected by the alleged deficient practice. Residents with the potential to be affected The Director of Nursing (DON) and Registered Nurse Supervisor (RN Supervisor) performed a 100% audit of all residents in the facility on 4-9-21. This audit observed the following: "Did the resident have medications at bedside, and/or request to self-administer any of their medications? If yes, "Do they have a Peak Self Administration of Medication Observation completed? If	

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F 554	Continued From page 2 the inhaler. A review of Resident #71's electronic medical record (EMR) revealed no assessments had been completed for the self-administration of the inhaler. On 4/5/21 at 10:30 AM, an observation was made of Resident #71 lying in her bed. An inhaler medication was observed on the over the bed table and within reach of the resident. Resident #71 was asked if the inhaler could be inspected, permission was provided, and the inhaler was identified as Albuterol Sulfate (Ventolin). Upon inquiry, the resident stated she kept the inhaler within reach and used it when she felt short of breath or was wheezing. Additional observations were made of the Albuterol Sulfate inhaler on Resident #71's over the bed table on 4/7/21 at 8:15 AM. On 4/7/21 at 9:30 AM, the Director of Nursing (DON) stated she was unable to locate a self-administration assessment for the Albuterol Sulfate inhaler in Resident #71's medical record. An interview was completed with Nurse #5 on 4/7/21 at 2:15 PM, who stated the facility did not have a self-administration assessment that was completed when a resident wished to self-administer a medication. She further stated an order should be obtained. The DON was interviewed on 4/8/21 at 8:49 AM and explained the facility did not have a self-administration assessment, however the staff were to assess orientation status and knowledge of their medications when a resident chose to	F 554	yes and are able to self-administer medications, "Do they have a physician order for medication self-administration? During this audit no other residents were found to be affected by the alleged deficient practice. Systemic changes All licensed nursing staff were educated by the DON and Staff Development Coordinator (SDC) on 4-21-21 regarding the following: "If a resident requests to self-administer any of their medication, a Peak Self Administration of Medication Observation will be completed. "If the resident is deemed safe to self-administer their medication, a physicians□ order will be obtained to self-administer the requested medication. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to their work assignment by the SDC, DON and/or RN Supervisor. Any newly hired licensed nursing staff will be educated by the Staff Development Coordinator during orientation. Monitoring: An audit was created to monitor the following: "Observe if any medications are left at the bedside for self-administration. "If identified, does the resident have a Peak Self Administration of Medication Observation completed?	

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F 554	Continued From page 3 self-administer medications. In addition, an order should be present. The DON added, Resident #71 was alert and oriented, knew her medications and was fully able to self-administer the inhaler. She acknowledged there was no self-administration assessment or order to self-administer the inhaler. On 4/8/21 at 9:40 AM, the DON stated 2 inhalers were found at the bedside of Resident #71 and an order had been provided by the physician to self-administer the inhaler. There was no mention of an assessment being completed. An interview was conducted with the Medical Director on 4/8/21 at 10:48 AM, where the observations of the Albuterol Sulfate inhaler at Resident #71's bedside and reported self-administration of the medication were discussed. The physician stated he was unaware of the medication being kept at bedside, prior to him being contacted by the facility earlier that morning for an order to self-administer the inhaler. The Medical Director further stated he would expect the facility to have a self-administration assessment that was completed initially, with routine reassessments to ensure it was clinically appropriate for residents to self-administer medications, as well as a physician's order. 1b) Resident #71 was originally admitted to the facility on 10/12/18. Her cumulative diagnoses included herpesvirus infection. The quarterly Minimum Data Set (MDS) assessment dated 2/15/21, indicated Resident #71 was cognitively intact. She required setup	F 554	"If deemed safe to self-administer medication, is there a physicians□ order to allow the resident to self-administer medications? The DON, RN supervisor and weekend RN supervisor will audit 25% of all residents weekly x 4 weeks, then monthly x 2 months starting on 4-12-21. The results of these audits will determine the need for further monitoring. The audits will be brought to the QAPI meeting monthly by the DON for review and further recommendations.	

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F 554	Continued From page 4	F 554		

assistance for eating, limited assistance for transfers, dressing and toileting, extensive assistance for bed mobility, and personal hygiene and was dependent on staff for bathing.

A review of Resident #71's care plan last reviewed/revised on 3/8/21 did not address the self-administration of medications.

Resident #71's current physician orders included a medication order for Zovirax (acyclovir) ointment topical application 5 times a day as needed, which was initiated on 11/12/20 and included Resident #71 may self-apply.

A review of Resident #71's electronic medical record (EMR) revealed no assessments had been completed for the self-administration of the ointment.

On 4/5/21 at 10:30 AM, an observation was made of Resident #71 lying in her bed. A tube of Acyclovir ointment was observed on the bedside table within ready of the resident. Upon inquiry, the resident stated she kept the ointment within reach and used it when she felt discomfort from the lesions on her body.

Additional observations were made of the Acyclovir ointment on Resident #71's bedside table on 4/7/21 at 8:15 AM.

On 4/7/21 at 9:30 AM, the Director of Nursing (DON) stated she was unable to locate a self-administration assessment for the Acyclovir ointment in Resident #71's medical record.

Nurse #3 was interviewed on 4/7/21 at 2:05 PM and stated she was aware Resident #71 had

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F 554	Continued From page 5	F 554		

Acyclovir ointment at her bedside and self-applied. The nurse was unaware of the facility having a self-administration assessment when a resident wanted to self-administer medications.

An interview was completed with Nurse #5 on 4/7/21 at 2:15 PM, who stated the facility did not have a self-administration assessment that was completed when a resident wished to self-administer a medication.

The DON was interviewed on 4/8/21 at 8:49 AM and explained the facility did not have a self-administration assessment, however the staff were to assess orientation status and knowledge of the medications when a resident chose to self-administer medications. The DON added, Resident #71 was alert and oriented, knew her medications and was fully able to self-administer the ointment. She acknowledged there was no self-administration assessment for the Acyclovir ointment.

An interview was conducted with the Medical Director on 4/8/21 at 10:48 AM, where the observations of the Acyclovir ointment at Resident #71's bedside and reported self-administration of the medication were discussed. The physician stated he was aware Resident #71 self-applied the ointment and had provided an order for her to do so. The Medical Director further stated he would expect the facility to have a self-administration assessment that was completed initially, with routine reassessments for residents who wished to self-administer medications to ensure it was clinically appropriate.

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F 584	Continued From page 6	F 584		
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. §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	F 584		4/12/21

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F 584	Continued From page 7 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident and staff interviews, the facility failed to ensure a resident's wheelchair was clean and sanitary for 1 of 3 residents reviewed for environmental concerns (Resident #11). The findings included: An observation was made on 4/5/21 at 10:15 AM of Resident #11 seated in her wheelchair in her room. On the seat of the wheelchair was a thick white substance and multiple areas of a dried yellow and white substance to the metal frame of the wheelchair. Resident #11 stated she couldn't remember when her wheelchair was last cleaned. On 4/7/21 at 8:41 AM Resident #11's wheelchair was observed while she was sitting on the side of her bed. The wheelchair was noted with a thick white substance to wheelchair seat and multiple areas of dried yellow and white substances to the wheelchair frame. The housekeeping director was interviewed on 4/7/21 at 4:30 PM. She explained there was a wheelchair cleaning schedule where each week on Sunday a certain hall's wheelchairs were washed. Each wheelchair in the facility was washed at least once a month according to the schedule. The housekeeping director further stated if a wheelchair became soiled before the scheduled cleaning day the nursing staff were to place the wheelchair on the maintenance hall.	F 584	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F584 Affected Resident Resident #11's wheelchair was cleaned by the Housekeeping Supervisor on 4-9-21. This wheelchair has been put on a 3x week cleaning schedule. The resident did not suffer any adverse effects from the alleged deficient practice. Residents with the potential to be affected The Housekeeping Supervisor completed a 100% audit of all resident wheelchairs on 4-9-21. There was one wheelchair that was identified with similar stains. This wheelchair was cleaned on 4-9-21 by the Housekeeping Supervisor and placed on a 3x a week wheelchair cleaning schedule. The Housekeeping Supervisor changed disinfectant cleaner to cut down on the white residue on the wheelchairs on 4-9-21. Systemic Changes	

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F 584	Continued From page 8 This would alert her the wheelchair was heavily soiled and required an additional cleaning. An interview was completed with Nurse Aide (NA) #3 on 4/8/21 at 8:38 AM. She explained if she noticed a wheelchair was soiled, she would wipe it out. She was unaware of a wheelchair cleaning schedule but was aware if a wheelchair was heavily soiled it should be placed on the maintenance hallway. She was unaware of what occurred after that. An observation was made on 4/8/21 at 9:39 AM of Resident #11's wheelchair while she was sitting in the resident lounge. A thick white substance remained to the wheelchair seat and multiple areas of dried yellow and white substances to the wheelchair frame. Accompanied by the housekeeping supervisor, an observation was made on 4/8/21 at 9:50 AM of Resident #11's wheelchair. She observed the wheelchair and verified it was in need of washing. She added the wheelchair had been washed 3 weeks ago and was scheduled to be washed this Sunday but would get it cleaned before then. The housekeeping director further stated she would have expected the staff to place the wheelchair on the maintenance hall when it was observed to be dirty so it could have been cleaned. She added new staff were present and not all were familiar with the washing schedule or protocol to follow when a wheelchair was soiled, and education was required. On 4/8/21 at 2:40 PM, the Director of Nursing was interviewed and stated it was her expectation for wheelchairs to be clean and sanitary.	F 584	The Staff Development Coordinator (SDC) educated 100% of all facility staff to ensure that any wheelchairs that are observed to not be clean should be taken out of service and housekeeping services to be notified so the wheelchair can be cleaned and sanitized. This was completed on 4-21-21. Any staff member out on leave or PRN status will be educated prior to returning to their work assignment by the SDC. Any newly hired staff will be educated by the SDC during orientation. The Housekeeping Supervisor updated the wheelchair cleaning schedule to include a cleaning schedule of 3x a week for heavily soiled wheelchairs and monthly for all other wheelchairs. This was completed on 4/21/21. All housekeeping staff were educated on the new wheelchair schedule on 4-21-21 by the Housekeeping Supervisor. Any housekeeping staff out on leave or PRN status will be educated by the Housekeeping Supervisor prior to returning to their assigned duties. Any newly hired housekeeping staff will be educated by the Housekeeping Supervisor during orientation. Monitoring The Housekeeping Supervisor will be auditing 25% of resident wheelchairs weekly for four weeks, then monthly for two months, audit started on 4-12-21. This audit will ensure that wheelchairs are	

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F 584	Continued From page 9	F 584	clean and sanitized. During the weekly audits if wheelchairs need to be cleaned more often, they will be placed on the 3x/week cleaning schedule. The results of these audits will determine the need for further monitoring. All results will be brought to Quality Assurance Performance Improvement (QAPI) monthly by the Housekeeping supervisor for review and further recommendations.	
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including	F 622		4/20/21

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Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.
(i) Documentation in the resident's medical record must include:
(A) The basis for the transfer per paragraph (c)(1)(i) of this section.
(B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).
(ii) The documentation required by paragraph (c)(2)(i) of this section must be made by-

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F 622	Continued From page 11 (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, Medical Director, and staff, the facility failed to allow a resident who exited the facility unsupervised to remain in the facility. This was for 1 of 1 resident (Resident #129) reviewed for facility initiated discharge. The findings included: Resident #129 was admitted to the facility on 3/2/21 with diagnoses that included metabolic encephalopathy, dementia, depression, and insomnia. A nursing note dated 3/9/21 at 8:38 PM indicated that at approximately 7:40 PM she was informed	F 622	By filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F622 Affected Resident Peak Resources Pinelake offered to readmit Resident #129 back to our facility. The guardian of Resident #129 chose to place Resident #129 in a nearby facility that has a long-term care locked unit.	

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F 622	Continued From page 12 that a resident headcount needed to be completed related to a call to the facility from a 911 dispatcher that a male was reportedly seen in a wheelchair down the street from the facility. A headcount was performed, and Resident #129 was not in the facility. The 911 dispatcher was informed that the male seen down the street from the facility was a facility resident. At approximately 7:50 PM a police officer (Police Corporal #1) called the facility and stated that he was picking up Resident #129 to bring him back to the facility. At 8:02 PM the police officer arrived at the facility with Resident #129 who was in his wheelchair. He had no signs or symptoms of acute distress or pain. He was assisted to his room by staff and was placed on one to one (1:1) monitoring for the remainder of the shift. A note dated 3/9/21 at 10:48 PM completed by the Administrator indicated he spoke with Resident #129 ' s Responsible Party (RP) to notify of his unsupervised exit. A note dated 3/11/21 at 8:50 AM completed by Social Worker (SW) #1 indicated Resident #129 was to discharge home that afternoon with his RP. A physician ' s discharge summary note dated 3/11/21 indicated Resident #129 was seen for discharge home to family. The physician wrote that Resident #129 recently had an unsupervised exit from the facility in which the police found him in the street on a road near the facility. A nursing note dated 3/11/21 at 3:38 PM completed by Nurse #1 indicated Resident #129 was discharged home.	F 622	Residents with potential to be affected The Social Worker reviewed all residents discharged during the last 30 days to ensure that resident was not discharged without proper reason and/or notification. This was completed on 4-7-21. No other resident was adversely affected by the alleged deficient practice. Systemic Changes The Staff Development Coordinator (SDC) educated the Administrator, Social Worker and Business Office Manager on Nursing Home Notice of Transfer / Discharge on 4-20-21. This education included the following: Discharges from the facility can only occur if: •It is necessary for the welfare of the resident and the residents' needs cannot be met in this facility. •The residents' health has improved sufficiently so that the resident no longer needs the services provided by this facility. •The safety of individuals in this facility is endangered due to the clinical or behavioral status of the resident. •The health of individuals in this facility would otherwise be endangered. •The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at this facility. •The facility ceases to operate.	

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F 622	Continued From page 13 A phone interview was conducted on 4/6/21 at 9:18 AM with Resident #129 ' s RP. Resident #129 ' s RP revealed that on the night of 3/9/21 she was awakened from her sleep by a phone call from the facility Administrator stating that Resident #129 had gotten out of the facility unsupervised that evening but was now back at the facility. She reported that the Administrator informed her that the facility couldn ' t keep him (Resident #129) because they couldn ' t have residents exiting the facility unsupervised. The RP stated that the Administrator said someone would call her tomorrow to discuss a plan. She indicated that the next day (3/10/21), one of the facility SWs (unable to recall which one) called her and told her they needed to do discharge planning and asked her when she could pick Resident #129 up. She indicated that she thought this meant she had to pick him up as soon as possible so she informed them she could pick him after work the next day. Resident #129 ' s RP indicated that on 3/11/21 after work she went to the facility and picked up Resident #129. During a phone interview with SW #1 on 4/6/21 at 9:50 AM she reported on 3/10/21 during the morning meeting, Resident #129 ' s unsupervised exit from the facility that occurred the previous night (3/9/21) was discussed and it was decided that he needed a discharge plan as this facility was not able to provide the level of care he needed as evidenced by him getting out of the facility without staff ' s knowledge. She said 1:1 was provided for a shift and then q 15 minute observations were conducted after the unsupervised exit, but that this was not an intervention that could continue indefinitely. SW #1 stated that after the morning meeting she called Resident #129 ' s RP and SW #2 was	F 622	Monitoring The Administrator will audit all discharges from the facility to ensure that the discharge is appropriate and appropriate notification has been given to the resident and/or resident representative. This will be done weekly for 4 weeks, then monthly for 2 months and audits will start on 4-12-21. The results of the audits will determine the need for further monitoring. All results will be brought to monthly QAPI meeting by the Administrator for review and recommendations.	

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F 622	Continued From page 14	F 622		

listening in by speaker phone. She informed Resident #129 ' s RP the facility couldn ' t provide the care Resident #129 needed and they needed to have a discharge plan. She reported that Resident #129 ' s RP seemed agreeable and stated that she could pick him up the following day (3/11/21) after she got out of work.

During a phone interview with SW #2 on 4/6/21 at 1:00 PM she reported on 3/10/21 during the morning meeting, Resident #129 ' s unsupervised exit from the facility that occurred the previous night (3/9/21) was discussed and the Administrator informed SW #1 and herself that that he spoke with Resident #129 ' s RP last night (3/9/21) after the incident and he told her that the facility was going to have to find somewhere else for him to stay or he would have to be discharged home. She was asked why the facility was no longer able to care for Resident #129 and she stated that she was unable to answer this question as this was management ' s decision. SW #2 reported that after the morning meeting (3/10/21) the Administrator told her and SW #1 to contact Resident #129 ' s RP and discuss discharge plans. She indicated SW #1 contacted Resident #129 ' s RP by phone and she listened in on speaker phone. SW #2 reported that SW #1 informed Resident #129 ' s RP that they needed to discuss discharge planning. She indicated SW #1 asked the RP if she was able to come get Resident #129 and if so when would she be able to do this. She reported that Resident #129 ' s RP said she would pick him up the following day (3/11/21) after she got out of work.

During an interview with the Administrator on 4/7/21 at 11:10 AM he verified that he phoned Resident #129 ' s RP after his unsupervised exit

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F 622	Continued From page 15 from the facility on the night of 3/9/21. He informed the RP the facility could not keep him and that she had 2 options: 1) take him home with her; 2) transfer to another facility with a secured unit without a guarantee that there would be an opening in this county. The Administrator was asked why the facility discharged the resident and he stated that he was afraid Resident #129 would get out of the facility again and he had not had the ability to provide him 1:1 care indefinitely. He explained that the only way to ensure Resident #129 had not exited the building unsupervised again was to have someone with him at all times. He acknowledged that the facility initiated discharge of Resident #129 had not met the regulatory requirements. An interview was conducted with the facility ' s Medical Director on 4/8/21 at 10:45 AM. He stated that Resident #129 was cognitively impaired and he required 24 hour care. The Medical Director was asked why the facility initiated discharge for Resident #129 after his unsupervised exit from the facility (3/9/21) when 24 hour caregivers were present in the facility. He stated that he had not known the unsupervised exit was the reason for Resident #129 ' s discharge on 3/11/21. He explained he thought it may have had to do with his insurance. The Medical Director acknowledged that this was not an appropriate reason to discharge a resident.	F 622		
F 624 SS=J	Preparation for Safe/Orderly Transfer/Dschrg CFR(s): 483.15(c)(7) §483.15(c)(7) Orientation for transfer or discharge.	F 624		4/9/21

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F 624	Continued From page 16 A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with family, Adult Protective Services (APS) Social Worker, Medical Director, and staff, the facility failed to verify a resident ' s discharge location and also failed to assess the home environment to ensure it was safe and provided the level of care required to meet the resident ' s needs resulting in a cognitively impaired resident being discharged to his home where he resided without supervision. Resident #129 was discharged on 3/11/21 and on 3/12/21 a home visit was conducted by APS who assessed the resident to not have the capacity to live alone and he was subsequently sent to the hospital where he remained as of 4/8/21. This was for 1 of 2 discharged residents (Resident #129) reviewed. Immediate Jeopardy began on 3/11/21 when Resident #129 was discharged to his home where he resided without supervision. The Immediate Jeopardy was removed on 4/8/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy) to ensure monitoring of systems put into place related to the discharge planning process are effective and to complete staff training.	F 624	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F624 Affected Resident Peak Resources Pinelake offered to readmit Resident #129 back to our facility but the guardian of Resident #129 chose to place Resident #129 in a nearby facility that has a long term care locked unit. Residents with potential to be affected The Social worker performed an audit on 4-7-21 on all residents that were discharged home for the past 30 days to ensure that no other residents were affected by the alleged noncompliance. No other residents suffered any adverse effect from the alleged noncompliance. Systemic Changes The Social Worker and all licensed nursing staff will be educated by 4-8-21 by	

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F 624	Continued From page 17 The findings included: The hospital discharge summary dated 3/2/21 indicated Resident #129 was admitted to the hospital on 2/11/21 after being found by his family member unresponsive at his home. His initial diagnoses were acute kidney injury and altered mental status. Throughout his hospital stay he experienced episodes of confabulation (the replacement of a gap in a person's memory by a falsification that he or she believed to be true), disorientation, and agitation. He was assessed by neurology and deemed to have a neurocognitive disorder. Resident #129 was being discharged to the facility as his Responsible Party (RP) was no longer able to care for him at home due to encephalopathy. Resident #129 was admitted to the facility on 3/2/21 with diagnoses that included metabolic encephalopathy, dementia, depression, and insomnia. A nursing note completed by the Clinical Care Coordinator (CCC) dated 3/2/21 indicated Resident #129 was admitted to the facility. He was alert and oriented to self only. An admission assessment dated 3/2/21 completed by the CCC indicated Resident #129 ' s current health problems included, in part, memory loss and balance problems. He utilized a walker and wheelchair. Resident #129 ' s mental status was assessed as alert and oriented to self only. He was noted with anxiety and restlessness. A physician history and physical dated 3/4/21 indicated that Resident #129 was admitted to the	F 624	the Staff Development Coordinator (SDC) on what constitutes an unsafe discharge and what steps must be taken to ensure that an unsafe discharge does not occur. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to the assigned duties by the SDC. Any newly hired Social Worker and/or licensed nursing staff will be educated by the SDC during orientation. All discharges will be discussed in our clinical meeting Monday through Friday to ensure that all residents are discharged safely. This clinical meeting will be made up of the Social Worker, SDC, Director of Nursing (DON), Therapy Manager, Minimum Data Set nurses #1 and #2 (MDS), Administrator and RN Supervisor. On Saturday and Sunday, the Weekend RN Supervisor will review the clinical aspects to ensure that the resident is being discharged safely. The Social worker was educated by the SDC on 4-8-21 to ensure that residents caretakers at the home will be there for the appropriate time frame for the care that is needed and to ensure that all aspects of the discharge are followed up on. For example, the correct address, caregivers are sure they can take care of the resident, equipment has been delivered, follow up doctor’s appointments have been made, Home health has been ordered, if needed and to ensure that resident will have the appropriate care when they return home. The Social worker will have a discharge meeting with the resident and/or resident representative 48 hours before discharge	

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F 624	Continued From page 18 facility from the hospital as his RP believed the resident was no longer able to take care of himself at his home and that he required long term placement. A 5-day Minimum Data Set (MDS) assessment dated 3/5/21 indicated Resident #129 ' s cognition was moderately impaired. The care plan for Resident #129 included a problem area of Resident #129/Resident #129 ' s RP requested resident to remain in the facility for long term care. This area was initiated on 3/5/21. The goal area (initiated 3/5/21 with a target date of 6/5/21) indicated Resident #129 was to remain in the facility for long term care. The interventions, also implemented on 3/5/21 included, in part, involve resident and family in care planning. Nursing notes dated 3/6/21 and 3/7/21 completed by Nurse #1 indicated Resident #129 was alert and oriented to self only. He was noted with wandering by self-propelling his wheelchair throughout the 7:00 AM to 7:00 PM shift. Nurse #1 indicated that safety precautions and redirection were needed related to his confusion. A nursing note dated 3/9/21 at 8:38 PM completed by Nurse #2 indicated that at approximately 7:40 PM she was informed that a resident headcount needed to be completed related to a call to the facility from a 911 dispatcher that a male was reportedly seen in a wheelchair down the street from the facility. A headcount was performed, and Resident #129 was not in the facility. The 911 dispatcher was informed that the male seen down the street from the facility was a facility resident. At	F 624	to arrange a safe discharge home and to ensure the home environment is safe. Once the resident is discharged, the Social Worker will call the resident and/or resident representative within 72 hours to ensure that all items needed are there, that the home environment is still safe and that resident is safe at the discharge location. Monitoring An audit will be conducted by the administrator to ensure that the Social Worker has conducted the 72 hour phone call to determine safe discharge. This audit will included all planned discharges from the facility. This audit will start on 4-9-21 and be weekly for 4 weeks and monthly for 2 months. The Administrator will bring all results of audits to the QAPI meeting monthly for review and further recommendations.	

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approximately 7:50 PM a police officer (Police Corporal #1) called the facility and stated that he was picking up Resident #129 to bring him back to the facility. At 8:02 PM the police officer arrived at the facility with Resident #129 who was in his wheelchair. He had no signs or symptoms of acute distress or pain. He was assisted to his room by staff and was placed on one to one (1:1) monitoring for the remainder of the shift.

A police report completed by Police Corporal (PC) #1 indicated on 3/9/21 at 7:41 PM he responded to a call received by 911 regarding a phone call about a sighting of an elderly male in a wheelchair headed away from the facility. PC #1 wrote that he went to the location Resident #129 was spotted and spoke with him. Resident #129 "advised that he was leaving a Christmas party and was headed home". The facility was phoned, and they completed a headcount and discovered Resident #129 was missing. PC #1 wrote that he took Resident #129 back to the facility. He indicated he spoke with the facility Administrator who stated that Resident #129 ' s family would be contacted and the facility would try to get him discharged home with family. PC #1 indicated he reported the incident to Adult Protective Services (APS).

A progress note dated 3/9/21 at 10:48 PM completed by the Administrator indicated he spoke with Resident #129 ' s RP to notify of his unsupervised exit.

A note dated 3/11/21 at 8:50 AM completed by Social Worker (SW) #1 indicated Resident #129 was to discharge home that afternoon with his RP. She wrote that he was to be evaluated by Physical Therapy/Occupational Therapy/and

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Speech Therapy to receive home health nursing for wound care, medication management, and education, and SW for community resources.

A physician ' s discharge summary note dated 3/11/21 indicated Resident #129 was seen for discharge home to family. Resident #129 was noted to be ambulatory in wheelchair throughout his stay at the facility. He recently had an unsupervised exit from the facility in which the police found him in the street on a road near the facility.

A nursing note dated 3/11/21 at 3:38 PM completed by Nurse #1 indicated Resident #129 was discharged home. He was picked up by his RP and medications were sent home with the resident.

A note dated 3/11/21 at 3:43 PM completed by SW #1 indicated APS were notified for suspicion of lack of care and supervision for Resident #129 following statements from his RP made when picking him up for discharge. APS informed the facility they had an active case for Resident #129, and they would send a SW out for a home visit.

An Emergency Department (ED) note dated 3/12/21 indicated Resident #129 was recently admitted to the hospital (2/11/21) and discharged to a facility (3/2/21). APS SW reported that he was seen at his home on 3/12/21 and was assessed to not have the capacity to live independently. The APS SW reported that there was an issue with Resident #129 being discharged from the facility inappropriately.

A hospital note dated 3/13/21 indicated during Resident #129 ' s 2/11/21 - 3/2/21 stay at the

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hospital he was seen by neurology and deemed to have a neurocognitive disorder. Neurology assessed him with poor insight and cognitive dysfunction and noted concern about his ability to return home alone safely and recommended 24 hour supervision. Resident #129 ' s RP reported that he was "able to get out" of the facility on 3/9/21 and then he was discharged home on 3/11/21. The RP reported that she picked him up from the facility, took him home, settled him in, and left. She further reported that on the morning of 3/12/21 she spoke with APS SW who was checking on Resident #129 and she informed her that Resident #129 was sent home from the facility independently. The APS SW had Resident #129 picked up by Emergency Medical Services (EMS) brought to the ED and she instructed that he was to stay in the hospital until long term placement was able to be arranged. This hospital note additionally indicated that Resident #129 ' s RP was not able to care for the resident as she worked, her spouse had medical issues, and she also cared for another family member with medical issues. It was noted that due to that combination, the RP was unable to take on someone else in her home. When Resident #129 was asked what had been going on and why he was at the hospital he reported a confabulated accounting that included, in part, "They brought me here to the hospital, then to an airport onto a helicopter down to the beach. Luckily I have had some experience dealing with the Italian medical society. They knew who I was so it made it go smoothly. If they needed something I gave it to them".

An Adult Protective Services Notice to Administrator letter received by the facility on 3/23/21 completed by Department of Social

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Services (DSS) APS SW indicated a protective services report had been received and evaluation for Resident #129. On the date of 3/9/21 DSS received concerns about maltreatment of Resident #129 and a thorough evaluation was conducted which yielded the following findings:
- Evidence of neglect was found.
- The need for protective services was substantiated.

A note dated 3/25/21 completed by SW #1 indicated a follow up call was made to Resident #129 ' s RP to follow up on the resident but the RP was unable to be reached.

A hospital note dated 4/6/21 indicated Resident #129 remained in the hospital (admitted 3/12/21) and discharge planning was in process with a local facility that had a secured memory care unit.

A phone interview was conducted with the APS SW on 4/6/21 at 8:20 AM. She indicated that an APS report was initially made by the local police department related to Resident #129 ' s unsupervised exit from the facility on 3/9/21. She stated that on 3/11/21 she received a report from the facility that Resident #129 was discharged from the facility on this date (3/11/21) and they were concerned the family member he was discharged to may not have been able to care for him. The APS SW spoke about Resident #129 ' s history indicating that in September 2020 he was found by a family member in his home (where he lived independently) with all 4 stove burners on and he was sleeping. She further reported that on 2/11/21 Resident #129 was admitted to the hospital after being found by his family member unresponsive at his home. She indicated he was in the hospital until 3/2/21 when he was admitted

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to the facility. The APS SW stated that she completed a home visit with Resident #129 on 3/12/21. She reported that Resident #129 was alone in his home and he was experiencing delusions. She indicated she strongly felt this was an unsafe living environment for Resident #129 and she contacted EMS for hospital evaluation where he was evaluated and admitted. She revealed he was still in the hospital as of 4/6/21. The APS SW further revealed that she substantiated the allegation of neglect based on the totality of the unsupervised exit on 3/9/21 and subsequent discharge to an unsafe environment 2 days later on 3/11/21. She reported that the facility claimed that his RP said she would be providing care for him. She indicated that she spoke to his RP and she indicated she had never told the facility she was going to provide care for him. She added that the hospital discharge summary from 3/2/21 on the date of admittance to the facility indicated that Resident #129's family member was no longer able to care for him at home due to his encephalopathy and this why was he was placed at the facility.

A phone interview as conducted with Nurse #1 on 4/6/21 at 1:12 PM. She indicated she worked with Resident #129 during his stay at the facility and that he was alert and oriented to self only with cognitive impairment and delusional thoughts. She reported that she was assigned to Resident #129 on the date of his discharge on 3/11/21. She indicated that she was informed by the Administrator that Resident #129 was discharging home and would be staying with his family. Nurse #1 indicated that on 3/11/21 Resident #129 ' s RP came to the facility to pick the resident up and as she was going through his medication list and orders with the RP she

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indicated that Resident #129 was going home by himself and she would not be with him to administer his medications. Nurse #1 reported that after Resident #129 left with his RP she went to talk to SW #1 and SW #2 about his discharge arrangements as she had not felt comfortable with Resident #129 going home to live alone without supervision. She stated that she shared with SW #1 and SW #2 that Resident #129 ' s RP indicated the resident was going to be living alone unsupervised and they informed her they would contact APS.

A phone interview was conducted on 4/6/21 at 9:18 AM with Resident #129 ' s RP. She reported that during Resident #129 ' s hospitalization from 2/11/21 through 3/2/21 she informed the hospital staff that she was unable to care for Resident #129 at home and this was why he required facility placement. Resident #129 ' s RP revealed that on the night of 3/9/21 she was awakened from her sleep by a phone call from the facility Administrator stating that Resident #129 had gotten out of the facility unsupervised that evening but was now back at the facility. She reported that the Administrator informed her that the facility couldn ' t keep him (Resident #129) because they couldn ' t have residents exiting the facility unsupervised. She stated that she believed she informed the Administrator that she was not able to care for Resident #129 at her home and that he would be residing alone in his home if he was discharged. The RP stated that the Administrator said someone would call her tomorrow to discuss a plan. She indicated that the next day (3/10/21), one of the facility SWs (unable to recall which one) called her and told her they needed to do discharge planning and asked her when she could pick Resident #129 up.

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She indicated that she thought this meant she had to pick him up as soon as possible so she informed them she could pick him after work the next day. Resident #129 ' s RP stated that she was not asked if she was taking Resident #129 home with her. She revealed that the facility was aware that she could not care for the resident herself as this was the reason he was placed at the facility when he was discharged from the hospital (3/2/21). She stated that she felt she had no other option but to take him home to live by himself. She explained that she worked full time and her husband and herself were already taking turns providing care to another family member with dementia who lived with them. Resident #129 ' s RP indicated that on 3/11/21 after work she went to the facility and picked up Resident #129. She reported that 3 staff members (names unknown) brought him out to car and she said to them that he was going home to live by himself and they acted they like they were surprised by that information. Resident #129 ' s RP stated that she took him to his home and dropped him off. She revealed that the next day (3/12/21) a SW from APS contacted her and said that Resident #129 was not safe at home by himself and that was when he was sent back to the hospital where he still remained.

During a phone interview with SW #1 on 4/6/21 at 9:50 AM she stated that she started orientation as the SW on 3/8/21 and that she was being trained by the outgoing SW (SW #2). She reported on 3/10/21 during the morning meeting, Resident #129 ' s unsupervised exit from the facility that occurred the previous night (3/9/21) was discussed and it was decided that he needed a discharge plan as this facility was not able to provide the level of care he needed as evidenced

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by him getting out of the facility without staff ' s knowledge. She said 1:1 was provided for a shift and then q 15 minute observations were conducted after the unsupervised exit, but that this was not an intervention that could continue indefinitely. SW #1 stated that after the morning meeting she called Resident #129 ' s RP and SW #2 was listening in by speaker phone. She informed Resident #129 ' s RP the facility couldn ' t provide the care Resident #129 needed and they needed to have a discharge plan. She reported that Resident #129 ' s RP seemed agreeable and stated that she could pick him up the following day (3/11/21) after she got out of work. She was asked if it was discussed where Resident #129 was going to reside at in the community and she stated that she assumed Resident #129 ' s RP was going to take him to her home to provide care. She revealed she had not verified where Resident #129 would be residing when speaking with his RP on 3/10/21. She was asked who she thought was going to provide care for Resident #129 when his RP was working. She revealed that she was aware his RP worked and that she assumed there was a caregiver in the home as his RP had another relative who had dementia living with her. She further revealed that she had not completed an assessment of the home environment to ensure it was safe and provided the level of care required to meet Resident #129 ' s needs. SW #1 was asked if she was aware the hospital discharge summary dated 3/2/21 revealed that Resident #129 was discharged to facility placement as his RP was no longer able to care for him at home. She indicated that she was unaware of that information.

This phone interview with SW #1 continued. She

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stated that on 3/11/21 after Resident #129 was picked up at the facility, Nurse #1 came into her office and reported that his RP stated that he was going to his own home to live alone. She indicated that this was a concern as he was not safe to live alone so she and SW #2 phoned APS and requested a safety check for Resident #129. She reported that APS told her they already had an active case open and they would send a SW out to his home.

During a phone interview with SW #2 on 4/6/21 at 1:00 PM she stated that she worked at the facility for about a month and her last day was 3/12/21. She reported on 3/10/21 during the morning meeting, Resident #129 ' s unsupervised exit from the facility that occurred the previous night (3/9/21) was discussed and the Administrator informed SW #1 and herself that he spoke with Resident #129 ' s RP last night (3/9/21) after the incident and he told her that the facility was going to have to find somewhere else for him to stay or he would have to be discharged home. She was asked why the facility was no longer able to care for Resident #129 and she stated that she was unable to answer this question as this was management ' s decision. SW #2 reported that after the morning meeting (3/10/21) the Administrator told her and SW #1 to contact Resident #129 ' s RP and discuss discharge plans. She indicated SW #1 contacted Resident #129 ' s RP by phone and she listened in on speaker phone. SW #2 indicated that SW #1 informed Resident #129 ' s RP that they needed to discuss discharge planning. She stated that the RP had not seemed surprised by this information. She indicated SW #1 asked the RP if she was able to come get Resident #129 and if so when would she be able to do this. She

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reported that Resident #129 ' s RP said she would pick him up the following day (3/11/21) after she got out of work. SW #2 indicated that she assumed from the conversation that Resident #129 ' s RP was unhappy that he was able to get out of the facility unsupervised so she wanted him to be discharged. SW #2 was asked if it was discussed where Resident #129 was going to reside at in the community and she stated that she assumed Resident #129 ' s RP was going to take him to her home to provide care. She revealed it had not verified where Resident #129 would be residing when SW #1 spoke with his RP on 3/10/21. She was asked who she thought was going to provide care for Resident #129 when his RP was working. She revealed that she was aware his RP worked and that she assumed there was a caregiver in the home as his RP had another relative who had dementia living with her. She further revealed that she had not completed an assessment of the home environment to ensure it was safe and provided the level of care required to meet Resident #129 ' s needs. SW #2 was asked if she was aware the hospital discharge summary dated 3/2/21 revealed that Resident #129 was discharged to facility placement as his RP was no longer able to care for him at home. She indicated that she was unaware of that information.

This phone interview with SW #2 continued. SW #2 confirmed SW #1 ' s statement that on 3/11/21 after Resident #129 was picked up at the facility by his RP, Nurse #1 came into their office and reported that his RP stated that he was going to his own home to live alone. She indicated that this was a concern as he was not safe to live alone so she and SW #1 phoned APS and requested a safety check for Resident #129. She

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reported that APS told her they already had an active case open and they would send a SW out to his home.

An interview with the Administrator on 4/7/21 at 11:10 AM confirmed he phoned Resident #129 ' s RP after his unsupervised exit from the facility on the night of 3/9/21. He informed her the facility could not keep him and she had 2 options: 1) take him home with her; 2) transfer to another facility with a secured unit without a guarantee that there would be an opening in this county. The Administrator indicated that she spoke about her living situation and informed him that she and her husband both worked opposite shifts and that she also cared for another family member who had dementia. The Administrator stated that during this phone call the RP stated that she would just take him home. The Administrator was asked if Resident #129 ' s RP could have felt like she had no choice but to take him home and he acknowledged that this was possible. The Administrator revealed he was unaware that SW #1 and SW #2 failed to confirm Resident ' s #129 ' s discharge location. He stated that the SWs should have verified the discharge location that Resident #129 was going to be staying at. The Administrator acknowledged his awareness the SWs failed to complete an assessment of the discharge home environment to ensure it was safe and provided the level of care required to meet Resident #129 ' s needs. The Administrator was asked if he was aware the hospital discharge summary dated 3/2/21 revealed that Resident #129 was discharged to facility placement as his RP was no longer able to care for him at home. He was unable to recall if he was aware of that information. The Administrator was asked why the facility discharged the resident and he stated

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that he was afraid Resident #129 would get out of the facility again and he had not had the ability to provide him 1:1 care indefinitely. He explained that the only way to ensure Resident #129 had not exited the building unsupervised again was to have someone with him at all times.

An interview was conducted with the facility ' s Medical Director on 4/8/21 at 10:45 AM. He stated that Resident #129 was cognitively impaired and he required 24 hour care. He stated that Resident #129 was not safe to live alone and/or to live in a home environment without a care giver present at all times. He reported that the facility had a responsibility to ensure the environment a resident was being discharged to was assessed for safety and for the ability to meet the resident ' s needs.

The Administrator and DON were notified of the Immediate Jeopardy on 4/7/21 at 2:40 PM.

On 4/8/21 at 12:03 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

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

Facility failed to ensure Resident #129 was discharged to a safe environment.

Resident #129 had a Minimum Data Set assessment (MDS) completed on 3-5-21. His BIMS (Brief Interview for Mental Status) score was calculated at 10, which is considered moderately Impaired.

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Resident #129 discharge plan was initiated on 3-10-21 by the Social worker. During this process, the social worker called the sister to ask questions on what address the resident would be going to, who would be providing supervision for resident #129, what home health agency they would like to use, what equipment that would be needed and who would be there to let home health and equipment company in at the address. The social worker failed to verify that the address that was given was the sister ' s address and not Residents #129 old home address. The home environment was not assessed for safety because the social worker assumed that the address given was the sister ' s address where 24 hour supervision would be given.

Resident # 129 was discharged home on 3-11-21. The Social worker contacted Adult Protective Services (APS) on 3-11-21 to notify them that Resident #129 sister made a comment on discharge that Resident #129 would be discharging to his home alone. The local APS social worker went to perform a safety check on 3-12-21. APS found the resident alone at his residence experiencing delusions and EMS was called to take the resident to the hospital. Resident is still at the hospital at this time. On 4-8-21 the discharge planner at the local hospital for Resident #129 was contacted by our admission coordinator. The discharge planner stated that the temporary guardian was working on resident #129 insurance authorizations to discharge him to a local facility in the area with a locked secured unit. Per the discharge planner the local facility has made an offer pending insurance authorization. The facility Admission coordinator notified the discharge planner for Resident #129 that the facility would accept the

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resident back at our facility if unable to place at the other local facility with the locked unit.

The Social worker performed an audit on 4-7-21 on all residents that were discharged home for the past 30 days to ensure that no other residents were affected by the alleged noncompliance. The social worker looked to see if follow up calls were made and received, were there any concerns from the RP or resident, did home health arrive as ordered, and was equipment delivered as ordered and if anyone living environment was unsafe. No other residents were found during this audit to be affected by the alleged noncompliance.

The alleged non-compliance resulted from failure to follow up with the sister of Resident #129 to ensure that the sister would be taking the resident home with her and providing 24 hour care as needed and not following up to ensure the resident was going to the sisters address instead of his old address. This also included the failure to assess the safety of the home environment he was being discharged to.

#2 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.

The Social Worker and all licensed nursing staff will be educated by 4-8-21 by the Staff Development Coordinator (SDC), Director of Nursing (DON) and RN Supervisor on what constitutes an unsafe discharge and what steps must be taken to ensure that an unsafe discharge does not occur. All discharges will be discussed in our clinical meeting Monday through Friday.

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This clinical meeting will be made up of the Social Worker, SDC, Director of Nursing (DON), Therapy Manager, Minimum Data Set (MDS) nurses #1, and #2, Administrator and RN Supervisor. Any discharges occurring on Saturday and Sunday, the RN Supervisor will ensure that safe discharge occurs.

The Social worker will be educated by the SDC by 4-8-21 on steps to ensure a safe discharge which includes : Ensure that resident caretakers at the home will be there for the appropriate time frame for the care that is needed and to ensure that all aspects of the discharge is followed up on, including the correct address, the caregivers ' ability to provide the required care for the resident, that equipment has been delivered, follow up doctor ' s appointments have been made, Home health has been ordered if needed and to ensure that resident will have the appropriate care when they return home.

To ensure that this alleged noncompliance will not occur the following items will be put in place. The Social worker will have a discharge meeting with the Resident Responsible Party (RP) or the Resident 48 hours before discharge to arrange a safe discharge home and to ensure the home environment is safe. Once the resident is discharged the social worker will have 72 hours to call the resident or RP at discharge location to ensure that all items needed are there, that the home environment is still safe and that resident is safe at location. This will be documented in a progress note in resident file.

TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL.

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The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.

Immediate Jeopardy Removal Date: 4-8-21

The facility alleges the removal of Immediate Jeopardy on 4/8/21.

On 4/8/21 the credible allegation of Immediate Jeopardy removal was validated by onsite verification. Record review and SW #1 interview verified an audit was completed on 4/7/21 for all residents discharged home in the past 30 days to ensure follow up calls were made and received, all discharge needs were met, and that the home environments were safe. An interview with the Administrator verified this facility would accept Resident #129 back if the placement arranged by the local hospital was not successful and/or if Resident #129 ' s guardian wished for him to return to this facility. This interview with the Administrator also verified that all discharges would be discussed in the clinical meeting Monday through Friday. This clinical meeting would be made up of the Social Worker, SDC, Director of Nursing (DON), Therapy Manager, Minimum Data Set (MDS) nurses #1, and #2, Administrator and RN Supervisor. For any discharges occurring on Saturday and Sunday, the RN Supervisor would ensure that safe discharge occurred. A review of inservices and inservice sign in sheets as well as staff interviews verified education was provided on 4/8/21 to the SW and all licensed nursing staff on what constitutes an unsafe discharge and what steps must be taken to ensure that an unsafe discharge

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F 624	Continued From page 35 does not occur. This also verified the SW was educated on 4/8/21 on the steps to ensure a safe discharge occurred which includes: 1) Ensure that resident caretakers at the home will be there for the appropriate time frame for the care that is needed; 2) Ensure that all aspects of the discharge are followed up on; and 3) Ensure the resident will have the appropriate care when they return home. The aspects of discharge that required follow up on included the correct address, the caregivers ' ability to provide the required care for the resident, that equipment has been delivered, follow up doctor ' s appointments have been made, and home health has been ordered if needed. Any licensed nursing staff not inserviced by 4/8/21 were required to be educated prior to working on the floor. The facility ' s IJ removal date of 4/8/21 was validated.	F 624		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of Activities of Daily Living (Residents #11, #43 and #75), bowel and bladder (Resident #43), and medications (Residents #130). This was for 4 of 20 residents reviewed. The findings included:	F 641	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality of care. F641 Affected Residents	4/23/21

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F 641	Continued From page 36 1) Resident #11 was originally admitted to the facility on 6/18/20 with diagnoses that included hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the body) due to a cerebral infarction (a stroke), dysphagia (difficulty swallowing) and presence of a feeding tube. A review of the physician orders revealed the following for Resident #11: - An order dated 6/18/20 for Nothing by mouth (NPO) status. - An order dated 6/18/20 to document the amount of formula and water provided every 8 hours. - An order dated 8/19/20 for complete nutritional tube feeding formula, 1 can every 4 hours with a water flush of 120 milliliters (ml) after each can. The quarterly Minimum Data Set (MDS) assessment dated 12/12/20 indicated Resident #11 was cognitively intact. She was coded as requiring supervision for transfers, toileting and dressing and limited assistance for bed mobility, personal hygiene, and bathing. The eating section was coded as activity occurred only once or twice during the seven day look back period. The swallowing/nutrition status section of the assessment indicated Resident #11 had a feeding tube present and received all nutrition and fluids via the tube. A review of the medical record for Resident #11 from 9/1/20 to 4/7/21 revealed all nutrition and fluids were provided via a feeding tube. On 4/7/21 at 9:52 AM, an observation occurred	F 641	Resident #130 Section N of the Minimum Data Set (MDS) dated 3/6/2021 was modified for accuracy and transmitted by MDS Coordinator #1 on 4/20/21. Resident #130 did not suffer any adverse effect from the coding inaccuracy Resident #75 Section G of the Minimum Data Set (MDS) dated 3/10/21, and resident #43 Section G and of the MDS dated 2/1/2021, and Resident #11 Section G of the MDS dated 12/12/20 was modified for accuracy and transmitted by MDS Coordinator #1 on 4/20/21. Resident #75, Resident #43, and Resident #11 did not suffer any adverse effect from the coding inaccuracies. Resident #43 Section H of the Minimum Data Set (MDS) dated 3/10/21 was modified for accuracy and transmitted by MDS Coordinator #1 on 4/20/21. Resident #43 did not suffer any adverse effect from the coding inaccuracy. Residents with the potential to be affected MDS Nurse # 1 & MDS Nurse #2 audited a 100% of the last MDS completed for all residents by 4-23-21. The audit included Section G, Section H, and Section N to ensure that these MDS sections were coded correctly and accurately reflected the status of the resident. Two additional items were identified. These items were corrected, the MDS' modified and transmitted by MDS Nurse #1 on 4-23-21. Systemic Changes	

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F 641	Continued From page 37 with Nurse #3 providing nutrition to Resident #11 via her feeding tube. Nurse #3 stated Resident #11 received all fluids, nutrition, and medication by the feeding tube. An interview occurred with MDS Nurse #1 on 4/7/21 at 4:28 PM. She reviewed the 12/12/20 MDS assessment and verified the eating portion of the MDS was marked as the activity occurred only once or twice. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the Nurse Aide for eating but should have been coded as total dependence and 1-person physical assistance as Resident #11 received all nutrition and fluids via a feeding tube. On 4/8/21 at 2:40 PM, the Director of Nursing was interviewed and stated it was her expectation for the MDS to be coded accurately. 2) Resident #75 was originally admitted to the facility on 9/16/20 with diagnoses that included Alzheimer's disease and type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated 3/10/21 indicated Resident #75 had severe cognitive impairment. She required supervision with eating, extensive assistance with bed mobility, dressing, personal hygiene, transfers and was dependent on staff for bathing. The toilet use section was coded as the activity occurred only once or twice during the seven day look back period. The bowel and bladder section of the assessment indicated Resident #75 was always incontinent of bowel and bladder.	F 641	Education was provided to MDS Coordinator #1 and MDS Coordinator #2, the Social Worker, the Dietary Manager, the Rehabilitation Manager, and the Activities Director on 4/23/2021 by the Regional Reimbursement Manager regarding the Resident Assessment Instrument (RAI) assessment process and the importance of coding the MDS accurately. Monitoring An audit tool was developed to monitor MDS assessments for proper coding of section G, Section H and Section N (injections). MDS Nurse #1 will audit MDS assessments completed by MDS Nurse #2 and MDS Nurse #2 will audit MDS assessments completed by MDS Nurse #1. Audits will be completed by the MDS coordinators for 25% of all MDS assessments weekly x 4 weeks, then 25% monthly for 2 months, audit will start on 4-12-21. The results of these audits will determine the need for further monitoring. Results of the audits will be brought to the QAPI meeting monthly by the MDS Coordinators for review and further recommendations.	

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A review of the nursing progress notes from 2/1/21 through 4/8/21 revealed Resident #75 required assistance with Activities of Daily Living (ADL's) to include toilet use.

An interview was completed with Nurse #5 on 4/8/21 at 11:00 AM, who was familiar with Resident #75 and stated extensive assistance was required for toilet use. Staff provided assistance with toileting and incontinence care every 2 to 3 hours and as needed.

An interview occurred with MDS Nurse #1 on 4/8/21 at 12:30 PM. She reviewed the 3/10/21 MDS assessment and verified the toilet use portion was marked as the activity occurred only once or twice. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the Nurse Aide for toilet use, but should have been coded as total dependence as Resident #75 was always incontinent of bowel and bladder and received assistance with toileting every 2 to 3 hours and as needed.

On 4/8/21 at 2:40 PM, the Director of Nursing was interviewed and stated it was her expectation for the MDS to be coded accurately.

3a) Resident #43 was originally admitted to the facility on 2/25/20 with a recent readmission of 12/11/20. Her diagnoses included traumatic brain injury and presence of a feeding tube.

A review of the physician orders revealed the following for Resident #43:

- An order dated 2/25/20 for Nothing by Mouth (NPO) status.

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- An order dated 11/25/20 for complete nutritional tube feeding formula, at 70 milliliters (ml)
per hour for 22 hours a day.
- An order dated 12/11/20 for feeding tube auto flush with 40 ml of water every hour for 22 hours a day.

The quarterly Minimum Data Set (MDS) assessment dated 2/1/21 indicated Resident #43 was in a persistent vegetative state. She was coded as requiring assistance with all Activities of Daily Living (ADL's). The eating section was coded as activity occurred only once or twice during the seven day look back period. The swallowing/nutrition status section of the assessment indicated Resident #43 had a feeding tube present and received all nutrition and fluids via the tube.

A review of the medical record for Resident #43 from 2/25/20 to 4/7/21 revealed all nutrition and fluids were provided via a feeding tube.

An interview occurred with MDS Nurse #1 on 4/7/21 at 4:38 PM. She reviewed the 2/1/21 MDS assessment and verified the eating portion was marked as the activity occurred only once or twice. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the Nurse Aide for eating but should have been coded as total dependence and 1-person physical assistance as Resident #43 received all nutrition and fluids via a feeding tube.

On 4/8/21 at 2:40 PM, the Director of Nursing was interviewed and stated it was her expectation for the MDS to be coded accurately.

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3b) Resident #43 was originally admitted to the facility on 2/25/20 with a recent readmission of 12/11/20. Her diagnoses included traumatic brain injury, retention of urine and neuromuscular dysfunction of the bladder.

The quarterly Minimum Data Set (MDS) assessment dated 2/1/21 indicated Resident #43 was in a persistent vegetative state. She was coded as requiring assistance with all Activities of Daily Living (ADL's). The toilet use section was coded as the activity did not occur during the seven day look back period. The bowel and bladder section of the assessment revealed Resident #43 was incontinent.

A review of the medical record for Resident #43 from 2/25/20 to 4/7/21 revealed assistance was provided with all ADL's to include incontinence care.

An interview occurred with MDS Nurse #1 on 4/7/21 at 4:38 PM. She reviewed the 2/1/21 MDS assessment and verified the toilet use portion was marked as the activity did not occur. She explained the ADL portion of the assessment was coded based on the ADL charting completed by the Nurse Aide for toilet use but should have been coded as total dependence as Resident #43 was incontinent of bowel.

On 4/8/21 at 10:20 AM, Nurse #5 stated Resident #43 required frequent assistance with incontinence care as the tube feed formula caused frequent loose stools.

On 4/8/21 at 2:40 PM, the Director of Nursing

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was interviewed and stated it was her expectation for the MDS to be coded accurately.

3c) Resident #43 was originally admitted to the facility on 2/25/20 with a recent readmission of 12/11/20. Her diagnoses included traumatic brain injury, retention of urine and neuromuscular dysfunction of the bladder.

The quarterly Minimum Data Set (MDS) assessment dated 2/1/21 indicated Resident #43 was in a persistent vegetative state. She was coded as always incontinent of bowel and bladder and no bowel or bladder appliances were being used.

A review of the February 2021 physician orders revealed an order for Resident #27 to have urinary catheter care every shift.

An observation was made on 4/7/21 at 8:46 AM of Resident #43 lying in bed and a urinary catheter present.

On 4/7/21 at 4:38 PM, an interview occurred with MDS Nurse #1 who reviewed the MDS dated 2/1/21 and indicated indwelling catheter should have been marked and urinary incontinence should have been coded as not rated since Resident #43 had a urinary catheter during the MDS 7 day look back period.

On 4/8/21 at 2:40 PM, the Director of Nursing was interviewed and stated it was her expectation for the MDS to be coded accurately.

4. Resident # 130 was admitted to the facility on

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F 641	Continued From page 42 3/3/21 with multiple diagnoses including right femur fracture. The admission Minimum Data Set (MDS) assessment dated 3/6/21 indicated that Resident #130 had moderate cognitive impairment and had received injection for 1 day during the assessment period. Resident #130 had a doctor's order dated 3/3/21 for Lovenox (an anticoagulant drug) 30 milligrams (mgs.) subcutaneous (SQ) once a day. The March 2021 Medication Administration Record (MAR) revealed that Resident #130 had received injection 3 times (3/4/21, 3/5/21 and 3/6/21) during the assessment period. MDS Nurse #1 was interviewed on 4/7/21 at 4:33 PM. She verified that Resident #130 had received injection 3 times during the assessment period. The MDS Nurse further stated that the admission MDS assessment dated 3/6/21 was not accurate and she would complete a modification assessment to correct the inaccuracy in the area of medications to reflect the 3 injections instead of 1. The Director of Nursing (DON) was interviewed on 4/8/21 at 2:43 PM. The DON stated that she expected the MDS assessments to be coded accurately.	F 641		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		4/26/21

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by:
Based on record reviews, observations, resident and staff interviews, the facility failed to provide nail care (Residents #20 and #31) and failed to ensure residents were free from unwanted facial hair (Residents #11 and #20). This was for 3 of 4 residents reviewed for Activities of Daily Living (ADL's).

The findings included:

1) Resident #20 was originally admitted to the facility on 11/18/19 with diagnoses that included Parkinson's disease, type 2 diabetes, muscle weakness and chronic pain.

The quarterly Minimum Data Set (MDS) assessment dated 1/1/21 indicated Resident #20 was cognitively intact. She required extensive assistance with personal hygiene and dressing and was dependent on staff for bathing.

A review of the nursing progress notes from 8/1/20 through 4/7/21 revealed no refusals of nail care or personal care assistance documented.

A review of the active care plan, last reviewed on 3/24/21, revealed a problem area for Resident #20 being at risk for poor hygiene/decline in function due to impaired mobility. The interventions included to provide limited to extensive assistance for ADL's.

An observation and interview occurred with Resident #20 on 4/5/21 at 10:45 AM. She was sitting on the side of her bed and was observed with a large amount of long facial hair to her jaw line, upper lip area and chin. Resident #20 was seen pulling on the facial hair to her chin and

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F677

Affected Resident

Resident #20 had nail care and unwanted facial hair removed on 4-7-21 and Resident #31 had nail care provided on 4-7-21. Resident #11 had unwanted facial hair removed on 4-9-21. This was completed by the certified nursing assistants (CNA) caring for these residents. The residents were not adversely affected by the alleged deficient practice.

Residents with potential to be affected

The Director of Nursing (DON), RN Supervisor, Staff Development Coordinator (SDC) and Social Worker performed a 100% audit on all residents in the facility on 4-9-21. During our audit three other residents were identified needing nail care and the CNA that was assigned to those residents provided nail care.

Systemic Changes

The Staff Development Coordinator (SDC) educated all licensed nursing staff

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stated, "a woman should not have facial hair". When questioned if staff offered assistance with the unwanted facial hair she stated, "No, but I would like it done at least every week". In addition, Resident #20 was observed to have long nails to both hands with a dark substance underneath the nails.

In an observation on 4/5/21 at 1:20 PM, Resident #20 was observed sitting up in bed. She had visible facial hair to her jaw line, upper lip, and chin, as well as long nails to both hands with a dark brown substance under the nails.

Resident #20 was observed on 4/7/21 at 8:33 AM lying in her bed. There was no observed facial hair and her nails were short and clean.

An interview occurred with Nurse Aide (NA) #3 on 4/7/21 at 2:10 PM. She explained NA's completed nail care with scheduled showers and were to ensure nails were short, clean, and free of jagged edges. She further stated female residents were to be asked about their facial hair when it was noted or during scheduled showers. The NA was assigned to Resident #20 on her scheduled shower day of 4/1/21 and stated she never asked Resident #20 if she wanted assistance to remove the facial hair.

On 4/7/21 at 2:15 PM, an interview was conducted with Nurse #5 who also acted as the Treatment Nurse. She explained during weekly skin assessments provided by herself or the floor nurses, nail care should be rendered if there was a need, however, the NA's provided nail care during personal care and showers. Nurse #5 further stated female residents should be asked by the NA's during the scheduled shower or and Certified Nursing Assistants by 4-21-21. The following items were included in the education.
•A resident who is unable to carry out activities of daily living must receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.
•Residents' with facial hair need to be shaved on shower days and as needed according to their preference. If the resident desires to maintain facial hair, notify nursing so an appropriate care plan can be developed for his/her desires
•Residents' nails need to be cleaned and trimmed with showers and as needed. If the resident eats with fingers or scratches frequently, nails will need to be cleaned more often.
•If the resident refuses any ADL care, notify the nurse and the nurse needs to document the refusal.

Monitoring

The DON, RN Supervisor, and/or SDC will audit 20% of all residents weekly for 4 weeks and monthly for 2 months, audit will begin on 4-12-21. The following items will be included in the audit.
•Has the resident been shaved as necessary and there are no excess facial hair?
•Does the resident appear to be well groomed, i.e "hair, nails, clean clothing ,etc.?
•Are the residents' nails clean and trimmed?
•If the resident refused ADL care, is that

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F 677	Continued From page 45 personal care if observed facial hair was desired to be removed and provide assistance. An interview was completed with NA #4 on 4/7/21 at 4:03 PM. She stated nail care was to be completed at the scheduled shower or when needed. Aides were able to provide nail care to all residents but were not able to manage toenail care for diabetic residents. She further stated female residents should be asked if they wanted facial hair removed. NA #4 stated she didn't notice the facial hair on Resident #20. The DON was interviewed on 4/8/21 at 8:45 AM and indicated NA's could clean under all resident's nails and cut fingernails for all residents. She stated it was her expectation for the aides to monitor, clean and trim nails during personal care, retrieving a nurse for any diabetic toenail care that was needed. Additionally, the DON stated it was her expectation that Resident #20 be free of unwanted facial hair and expected the NA's to manage this task during her scheduled showers or when observed. 2) Resident #31 was originally admitted to the facility on 2/11/14 with diagnoses that included Alzheimer's disease, traumatic brain injury and osteoarthritis. A quarterly Minimum Data Set (MDS) assessment dated 1/8/21 indicated Resident #31 had impaired cognition. She was dependent on staff for dressing, toileting, personal hygiene, and bathing. Limited range of motion was present to both lower extremities. A review of Resident #31's active care plan, last reviewed on 1/28/21, included a problem area for	F 677	documented by the licensed nurse? The DON will bring the audit results to QAPI monthly for review and further recommendations.	

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fragile skin/skin tears. The interventions included fingernails to be trimmed.

A review of the nursing progress notes from 10/1/20 through 4/7/21 revealed no refusals of nail care documented.

An observation was made of Resident #31 on 4/5/21 at 10:00 AM while she was lying in bed. She was observed to have long nails to both hands with a brown substance under fingernails to both hands.

In an observation on 4/5/21 at 1:00 PM, Resident #31 was lying in bed and had recently completed the lunch meal. She was observed with long fingernails to both hands with a brown substance under her fingernails.

An observation was made of Resident #31 on 4/7/21 at 8:27 AM while she was lying in bed. She was observed to have short, clean fingernails.

An interview occurred with Nurse Aide (NA) #3 on 4/7/21 at 2:10 PM. She explained NA's completed nail care with scheduled showers and were to ensure nails were short, clean, and free of jagged edges.

On 4/7/21 at 2:15 PM, an interview was conducted with Nurse #5 who also acted as the Treatment Nurse. She explained during weekly skin assessments provided by herself or the floor nurses, nail care should be rendered if there was a need, however, the NA's provided nail care during personal care and scheduled showers.

An interview was completed with NA #4 on 4/7/21 at 4:03 PM. She stated nail care was to be

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completed at the scheduled shower or when needed. Aides were able to provide nail care for all residents but were not able to manage toenail care for diabetic residents.

The DON was interviewed on 4/8/21 at 8:45 AM and indicated NA's could clean under all resident's nails and cut fingernails for all residents. She stated it was her expectation for the aides to monitor, clean and trim nails during personal care, retrieving a nurse for any diabetic toenail care that was needed.

3) Resident #11 was originally admitted to the facility on 6/18/20 with diagnoses that included hemiplegia (paralysis to one side of the body) and hemiparesis (weakness to one side of the body) related to a cerebral infarction (a stroke).

A quarterly Minimum Data Set (MDS) assessment dated 12/12/20 indicated Resident #11 was cognitively intact. She required limited assistance with personal hygiene and bathing and had limited range of motion to one side of her upper and lower extremities.

A review of Resident #11's active care plan, last reviewed on 3/26/21, included a problem area of being at risk for poor hygiene/decline in function due to impaired mobility. The interventions included to provide limited to extensive assistance for Activities of Daily Living (ADL's).

A review of the nursing progress notes from 9/1/20 through 4/7/21 revealed no refusals of nail care documented.

An observation and interview occurred with Resident #11 on 4/5/21 at 10:15 AM. She was

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sitting in a wheelchair in her room and stated staff assisted with her personal care and bathing due to limitations from a stroke. She was observed with facial hair to the jaw line on both sides. Resident #11 stated she had not been asked about the unwanted facial hair during her personal care or scheduled showers but would like it removed.

In an observation on 4/7/21 at 8:41 AM, Resident #11 was observed sitting in her wheelchair in her room. She had visible facial hair to her jaw line and stated she would like it removed weekly or when noticed.

An interview occurred with Nurse Aide (NA) #3 on 4/7/21 at 2:10 PM. She explained female residents were to be asked about their facial hair when it was noted or during scheduled showers. The NA stated she had not noticed the facial hair on Resident #11.

On 4/7/21 at 2:15 PM, an interview was conducted with Nurse #5 who also acted as the Treatment Nurse. She explained female residents should be asked by the NA's during the scheduled shower or personal care, if observed facial hair was desired to be removed and provide assistance.

An interview was completed with NA #4 on 4/7/21 at 4:03 PM. She stated female residents should be asked if they wanted facial hair removed. NA #4 stated she didn't notice the facial hair on Resident #11.

The Director of Nursing was interviewed on 4/8/21 at 8:45 AM and indicated it was her expectation that Resident #11 be free of

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F 677	Continued From page 49 unwanted facial hair and expected the NA's to manage this task during her scheduled showers or when observed.	F 677		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview with the Medical Director, Police Corporal, and staff, the facility failed to prevent a resident who had cognitive impairment and known wandering behaviors from exiting the facility unsupervised at night. On 3/9/21 Resident #129 exited the facility unsupervised and he self-propelled himself by wheelchair approximately 0.16 miles away from the facility on a roadway that had no sidewalks. This was for 1 of 3 residents reviewed who experienced wandering behaviors. Immediate Jeopardy began on 3/9/21 when Resident #129 exited the facility unsupervised at night. The Immediate Jeopardy was removed on 4/8/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility remains out of compliance a lower scope and severity level of D (no actual harm with a potential for minimal harm that is not Immediate Jeopardy)	F 689	Filing the plan of correction does not constitute that the alleged deficiencies did in fact exist. The plan of correction is filed as evidence of the facility□s desire to comply with the requirements and to continue to provide high quality of care. F689 Resident affected An Elopement assessment was completed on Resident #129 on 03/10/2021 by The Staff Development Coordinator (SDC), Director of Nursing (DON) and RN Supervisor . Resident #129□s picture and name was added to the elopement book. The elopement book contains enlarged photographs and names of residents at risk for elopement. This book is maintained at the nursing station and front desk at the facility. A	4/27/21

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F 689	Continued From page 50 to ensure monitoring of systems are put in place and to complete employee in-service training. The findings included: Resident #129 was admitted to the facility on 3/2/21 with diagnoses that included metabolic encephalopathy (a disturbance of brain function), dementia, depression, and insomnia. The hospital discharge summary dated 3/2/21 indicated that throughout Resident #129 ' s stay at the hospital he experienced episodes of confabulation (the replacement of a gap in a person's memory by a falsification that he or she believed to be true), disorientation, and agitation. He was noted to require facility placement due to encephalopathy. A nursing note completed by the Clinical Care Coordinator (CCC) dated 3/2/21 indicated Resident #129 was admitted to the facility. He was alert and oriented to self only. An admission assessment dated 3/2/21 completed by the CCC indicated Resident #129 ' s current health problems included, in part, memory loss and balance problems. He utilized a walker and wheelchair. Resident #129 ' s mental status was assessed as alert and oriented to self only. He was noted with anxiety and restlessness. A 5-day Minimum Data Set (MDS) assessment dated 3/5/21 indicated Resident #129 ' s cognition was moderately impaired. He was assessed with no psychosis, behaviors, or wandering. Resident #129 required supervision of 1 for bed mobility, transfers, and toileting, and supervision with set	F 689	Resident experiences wandering care plan was added on 3/09/2021 by the MDS Coordinator. This care plan included the following: Remove resident from other resident□s rooms and unsafe situations; When resident begins to wander, provide comfort measures for basic needs (e.g. pain, hunger, toileting, to hot / Cold , etc.); Provide care, activities, and a daily schedule that resembles the resident□s prior lifestyle. The Resident #129 Resident #129 was immediately placed on 1:1 monitoring for the remainder of the shift, and then 15-minute monitoring checks to ensure resident safety. There were no additional attempts to exit the facility without supervision. A head to toe skin assessment was completed on 3-9-21 by the hall nurse and no injury was noted. Resident#129 is currently residing in a local facility in their skilled locked unit. Residents with the potential to be affected A full census was taken on 3-9-21 by the hall nurses to ensure that all residents were in the facility. During this audit all residents were accounted for. The Maintenance Director changed the codes on all doors in the facility on 3-9-21 at 9:45pm. The 400 hall door was being watched by the staff that was completing 15 minute watches on the resident. On 3-10-21 at 10am an outside door company came to the facility and corrected both emergency kill switches. An audit was completed by the Minimum Data Set nurse 1 (MDS 1) on 4-7-21 of all residents at risk for elopement to ensure	

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F 689	Continued From page 51 up help only for locomotion on the unit. He had no functional impairment with range of motion, and he utilized a wheelchair. A nursing note dated 3/6/21 completed by Nurse #1 indicated Resident #129 was alert and oriented to self only. He was noted with wandering by self-propelling his wheelchair throughout the 7:00 AM to 7:00 PM shift. Nurse #1 indicated that safety precautions and redirection were needed related to his confusion. A nursing note dated 3/7/21 completed by Nurse #1 indicated Resident #129 was alert and oriented to self only. He was noted with wandering by self-propelling his wheelchair throughout the 7:00 AM to 7:00 PM shift. Nurse #1 indicated that safety precautions and redirection were needed related to his confusion. A nursing note dated 3/9/21 at 8:38 PM completed by Nurse #2 indicated that at approximately 7:40 PM she was informed that a resident headcount needed to be completed related to a call to the facility from a 911 dispatcher that a male was reportedly seen in a wheelchair down the street from the facility. A headcount was performed, and Resident #129 was not in the facility. The 911 dispatcher was informed that the male seen down the street from the facility was a facility resident. At approximately 7:50 PM a police officer (Police Corporal #1) called the facility and stated that he was picking up Resident #129 to bring him back to the facility. At 8:02 PM the police officer arrived at the facility with Resident #129 who was in his wheelchair. He had no signs or symptoms of acute distress or pain. He was assisted to his room by staff and was placed on one to one (1:1)	F 689	that interventions are in place to provide for the safety of the resident and to ensure that any resident at risk for elopement has been assessed and a photo and facesheet is located in the elopement risk book. No additional residents were adversely affected by the deficient practice. Systemic Changes All staff were educated by the SDC, DON and RN Supervisor on 4/8/21 on the following: "Door alarm procedures and the requirement to go to the door that is alarming to ensure that no one has exited the facility. This was completed on 4/8/2021. "The door of the 400 hall will be kept open where the 400 hall is visible from the 300 hall. If there is a resident requiring isolation secondary to Covid-19 or being quarantined for any reason, the 400 hall the doors will be closed and a CNA will be assigned to that hall at all times. Any staff out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Nursing Supervisor. Any newly hired staff will be educated during orientation by the Staff Development Coordinator. All licensed nursing and certified nursing assistants were educated by the SDC, DON and RN Supervisor on the importance of supervising residents and ensuring that residents are safe while in the facility. The supervision includes performing rounds immediately after shift changes to ensure that all residents are	

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F 689	Continued From page 52 monitoring for the remainder of the shift. A Safety Event - Elopement/Wandering form with an event date of 3/9/21 at 7:40 PM and a completion date of 3/10/21 at 1:02 AM was completed by Nurse #2. This form indicated that Resident #129 eloped from the facility on 3/9/21. Nurse #2 wrote that at 7:41 PM the facility was notified by 911 dispatch that a man (Resident #129) was seen at/near a roadway adjacent to the facility. Resident #129 was noted with no injuries. Nurse #2 indicated on the form that Resident #129 had exhibited the following behaviors prior to the elopement: - Resisting redirection from staff - Verbalizing statements about leaving - Wandering with no rational purpose and attempting to open doors - Resident verbalized statements regarding going to see his family Nurse #2 indicated that the immediate measures taken were 1:1 care to be followed by q (every) 15 minute checks. A typed statement dated 3/9/21 completed by the Administrator indicated he interviewed the nurse assigned to Resident #129 at the time of his unsupervised exit from the facility on 3/9/21. The statement read, "[Nurse #2] stated that she heard a door alarm go off around 7:20pm but it only stayed on for a short period and it went back off. She stated she did not stop her [medication] pass because the alarm went back off and she thought it was the pharmacy coming in. She was performing her [medication pass] on the lower 300 hall during this time. [Nurse #2] took the call from police that notified her of a missing resident." This statement included no signature	F 689	accounted for and safety is maintained. Rounds will include having CNAs and Nurses round on opposing ends of the halls. Any licensed nurse or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Nursing Supervisor. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator. This was completed on 4/8/21. The Administrator educated the Maintenance Director that all door kill switches must be fully functional at all times and the key codes will be changed monthly. This education was completed on 3-9-21. Monitoring The Maintenance Director monitored all kill switches for function and alarm daily for two weeks starting 03-09-21. These audits will continue weekly going forward. The 400 hall fire door will be monitored by the maintenance director weekly to ensure that it is open, unless signage is otherwise posted. Maintenance director will perform door alarm drills weekly for 4 weeks and monthly for 4 months starting on 4-23-21. Drills will alternate between 12 hour day shift and 12 hour night shift. The staff is consistent through the weekend. The Director of Nursing will audit that a CNA is assigned to the 400 hall whenever	

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F 689	Continued From page 53 from Nurse #2. A phone interview was conducted with Nurse #2 on 4/6/21 at 12:10 PM. She stated that she worked with Resident #129 during the second shift on the day of his admission (3/2/21) and then once again on the night of his unsupervised exit from the facility. She stated that Resident #129 was alert and oriented to self only. She indicated that he was not oriented to time, place, or situation. She reported that on 3/2/21 Resident #129 repeatedly self-propelled his wheelchair to the double doors that separated his hall from the 300 hall, and he was trying to open them. He was difficult to redirect and became agitated when it was explained to him that this was the quarantine hall (400 hall) and he needed to remain on this hall. Nurse #2 indicated that the NA and nurse who were assigned to Resident #129 ' s hall were also assigned to part of the 300 hall. She reported that there were double doors that were kept closed that led into Resident #129 ' s hall from the 300 hall as Resident #129 resided on the quarantine hall (400 hall). She stated that Resident #129 ' s hall was not visible from the 300 hall due to the double door closure. Nurse #2 stated that on the night of the incident (3/9/21) she was working the 7:00 PM to 7:00 AM shift and she had not laid eyes upon Resident #129 until after he was returned to the facility by the police (approximately 8:02 PM). She explained that she began her medication pass on the 300 hall and had not entered Resident #129 ' s hall. She verified she had not known he was missing until the 911 dispatcher phoned the facility and informed them an elderly male in a wheelchair was spotted heading away from the facility around 7:40 PM. She reported that this was when the facility staff completed a headcount and	F 689	the door must be closed. These audits will be conducted by the DON during the day shift. A licensed nurse will be assigned to conduct audits during the night shift. The Director of Nursing started an audit on 4-27-21 to ensure the 400 hall nurse and CNAs are starting their rounds on opposite end of the 400 hall. This audit will be conducted by the Director of Nursing during the day shift. A licensed nurse from a different hallway will conduct audits during the night shift and on weekends. These audits will continue weekly for 4 weeks and monthly for 4 months. The results of these audits will determine the need for further monitoring. The maintenance director and DON will bring all audits to our monthly Quality Assurance and Performance Improvement (QAPI) meeting for further review and recommendations.	

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she realized Resident #129 was missing. Nurse #2 had not recalled hearing an alarm going off indicating that an exit door was opened. She revealed that Resident #129 was dressed in a gown with pants, a shirt, and a jacket over top of the gown when he was returned to the facility by the police. Nurse #2 indicated that she was not entirely surprised that he got out of the facility since he was able to move about independently and he had spoken to her about his family when she worked with him. She further indicated that it was not safe for Resident #129 to be out of the facility without supervision.

A police report completed by Police Corporal (PC) #1 indicated on 3/9/21 at 7:41 PM he responded to a call received by 911 dispatch regarding a phone call they received about a sighting of an elderly male in a wheelchair headed away from the facility. PC #1 wrote that he went to the location Resident #129 was spotted and spoke with him. Resident #129 "advised that he was leaving a Christmas party and was headed home". The facility was phoned, and they completed a headcount and discovered Resident #129 was missing. PC #1 wrote that he took Resident #129 back to the facility. He indicated that he spoke with the nurse, Nurse #2, who was assigned to Resident #129 at that time (2nd shift from 7:00 PM to 7:00 AM) on 3/9/21. She informed PC #1 that she received a report on her assigned residents around 7:00 PM from the nurse who had worked the previous shift (3/9/21 7:00 AM to 7:00 PM) and she then began passing medications to residents on the 300 hall. She stated that around 7:20 PM she heard a facility door alarm going off during her medication pass. Nurse #2 indicated that Nurse #4 checked the main entrance/exit door of the facility when the

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alarm went off. PC #1 wrote that he then spoke with Nurse #4 who reported that she was in the copier room (near the main entrance of the facility) when the alarm went off and she stuck her head out of the copier room door and had not seen anything or anyone. She indicated the alarm went off for about 3 seconds and then shut off. Nurse #4 stated that she had not heard the front door open or close and had not seen anyone pass her to get to the front entrance/exit of the facility. PC #1 wrote that he spoke with the Administrator and he reported a staff member was assigned to be with Resident #129 at all times. PC #1 additionally wrote that he reported the incident to Adult Protective Services (APS).

During a phone interview with PC #1 on 4/6/21 at 11:00 AM he stated that a passerby noticed Resident #129 on a roadway adjacent to the facility in his wheelchair on the night of 3/9/21 and the passerby phoned 911 around 7:40 PM. He reported that he went to the location Resident #129 was spotted at and he observed him seated in his wheelchair on the roadway. He stated that Resident #129 told him he was just leaving a Christmas party and he lived in the area and was headed home. PC #1 indicated this was a windy 2 lane roadway with no shoulder (strip of pavement on the exterior the lanes) on each side, and no sidewalks. He further indicated that it was dark outside. PC #1 reported that he took Resident #129 him back to the facility arriving there at approximately 8:00 PM.

A typed statement dated 3/9/21 completed by the Administrator indicated he interviewed the Nursing Assistant (NA #2) assigned to Resident #129 at the time of his unsupervised exit from the facility on 3/9/21. The statement read, "[NA #2]

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stated that [Resident #129] was [sitting] in his wheelchair watching TV at 7:10pm [and] this was the last time she put eyes on [Resident #129] before incident. She stated she was doing [Activities of Daily Living] care on another resident around 7:20pm and she heard a wired alarm go off for around 5 seconds and it turned off. She did not come out of the room to check because the alarm went off so fast she thought it was pharmacy." The statement included no signature from NA #2.

A phone interview was conducted with NA #2 on 4/6/21 at 12:30 PM. NA #2 reported that she worked with Resident #129 for the first time during the second shift (7:00 PM to 7:00 AM) on 3/9/21. She confirmed she was assigned to him during the time of his unsupervised exit from the facility. NA #2 stated that on 3/9/21 at approximately 6:45 PM during a round she completed with NA #1, the NA who was completing her 7:00 AM to 7:00 PM shift on 3/9/21, she observed Resident #129 seated in his wheelchair in his room watching television. She revealed that she had not seen Resident #129 again until he was returned to the facility by the police around 8:00 PM. The typed statement dated 3/9/21 completed by the Administrator that indicated he interviewed NA #2 and she reported that she last saw Resident #129 at 7:10 PM was reviewed with NA #2. She revealed she had never seen this typed statement before, she had not reported this information to the Administrator, and that this was not accurate information. She explained that she spoke with the Administrator on 3/9/21 after the incident, but she had not said that she saw Resident #129 at 7:10 PM. NA #2 reiterated that she last saw Resident #129 at approximately 6:45 PM. She explained that the

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NA and nurse who were assigned to Resident #129 ' s hall were also assigned to part of the 300 hall. NA #2 reported that there were double doors that were kept closed that led into Resident #129 ' s hall from the 300 hall as Resident #129 resided on the quarantine unit. She stated that Resident #129 ' s hall was not visible from the 300 hall due to the double door closure. NA #2 reported that she recalled a facility door alarm going off sometime after 7:00 PM while she was providing care to a resident on the 300 hall and she revealed she had not responded to the alarm. She indicated that by the time she completed care the alarm had ceased sounding and she assumed it was a pharmacy staff member who entered one of the facility doors and manually shut the alarm off. NA #2 was asked if it was a normal occurrence for the pharmacy staff to come into the facility, set off the alarm, and then shut the alarm off. She indicated that this happened several times when she was working. NA #2 revealed that Resident #129 was dressed in a gown with pants, a shirt, and a jacket on over top of it when he was returned to the facility by the police. She indicated that he had independently dressed himself over top of the gown.

A typed statement dated 3/9/21 completed by the Administrator indicated he interviewed Nurse #4 working at the time of Resident #129 ' s unsupervised exit from the facility. The statement indicated that Nurse #4 was making copies in an office near the front door at the time the alarm sounded. Nurse #4 admitted to hearing the alarm but stated that it was "very short and very faint". She reported that she had not seen any residents coming up the 300 hall or toward the hall to the front entrance/exit door when she was making

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copies. Nurse #4 indicated that she had not visually observed Resident #129 on 3/9/21 until after he was returned to the facility by the police. This statement included no signature from Nurse #4.

A phone interview was attempted with Nurse #4 on 4/6/21 at 2:38 PM but she was unable to be reached.

An "Additional Nursing Admission Data" form completed by the CCC with an observation date of 3/2/21 at 2:39 PM and a completion date of 3/10/21 at 8:46 AM indicated Resident #129 had no wandering behaviors. Under the question that asked for specific information or interventions related to wandering behaviors the CCC wrote, "Not reported from hospital nurse".

A clinical observation form dated 3/10/21 completed by the Director of Nursing (DON) with an observation time of 8:00 AM and completion time of 3:51 PM indicated Resident #129 rested in bed all night and was up in his chair at the time of the observation. He was assessed with no distress or pain. The DON wrote that Resident #129 was able to recall leaving the facility last evening and he stated, "He didn ' t know why he did that".

A note dated 3/11/21 at 8:50 AM completed by Social Worker (SW) #1 indicated Resident #129 was to discharge home that afternoon with his Responsible Party (RP).

A Facility Reported Incident (FRI) with an investigation end date of 3/11/21 was completed by the DON and the Administrator for an allegation of neglect related to Resident #129 ' s

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unsupervised exit from the facility on 3/9/21. This investigation included a letter dated 3/15/21 completed by the Administrator which indicated that Resident #129 would not state how he got out of the facility. The investigation concluded through staff interviews that a door alarm went off for approximately 5 seconds when Resident #129 exited the facility unsupervised on 3/9/21. The door alarm required the activation of a "kill switch" that was accessed by removing the cover over the switch which manually shut the alarm off. The facility believed Resident #129 was watching and waiting for the shift to change so he could exit the facility by a door located on his hall that led to the outside. This required Resident #129 to remove the cover over the "kill switch" of the door, flip the switch to turn off the door alarm, prop the door open with his foot, flip the switch back on to reset the alarm, and then replace the cover prior to exiting the facility. The facility unsubstantiated the allegation of neglect stating that, "Resident did not present as an elopement risk during his stay [at the facility]". Included in this FRI was a plan of correction implemented by the facility that listed the following actions and monitoring:

Actions:

- The key code on all doors in the facility were changed by 9:45 PM on 3-9-21 by the Maintenance Director.
- Facility staff conducted a full census bed count on 3-9-21, all residents were accounted for.
- All staff were educated on the facility ' s Elopement Policy by 3-10-21 by the Administrator, Director of Nursing and/or Staff Development Coordinator
- All kill switches were rewired on 3-10-21 to alarm if anyone cuts them off and back on. The alarm would continue to alarm until someone

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entered the key code in to reset door.
- Elopement assessment was completed on 3-10-21 for Resident #129 and all residents previously identified as exit seekers.
- Resident #129 ' s information and picture was added to the elopement book. All other residents previously identified as exit seekers were in the elopement book.
- Elopement care plan was added on 3-9-21 for Resident #129

Monitoring:
- An audit tool was developed by the Quality Assurance and Performance Improvement (QAPI) team to monitor for and ensure that all door kill switches were fully functioning.
- The Maintenance Director would monitor all kill switches for function and alarm daily for two weeks and then weekly.
- Key codes would be changed monthly by the Maintenance Director

The above plan of correction had not addressed the failure to provide any form of supervision, because could not be seen from the quarantine hall (400 hall) to the 300 hall.

On 4/5/21 at 11:00 AM the 300 hall was observed to have closed double doors that separated this hall from the 400 hall, which was where Resident #129 had resided. There was no ability to see Resident #129 ' s hall from the 300 hall when the double doors were closed. The hall Resident #129 resided on was observed to have an exit door that led to the outside.

During an interview with the Administrator on 4/7/21 at 11:10 AM he reported that Resident #129 was alert and oriented to self with intermittent confusion. He stated that Resident

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#129 tended to be more oriented during the day with increasing confusion as the day progressed. The Administrator revealed that on the day of his admission Resident #129 stated that he had just come from a party, which was inaccurate as he was transferred to the facility from the hospital. He further revealed that he heard Resident #129 talking about his family on multiple occasions and self-propelling his wheelchair throughout the hallway he resided on. He stated that Resident #129 was very intelligent, and that staff had observed him "tinkering" with light switches located on his hall. He reported that the Activities staff provided him with puzzles and other items to keep him busy. The Administrator reported that he was unaware of any instances in which Resident #129 tried to exit the facility prior to 3/9/21 indicating that this was why the allegation of neglect was unsubstantiated by the facility. The facility ' s investigation of Resident #129 ' s 3/9/21 unsupervised exit from the facility that revealed the resident got out of the building through an exit door that led to the outside that was located on the hall he resided on was reviewed with the Administrator. He explained that based on the investigation, Resident #129 flipped the "kill switch" which was located near the exit door and that this switch turned off the door alarm. He confirmed the facility ' s plan of correction was focused on the functioning of this door alarm. He stated that all exit doors in the facility were rewired so that so that a numerical code had to be entered for the alarm to turn off. The Administrator was asked if any procedures were changed and/or if any education was provided to address the failure to provide any form of supervision, monitoring, and/or observation of Resident #129 and the other residents on the hall he resided on from 6:46 PM

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through 7:41 PM on 3/9/21. He revealed that no changes were made, and no education was completed related to this failure to provide supervision, monitoring, and/or observation of Resident #129 and the other residents on the hall he resided on. The Administrator confirmed the staff interviews that indicated the NA and nurse who were assigned to Resident #129 ' s hall were also assigned to the 300 hall. He additionally confirmed that the double doors between Resident #129 ' s hall and the 300 hall were kept closed which resulted in the inability to see the hall Resident #129 resided on from the 300 hall. The Administrator revealed that the facility initiated discharge for Resident #129 on 3/10/21 and he was discharged to the community on 3/11/21. The Administrator was asked why the facility discharged the resident and he stated that he was afraid Resident #129 would get out of the facility unsupervised again and that he had not had the ability to provide him 1:1 care for him indefinitely. He explained that the only way to ensure Resident #129 had not exited the building unsupervised again was to have someone with him at all times and that the facility was not able to staff someone for 1:1 care indefinitely.

The facility ' s exterior surroundings were observed with the Administrator on 4/7/21 at 12:30 PM and the area included a large pond on the left side of the facility (when facing the facility) and on the right, back, and front of the facility were wooded areas. The section of the road Resident #129 was found by PC #1 was a 2 lane windy road with no visible pavement markings separating the lanes, no shoulder, and no sidewalk. This road was bordered by a downward sloping grassy area on each side and

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the speed limit was 35 miles per hour. The distance to the location Resident #129 was found at by the police was measured with the Administrator and was found to be approximately 0.16 miles from the door he exited the facility from. The Administrator revealed that it was not safe for Resident #129 to be out of the facility unsupervised. On 3/9/21, the date of Resident #129 ' s unsupervised exit from the facility, the sunset was at 6:21 PM (https://sunrise-sunset.org) and the temperature at 7:53 PM was 60 degrees (www.wunderground.com) in the city Resident #129 was located in.

A phone interview was conducted with Nurse #1 on 4/6/21 at 8:47 AM. She indicated she worked with Resident #129 during his stay at the facility and that he was alert and oriented to self only. She reported that Resident # 129 self-propelled his wheelchair throughout the hall he resided on and on one occasion when she was working with him he went to the double doors that separated his hall from the 300 hall and opened them. She indicated she redirected him back to his hall as he was supposed to remain on that hall (400 hall) as it was the quarantine unit.

A phone interview with Nurse #3 on 4/6/21 at 10:21 AM confirmed Resident #129 was alert and oriented to self only. He self-propelled his wheelchair throughout his hall consistently during the day. Nurse #3 reported that on one occasion when she was working with Resident #129, he went to the exit door located on his hall and was pressing on that door which caused the alarm to go off. She indicated she was on the hall at that time and she was able to redirect him before he was able to open the door completely. She was

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asked if she reported this to the DON or Administrator and she stated she had not thought to report it because he had not gotten out.

A phone interview with NA #1 on 4/6/21 at 10:43 AM indicated that Resident #129 was able to self-propel his wheelchair up and down the hall he resided on. She indicated that one time when she was working with Resident #129 he opened the double doors that separated his hall from the 300 hall, and he was self-propelling his wheelchair down the 300 hall when she saw him and redirected him back to his hall. She reported that Resident #129 was alert but was oriented to self only. She explained that he was always talking about different things and she provided an example that one second, he was be talking about his family and the next second he was talking about a being on a farm.

During a phone interview on 4/6/21 at 3:55 PM with the DON she acknowledged that Resident #129 had wandering behaviors, but she had not considered these to be exit seeking behaviors. She explained that she thought he was just exploring his new environment and was curious. She reported that she was unaware he was observed pressing on the exit door located on his hallway by Nurse #3. She reported that she thought Resident #129 was alert and oriented explaining that on one occasion when she was providing him with wound care, he was telling her how to complete the wound care. She revealed that she had not known he was disorientation to place, time, and situation (as indicated by nursing documentation and staff interviews). The facility ' s investigation of Resident #129 ' s 3/9/21 unsupervised exit from the facility that revealed Resident #129 got out of the building through an

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exit door that led to the outside that was located on the hall he resided on was reviewed with the DON. She verified the investigation indicated that Resident #129 flipped the "kill switch" which was located near the exit door and that this switch turned off the door alarm. She confirmed the facility ' s plan of correction was focused on the functioning of this door alarm. She explained that all exit doors in the facility were rewired so that a numerical code had to be entered for the alarm to turn off. The DON was asked if any procedures were changed and/or if any education was provided to address the failure to provide any form of supervision, monitoring, and/or observation to Resident #129 and the other residents on the hall he resided on from 6:46 PM through 7:41 PM on 3/9/21. She indicated that no changes were made, and no education was completed related to this failure to provide supervision, monitoring, and/or observation of Resident #129 and the other residents on the hall he resided on. The DON confirmed the staff interviews that indicated the NA and nurse who were assigned to the hall Resident #129 resided on were also assigned to the 300 hall. She additionally confirmed that the double doors between Resident #129 ' s hall and the 300 hall were kept closed which resulted in the inability to see Resident #129 ' s hall from the 300 hall. The DON revealed that the nurse and NA assigned to those halls could have planned things out better so that one person started their shift working on the 300 hall and worked their way up and the other started their shift working on Resident #129 ' s hall and worked their way down. She acknowledged that it would have taken Resident #129 some time to put clothing on over top of his gown and to then disarm the "kill switch" and exit the facility.

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An interview was conducted with the facility ' s Medical Director on 4/8/21 at 10:45 AM. He stated that Resident #129 was cognitively impaired. He reported that he was able to answer questions that related to the present time, but if he was asked to go back and forth between the present and past he confabulated information. The Medical Director provided an example stating that when he saw Resident #129 after his unsupervised exit from the facility the resident said he was banging on the door to get back into the facility, but it was known that this was not true because the police brought him back. Resident #129 had not recalled the police bringing him back and he said he had not remembered how he got out. The Medical Director stated that Resident #129 was fixated on wanting to go home and that every time he spoke to the resident he talked about going home with his family. He indicated that based on this fixation of wanting to go home, his cognitive impairment, and his wandering behaviors he was at risk of an unsupervised exit from the facility. The Medical Director revealed that the facility had not provided the necessary supervision to Resident #129 on 3/9/21 when he exited the facility unsupervised. He stated that he was aware that the NA and nurse assigned to the hall Resident #129 resided on were also assigned to the 300 hall and that there was no visual line of sight from one hall to the other when the double doors between these halls were closed. He indicated that there needed to be some type of rotation with the nurse and the NA so that there was someone on both halls at regular intervals. He added that the residents on the hall Resident #129 had resided on were newly admitted residents and that the facility staff were just getting to know them which

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made the supervision and monitoring of these residents even more important.

The Administrator and DON were notified of the Immediate Jeopardy on 4/7/21 at 2:40 PM.

On 4/8/21 at 3:48 PM the facility provided the following credible allegation of Immediate Jeopardy removal:

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

Resident #129 was admitted to the facility on 3/2/2021 with diagnoses that included metabolic encephalopathy, dementia, depression, and insomnia. Resident #129 ' s baseline cognitive status was alert and oriented to self only with periods of disorientation to place, time, and situation. Resident #129 was able to propel throughout the unit, at times requiring redirection to his room. An elopement assessment was not conducted upon admission, per policy.

On the evening of 3/09/2021 at 7:41 PM, facility staff received a phone call from 911 dispatch that a resident from the facility was found on a street near the facility. Facility staff conducted a full census bed count immediately. All residents were accounted for except for Resident #129. Resident #129 was returned to the facility by Police at 8:01 PM. Upon return to the facility, Resident #129 was assisted to his room by Nurse #2. Nurse #2 performed a comprehensive assessment of Resident #129. Resident #129 did not have any observed injuries or other adverse findings.

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Resident was alert and oriented to person.

Resident #129 was immediately placed on 1:1 monitoring for the remainder of the shift, and then 15-minute monitoring checks to ensure resident safety. There were no additional attempts to exit the facility without supervision. The resident representative and physician were notified of the incident by facility nursing staff on 3/09/2021 at 10:48 PM by the administrator and hall nurse.

According to Nurse #2 and CNA #2, a 5 second alarm had sounded at 7:20 PM. Neither Nurse #2 nor CNA #2 checked to see if a resident had exited one of the doors. The resident was last observed at 6:45 PM by Nurse Aide # 2.

An Elopement assessment was completed on Resident #129 on 03/10/2021 by The Staff Development Coordinator (SDC), Director of Nursing (DON) and RN Supervisor. It was determined that Resident #129 was at continued risk for elopement. Resident #129 ' s picture and name was added to the elopement book. The elopement book contains enlarged photographs and names of residents at risk for elopement. This book is maintained at the nursing station and front desk at the facility. A "Resident experiences wandering" care plan was added on 3/09/2021 by the MDS Coordinator. This care plan included the following: Remove resident from other resident ' s rooms and unsafe situations; When resident begins to wander, provide comfort measures for basic needs (e.g. pain, hunger, toileting, to hot /cold, etc.); Provide care, activities, and a daily schedule that resembles the resident ' s prior lifestyle.

The Maintenance Director changed the codes on

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all doors in the facility on 3-9-21 at 9:45pm. At this time the investigation by the administrator was still ongoing and it was unclear if the resident had remembered the code to exit the facility. Later on that night it was found that this would have been impossible as the door would have continued to alarm if this had occurred. When the investigation was completed that night it was found that the resident had turned the door off with an emergency kill switch located at the door, which allowed the resident to get out of the door without the alarm staying on to alert staff. The maintenance director checked all emergency switches that night and found that only two doors would do this. One door was located on the 400 hall and the other was in the TV room. The door to the TV room was locked until our outside door company could come and correct the issue. The 400 hall door was being watched by the staff that was completing q15 watches on the resident.

On 3-10-21 at 10am an outside door company came to the facility and corrected both emergency kill switches. You can still turn the door magnet off to open the door but the alarm will continue to alarm until someone manually types in the code to the key pad to reset the door.

The resident is currently at a local hospital pending discharge to a facility with a locked unit. Facility Admission Coordinator has notified the hospital discharge planner that we will accept the Resident #129 back to our facility if the other local facility in the area with the locked unit is unable to take him. The facility Admission Coordinator notified the discharge planner to notify the guardian that we will take resident #129 back unless they don ' t want resident #129 to come back to facility at 3:25pm 4-8-21.

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PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

(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 689	Continued From page 70	F 689		

An audit was completed by the Administrator on 3-9-21. The Administrator reviewed all residents who are currently at risk for elopement to ensure that appropriate interventions are in place to prevent elopement and ensure resident safety. There were no additional residents identified as having been affected by the alleged deficient practice.

An audit was completed by the Minimum Data Set nurse 1 (MDS 1) on 4-7-21 of all residents to check for the following items, does the resident display behaviors that place them at risk for elopement, is a wander guard in place and has an order been written, is a photo in elopement risk book and is the elopement risk care plan in place. No new residents were identified at this time.

#2 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.

The key code on all doors in the facility was changed by 9:45pm on 03/09/2021 by the Maintenance Director.

All emergency kill switches are required switches that are located at every exit door that will disarm the magnet locks in case of emergency. The emergency kill switches were rewired on 03/10/2021 by Maintenance Director and a local security company to alarm if anyone cuts them off and back on. The alarm will continue to alarm until someone puts the key code in to reset door.

All staff will be inserviced by the SDC, DON and

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RN Supervisor on door alarm procedures and the requirement to go to the door that is alarming to ensure that no one has exited the facility; once a census check is completed and everyone is accounted for the staff can enter the door code in to reset the door, this will be completed by 4-8-21. All licensed nursing staff, medication aides, and certified nursing assistants were educated on the Peak Resources Elopement Policy by Administrator, Director of Nursing and/or Staff Development Coordinator. This was completed by 03/10/2021 All licensed staff and CNA will be educated by the SDC, DON and RN supervisor on the importance of supervising residents and ensuring that residents are safe while in the facility. This also includes checking on your residents during staff change and alternating care between the CNAs and Nurses on the hall for example have the CNA start her round on one end of the hall and have the nurse start her round on the other end of the hall, this will be completed by 4-8-21.. Any licensed nurse, medication aide and/or Certified Nursing Assistant out on leave or on PRN status will be educated prior to returning to duty by the Director of Nursing, Staff Development Coordinator, and/or the Nursing Supervisor. The Director of Nursing, Staff Development Coordinator and the Nurse Supervisor were advised of this responsibility on 04/08/2021. The Director of Nursing will be responsible for tracking staff that have not received the education. Any newly hired licensed nurse will be educated during orientation by the Staff Development Coordinator.

The Administrator educated the Maintenance Director that all door kill switches must be fully functional at all times. This education included that the Maintenance Director will monitor all kill

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F 689	Continued From page 72	F 689		

switches for function and alarm daily for two weeks and then weekly. In addition, the Maintenance Director will change the key codes monthly. This education was completed on 3-9-21.

To help create more supervision on the 400 hall, the door of the 400 hall will be kept open where the 400 hall exit door is visible from the 300 hall. If there is a covid positive resident that is being housed on the 400 hall the doors will be closed and a CNA will be assigned to that hall at all times. The 400 hall has as sign located on it to keep the door open unless a covid positive resident is being housed in the isolation unit. The 400 hall door was open on 4-8-21 at 2:30pm. All staff will be educated on the procedures of the 400 hall door by 4-8-21. The DON will be responsible to ensuring the door stays open and if it has to be closed that it only stay closed for the quarantine period that is necessary for the COVID resident to be clear. If the door must be closed it will be notified to all staff by the SDC when the COVID positive notice is posted.

TITLE OF THE PERSON RESPONSIBLE FOR IMPLEMENTING THE CREDIBLE ALLEGATION FOR IMMEDIATE JEOPARDY REMOVAL.
The Administrator and the Director of Nursing will be ultimately responsible to ensure the implementation of credible allegation to remove this alleged immediate jeopardy.

Immediate Jeopardy Removal Date: 4-8-21

The facility alleges the removal of Immediate Jeopardy on 4/8/21.

On 4/8/21 the credible allegation of Immediate

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Jeopardy removal was validated by onsite verification. Record review verified a care plan related to wandering was added for Resident #129 on 3/9/21, an elopement assessment was completed on 3/10/21, and he was also added to the facility ' s elopement book. Record review also verified all residents identified as at risk for elopement had elopement risk assessments completed, had care plans related to the risk for elopement, were in the facility ' s elopement book, and had a wander guard in place as ordered by the physician. An interview with the Maintenance Director confirmed the numerical codes to all doors were changed on 3/9/21 and the emergency "kill switches" were rewired on 3/10/21 and now required a numerical code to turn off the alarm. The Maintenance Director also confirmed he was educated by the Administrator on 3/9/21 that all door "kill switches" must be fully functional at all times and that he was responsible for monitoring these switches for function and alarm daily for two weeks and then weekly. In addition, the Maintenance Director stated that he was changing the numerical key codes monthly. An observation was completed on 4/8/21 verifying: 1) The kill switches were rewired and now required a numerical code to turn off the alarms and 2) The double doors separating the 300 hall from the 400 hall were open. A review of hospital records dated 4/7/21 indicated Resident #129 was accepted at a local facility with a locked unit and discharge planning was in process. An interview with the Administrator on 4/8/21 verified this facility would accept Resident #129 back if the placement arranged by the local hospital was not successful and/or if Resident #129 ' s guardian wished for him to return to this facility. This interview with the Administrator also verified an audit was completed by himself on 3/9/21 of

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F 689	Continued From page 74	F 689		

all residents who were at risk for elopement to confirm appropriate interventions were in place to prevent elopement and ensure resident safety and an additional audit was completed by the MDS Nurse on 4/7/21 of all residents to check for the following items: did the resident display behaviors that placed them at risk for elopement, was a wander guard in place and had an order been written, was a photo in the elopement risk book, and was the elopement risk care plan in place. A review of inservices and inservice sign in sheets as well as staff interviews with various disciplines (Nurses, NAs, SW, Business Office Manager, Admissions Coordinator, etc.) verified education was provided for the required participants on the following: 1) Door alarm procedures and the requirement to go to the door that was alarming to ensure that no resident had exited the facility and that a census check must be completed and all residents accounted for before the staff were permitted to enter the numerical door code to reset the door ceasing the alarm; 2) The Elopement Policy; 3) The importance of supervising residents and ensuring that residents were safe while in the facility (to include checking on your assigned residents during staff change and alternating care between the CNAs and Nurses on the hall); 4) The door to the 400 hall was to be kept open if the facility had no COVID positive residents allowing for the exit door on that hall to be visible; and 5) If a COVID positive resident resided on the 400 hall the double doors were to be kept closed and an NA would be assigned to that hall at all times. Any staff not inserviced by 4/8/21 were required to be educated prior to working on the floor.

The facility ' s IJ removal date of 4/8/21 was validated.

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F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, observation, Physician and staff interview, the facility failed to discontinue Lovenox (an anticoagulant drug) per the hospital discharge summary instruction for 1 of 6 sampled residents observed during the medication pass (Resident #130). Resident #130 received the medication for 11 days beyond the hospital discharge's intended stop date. Findings included: The hospital discharge summary dated 2/19/21 revealed that Resident #130 was admitted to the	F 757	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F757 Resident affected Resident #130's Lovenox was	4/21/21

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F 757	Continued From page 76 hospital due to right femur fracture and she underwent reconstruction of the right femur. The hospital records revealed that due to her immobility and high risk for deep vein thrombosis (DVT) a low dose of Lovenox and Aspirin were added for 30 days. Resident #130 was admitted to Nursing Facility X on 2/19/21. The February 2021 Medication Administration Record (MAR) from Nursing Facility X revealed Resident #130 had received Lovenox for 7 days. Resident #130 was transferred to the current facility on 3/3/21. Resident #130 was admitted to the facility on 3/3/21 with multiple diagnoses including right femur fracture. The admission Minimum Data Set (MDS) assessment dated 3/6/21 indicated that Resident #130 had moderate cognitive impairment and had received Lovenox for 3 days during the assessment period. Resident #130 had a doctor's order dated 3/3/21 for Lovenox 30 milligrams (mgs.) subcutaneous (SQ) once a day. The order did not have a stop date. Resident #130's doctor's progress notes dated 3/12/21, 3/15/21 and 3/18/21 revealed that low dose of Lovenox and Aspirin were added for 30 days post hospital discharge for DVT prophylaxis due to history of high risk of possible venous thrombosis. Resident #130 was observed to receive Lovenox 30 mgs SQ to right upper quadrant on 4/7/21 at 8:25 AM medication pass. The Lovenox was administered by Nurse # 7.	F 757	discontinued on 4-7-21. Resident #130 did not suffer any adverse effect from the alleged deficient practice. Resident with the potential to be affected An audit was completed by the Director of Nursing (DON), RN Nurse Supervisor, Minimum Data Set (MDS) Nurse #1 and MDS Nurse #2, Treatment Nurse and Staff Development Coordinator for all residents with orders for anticoagulants on 4-21-21. This audit compared the Discharge Summary to the order transcribed into the electronic medication administration record to ensure that the order was transcribed accurately, per physicians' order. All orders were transcribed accurately. No other resident suffered any adverse effect from the alleged deficient practice. Systemic Changes Current policies were reviewed by the Director of Nursing and Administrator regarding the transcription of medication to the Electronic Medication Administration Record (EMAR) on 4-21-21. No changes were made to current policies. All licensed nursing staff were educated by the Staff Development Coordinator on 4-21-21. This education included the following items: •When a person admits to the facility, the admission orders must be transcribed to the electronic medication administration record.	

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F 757	Continued From page 77 Resident #130's Medication Administration Records (MARs) were reviewed. The March 2021 and April 2021 MARs revealed that Resident #130 had received Lovenox for 34 days at the facility (3/4 through 3/30/21 and 4/1 through 4/7/21). Nurse #7 was interviewed on 4/7/21 at 10:34 AM. She stated that the MAR did not have a stop date for the Lovenox. Nurse #7 stated that whoever did the admission orders should have asked for the stop date or read the hospital discharge summary. MDS Nurse #2 was interviewed on 4/7/21 at 10:49 AM. She stated that at times she helped with the admissions and on 3/3/21, she admitted Resident #130. She reported that she transcribed the medications from the FL2 (a North Carolina (NC) form with resident care information including medications). The MDS Nurse verified that she had transcribed an order for Lovenox without a stop date. She acknowledged that she did not read the hospital discharge summary and she did not ask for the stop date from the doctor. The Physician was interviewed on 4/8/21 at 10:53 AM. The Physician expected the nursing staff to follow through with the orders from the hospital and the Lovenox should have been discontinued after 30 days of hospitalization. The Director of Nursing (DON) was interviewed on 4/8/21 at 2:43 PM. The DON stated that she expected the admission nurse to read the hospital discharge summary when admitting a resident and to ensure order for Lovenox have a stop date.	F 757	•The transcription of the admission orders to the EMAR is verified by another licensed nurse for accuracy. •Medication orders for Lovenox therapy must have an end date per the physician order. •If there is no end date for Lovenox, you must call the MD and obtain one. Any licensed nursing staff out on leave or on PRN status will be educated by the Staff Development Coordinator prior to returning to their assignment. Newly hired licensed nursing staff will be educated during orientation by the Staff Development Coordinator. Monitoring: An audit tool was developed to monitor the following: •Were the admission orders transcribed to the electronic medication administration accurately? •Is the resident on Lovenox? •Is there a stop date for the Lovenox? The DON and RN Supervisor will audit 25% of all residents' admission orders and compare to the discharge summary to ensure orders have been transcribed accurately starting on 4-12-21. This audit will be completed weekly for four weeks, then monthly for 2 months. The results of these audits will determine the need for further monitoring. QAPI: All audit information will be brought to the QAPI meeting monthly by the DON to be	

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F 757	Continued From page 78	F 757	analyzed and reviewed by the QAPI Committee.	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		4/26/21

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F 758	Continued From page 79 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interviews with the Medical Director, Nurse Practitioner, and staff, the facility failed to have an adequate clinical indication for the use of an antipsychotic medication for 1 of 5 residents (Resident #72) reviewed for unnecessary medications. The findings included: Resident #72 was admitted to the facility on 12/23/19 with diagnoses that included dementia without behavioral disturbance. A physician ' s order dated 12/23/19 indicated Seroquel 12.5 milligrams (mg) once daily (9:00 AM) for Resident #72. A physician ' s order dated 12/23/19 read for staff to: Specific Behaviors: Select the letter code that best describes the observed event(s) three times daily. A-Attempts to exit facility unsupervised,	F 758	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F758 Affected resident Resident # 72 Seroquel was discontinued on 4-19-21. The resident did not suffer any adverse effects from the alleged deficient practice. Residents with the potential to be affected An audit was completed by the Director of Nursing (DON), RN Supervisor, Minimum data set (MDS) nurses #1 and #2, the Treatment Nurse and the Staff Development Coordinator (SDC) on	

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F 758	Continued From page 80 B-Inappropriate wandering in facility, C-Yelling & Screaming D-Clear threats of violence towards others and/or staff, E-Swings at others/staff, F-Picks & Scratches, G-Pinching, H-Pulling Hair, I-Throws objects, J-Self-inflicted injuries, K-Running into others, L-Biting, M-Hitting, N-Kicking, O-Attacks with object as weapon, P-Hallucination (visual), Q-Hallucination (auditory), R-Delusions, S-Paranoia, T-Disrobing, U-Sexual aggression, V-Playing in feces, W-Anxiousness, X-Agitation without harm to self or others Y- (Specify), Z- (Specify) The admission Minimum Data Set (MDS) assessment dated 12/26/19 indicated Resident #72 ' s cognition was severely impaired. She had no signs or symptoms of psychosis, no behaviors, and no rejection of care. Resident #72 ' s active diagnoses had not included any psychiatric or mood disorders. She received routine antipsychotic medication on 3 of 3 days during the MDS review period (12/23/19 - 12/26/19). A Nurse Practitioner (NP) note dated 12/27/19 indicated Resident #72 was pleasant and engaging. She was noted with underlying dementia with no behavioral issues. The diagnosis and assessment section of this NP note indicated Resident #72 ' s diagnoses included dementia without behavioral disturbance and she had no acute behavioral issues. She was on Seroquel 12.5 mg daily and the goal was to wean and discontinue the Seroquel if no behaviors arose. The NP wrote that there was anticipation of gradual decline in function and cognition with the natural progression of the disease process.	F 758	4-15-21 on all residents in the facility that have scheduled antipsychotic medication orders for the following: •Appropriate clinical indication for the antipsychotic medication. •Gradual Dose Reductions have been attempted for all residents on scheduled Antipsychotic medication; and if the GDR failed, that there is documentation regarding the clinical reasoning for the GDR failure. There were no additional residents identified during this audit that were adversely affected by the alleged deficient practice. Systemic Changes All licensed nursing staff have been educated on 4-26-21 by the Staff Development Coordinator on the following items. 1 Any resident who is ordered an antipsychotic medication must have an appropriate clinical indication for the medication 2.Any behaviors that a resident exhibits must be documented in the chart 3.The residents must be free of unnecessary psychotropic medications 4.If there are no clinical indication for the antipsychotic medication, the MD must be notified 5.Gradual Dose Reductions have been attempted for all residents on scheduled Antipsychotic medication; and if the GDR failed, that there is documentation regarding the clinical reasoning for the GDR failure.	

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F 758	Continued From page 81 An NP note dated 1/10/20 indicated Resident #72 had no acute behavioral issues. Her current medication regimen included Seroquel 12.5 mg daily related to dementia without behavioral disturbance and this would be considered for discontinuation in the future. An NP note dated 1/14/20 indicated Resident #72 had no acute behavioral issues. A trial discontinuation of Seroquel 12.5 mg once daily was to be conducted. A physician ' s order dated 1/14/20 indicated a discontinuation of the 12/23/19 order for Seroquel 12.5 mg once daily for Resident #72. A nursing note dated 1/14/20 indicated the NP provided a new order to discontinue Seroquel and monitor for behaviors. Resident #72 ' s Responsible Party (RP) was made aware of the change. A nursing managed care note completed 1/15/20 by Nurse #2 indicated Resident #72 was alert, verbal, and oriented to self only. She was pleasantly confused and was cooperative with care. She was noted to require frequent monitoring related to poor safety awareness and frequently transferring self from bed to wheelchair. Resident #72 self-propelled wheelchair in hallway trying to turn off the lights and "lock up" which required redirection. A nursing managed care note completed 1/15/20 by Nurse #8 indicated Resident #72 had confusion per baseline. She was easily redirected with fostered support and encouragement. Resident #72 required frequent monitoring due to	F 758	Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the Staff Development Coordinator. Any newly hired licensed nursing staff will be educated by the SDC during orientation. Monitoring The Interdisciplinary Team, consisting of the Treatment Nurse, RN supervisor, MDS nurses, SDC, DON, Administrator, Social Worker and Therapy manager will meet daily Monday thru Friday and review all new orders for antipsychotic medications. During this meeting this team will ensure that there are documented clinical indications for the antipsychotic medication. The DON and RN Supervisor will audit 25% of all residents receiving scheduled antipsychotic medication for the following items weekly for four weeks, then monthly for 2 months, audit will begin on 4-12-21. The results of these audits will determine the need for further monitoring. 1.Is there a proper clinical indication for medication? 2.Is there documented evidence of a GDR trial? 3.Is there documentation regarding the clinical reasoning for the failure of the GDR trial? All audit information will be brought to the QAPI meeting monthly by DON to be analyzed and reviewed by the QAPI Committee.	

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poor safety awareness and frequent attempts to transfer self.

A nursing managed care note completed 1/16/20 by Nurse #3 indicated Resident #72 was up this shift with staff supervision.

A physician ' s note dated 1/16/20 indicated Resident #72 was cooperative, in no acute distress, and her mental status was at baseline. She was seen self-propelling in her wheelchair.

A nursing managed care note completed 1/17/20 by Nurse #5 indicated Seroquel was discussed with Resident #72 ' s family and the NP.

A hard copy nursing communication to physician form dated 1/17/20 (no time noted) completed by Nurse #2 read, "[Responsible Party] states she would like for [Resident #72] to have order for Seroquel back related to agitation/behaviors.

An NP note dated 1/17/20 indicated Resident #72 recently had a GDR of Seroquel discontinuing the medication on 1/14/20. She indicated that since that time the resident was noted to have more agitation, more anxiety, and more resistance to care. She reported that this was demonstrated with the staff as well as with her family. The NP wrote, "Family has requested that the Seroquel be restarted ...this is a documented failure of attempted GDR". The note revealed that Resident #72 was cooperative, in no acute distress, was presently up in wheelchair, had been participating in activities, had no behaviors, and was pleasant with dementia at baseline. The NP indicated that Resident #72 had a diagnosis of Alzheimer ' s disease with "no acute behaviors noted at the time of the examination although

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family and staff report increased behaviors over the past 2 days". The NP also indicated that Resident #72 had a diagnosis of dementia without behavioral disturbance and that for the past few days there had been an increase in her behaviors with agitation requiring redirection. The NP wrote that the change in behavioral onset was with the discontinuation of Seroquel and the plan was to restart Seroquel 12.5 mg and a GDR failure was noted with discontinuation of Seroquel.

A nursing note dated 1/17/20 at 4:12 PM indicated the NP was made aware of Resident #72 ' s family ' s request to restart Seroquel. A new order to start Seroquel 12.5 mg was received. The RP was made aware and they reported that Resident #72 had verbal behaviors directed toward them.

A physician ' s order dated 1/17/20 entered at 4:17 PM indicated Seroquel 12.5 mg once daily for Resident #72.

The January 2020 Medication Administration Record (MAR) indicated Resident #72 was administered Seroquel 12.5 mg once daily in the morning from 1/1/20 through 1/14/20. This Seroquel was discontinued on 1/14/20 (after the morning dose was administered) and was not received by Resident #72 on 1/15/20, 1/16/20, 1/17/20. The Seroquel 12.5 mg once daily was reinitiated in the afternoon on 1/17/20 and was administered 1/18/20 through 1/31/20. A review of the nursing behavioral documentation on the MAR for January 2020 indicated staff documented behaviors by a letter code (as noted in the 12/23/19 physician ' s order) and if there were no behaviors the nurse documented "none"

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or "0". This was completed once per shift for a total of 3 documentations per day (4:45 AM - 6:45 AM, 12:45 PM - 2:45 PM, 8:45 PM - 10:45 PM). The behavioral documentation revealed the following information for Resident #72:

1/1/20 - 1/14/20 (Seroquel administered once daily in the morning)
- Anxiousness: 1/3/20 (8:45 PM - 10:45 PM), 1/6/20 (8:45 PM - 10:45 PM), 1/9/20 (8:45 PM - 10:45 PM), 1/14/20 (8:45 PM - 10:45 PM)
- Inappropriate wandering in facility: 1/6/20 (8:45 PM - 10:45 PM)
- Agitation without harm to self or others: 1/13/20 (4:45 AM - 6:45 AM)
- No behaviors: all remaining dates and shifts (37 out of 42 total documentations)

1/15/20 - 1/17/20 (Seroquel not administered due to GDR discontinuation)
- Attempts to ambulate self: 1/15/20 (8:45 PM - 10:45 PM)
- No behaviors: all remaining dates and shifts (8 out of 9 total documentations)

1/18/20 - 1/31/20
- Anxiousness 1/20/20 (8:45 PM - 10:45 PM), 1/23/20 (8:45 PM - 10:45 PM), 1/31/20 (8:45 PM - 10:45 PM)
- Inappropriate wandering in facility: 1/19/20 (8:45 PM - 10:45 PM), 1/26/20 (4:45 AM - 6:45 AM)
- No behaviors: all remaining dates and shifts (37 out of 40 total documentations)

The above nursing behavioral documentation revealed no anxiety, agitation, or resistance to care to correspond with the 1/17/20 NP note that indicated Resident #72 ' s Seroquel was reinitiated as a result of these behaviors resulting in a failed GDR.

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A review of the nursing notes, managed care notes, and MAR documentation from the 3 day period when Seroquel was discontinued in January 2020 (1/15/20, 1/16/20, and 1/17/20) indicated the staff who worked with Resident #72 included Nurse #2, Nurse #8, Nurse #3, and Nurse #5. Interviews were conducted/attempted with these nurses and revealed the following:

- A phone interview was attempted with Nurse #2 on 4/8/21 at 11:39 AM, but she was unable to be reached. Nurse #2 documented the hard copy nursing communication to physician form dated 1/17/20 indicating Resident #72 ' s RP wanted Seroquel to be reinitiated related to "agitation/behaviors".

- A phone interview was attempted with Nurse #8 on 4/8/21 at 11:40 AM, but she was unable to be reached.

- A phone interview was conducted with Nurse #3 on 4/8/21 at 11:45 AM. She was unable to recall the 1/14/20 - 1/17/20 discontinuation of Seroquel for Resident #72, but stated that if she was having behaviors of agitation, anxiety, and/or resistance to care she would ' ve documented this on the behavioral section of the MAR.

- An interview was conducted with Nurse #5 on 4/8/21 at 11:48 AM. She was unable to recall the 1/14/20 - 1/17/20 discontinuation of Seroquel for Resident #72, but stated that if she was having behaviors of agitation, anxiety, and/or resistance to care she would ' ve documented this on the behavioral section of the MAR.

A NP note dated 7/9/20 indicated Resident #72 was cooperative, in no acute distress, had no

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acute behavioral issues, and was at her baseline dementia mental status. The NP wrote that a previous attempt to reduce Seroquel led to increased agitation and behaviors subsequently failing the GDR.

A physician note dated 8/25/20 indicated Resident #72 was cooperative, in no acute distress, had no acute behavioral issues, and was at her baseline dementia mental status.

A physician note dated 9/1/20 indicated Resident #72 was pleasant and stable with dementia. She had no acute behavioral issues, no acute distress, and she was cooperative.

A physician ' s note dated 10/23/20 indicated Resident #72 was pleasant, cooperative, and at baseline mental status with dementia. She was noted with no behavioral issues.

A physician ' s note dated 12/14/20 indicated Resident #72 was cooperative and pleasant with no behavioral issues.

An NP note dated 2/4/21 indicated Resident #72 had no acute behavioral issues, she was cooperative, and in no acute distress. She was noted to be able to self-propel her wheelchair in the hallways and she reported she was "getting exercise". The NP wrote that she had no behavioral issues and readily engaged appropriately to conversation. In the diagnosis and assessment section of the NPs note she wrote that Resident #72 previously failed a GDR of Seroquel (January 2020).

A pharmacy monthly Medication Regimen Review (MRR) dated 2/6/21 completed by the Pharmacy

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Consultant indicated that Resident #72 had been on Seroquel 12.5 mg since January 2020. He wrote that there was no recent psychiatric follow up and no target behaviors for Seroquel treatment. The Pharmacy Consultant communication to nursing form related to this MRR for Resident #72 read, "The resident is on Seroquel 12.5 [mg once daily in the morning] for dementia. No recent [psychiatric] follow-up available. Please clarify target behaviors for Seroquel therapy". Handwritten on this form (with no date or signature) was "Target behavior [every] shift".

A physician ' s order dated 2/24/21 for Resident # 72 read, "Target Behavior: decreased outburst/irrational behavior. At the end of each shift mark Frequency-how often behavior occurred & Intensity-how resident responded to redirection. Intensity Code: 0=Did Not Occur; 1=Easily Altered; 2=Difficult to Redirect". This was to be completed twice per day and documented on the MAR.

The quarterly Minimum Data Set (MDS) assessment dated 2/26/21 indicated Resident #72 ' s cognition was severely impaired. She had no signs or symptoms of psychosis, no behaviors, and no rejection of care. Resident #72 ' s active diagnoses had not included any psychiatric or mood disorders. She received routine antipsychotic medication on 7 of 7 days. The MDS indicated Resident #72 had a GDR of the antipsychotic last conducted on 1/14/20 and the physician documented that a GDR was clinically contraindicated on 7/9/20.

A pharmacy monthly Medication Regimen Review

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(MRR) dated 3/5/21 completed by the Pharmacy Consultant for Resident #72 indicated the facility needed to readdress target behaviors for Seroquel prescribed for dementia. The Pharmacy Consultant communication to nursing form related to the MRR for Resident #72 read, "The resident is on Seroquel 12.5 [once daily in the morning] for dementia. No recent [psychiatric] follow-up available. Please clarify target behaviors for Seroquel therapy. MDS 2/26 showed no behaviors. [Centers for Medicare & Medicaid Services] requires behaviors with diagnoses of dementia to support antipsychotic therapy.

A review of the nursing behavioral documentation on the MAR from January 2021 through 4/5/21 indicated staff continued to document behaviors by a letter code (as noted in the 12/23/19 physician ' s order) and if there were no behaviors the nurse documented "none" or "0". This was completed once per shift for a total of 3 documentations per day (4:45 AM - 6:45 AM, 12:45 PM - 2:45 PM, 8:45 PM - 10:45 PM). The behavioral documentation revealed the following information for Resident #72:

January 2021
- Inappropriate wandering in the facility: 1/3/21, 1/12/21, 1/16/21 (all 12:45 PM to 2:45 PM)
- Anxiousness: 1/7/21 (8:45 PM - 10:45 PM)
- No behaviors: all remaining dates and shifts (89 of 93 total documentations)

February 2021
- Inappropriate wandering in facility: 2/4/21, 2/8/21, 2/22/21, 2/27/21, 2/28/21 (all 12:45 PM to 2:45 PM)
- No behaviors: all remaining dates and shifts (79

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F 758	Continued From page 89 out of 84 total documentations) March 2021 - Inappropriate wandering in facility: 3/4/21 (12:45 PM - 2:45 PM) - No behaviors: all remaining dates and shifts (92 out of 93 total documentations) 4/1/21 - 4/5/21 - No behaviors: all dates and shifts (15 out of 15 total documentations) A review of the nursing target behavior (decreased outburst/irrational behavior) documentation on the MAR from 2/24/21 through 4/5/21 revealed no episodes of outbursts or irrational behaviors for Resident #72. Resident #72 ' s active care plan was reviewed on 4/5/21. This included the problem area of the risk for adverse side consequence related to receiving antipsychotic medication for treatment of Alzheimer's dementia. This area was initiated on 1/31/20 and last reviewed on 3/15/21. The interventions included, in part: - Assess if the resident ' s behavioral symptoms present a danger to the resident and or others. Intervene as needed. - Assess/record effectiveness of drug treatment. - Attempt a gradual dose reduction if not contraindicated. - Monitor resident ' s behavior and response to medication. - Review for continued need at least quarterly. - Try non-pharmacological interventions before initiated drug therapy. The active care plan had not included any areas related to specific behaviors, anxiety, agitation, or resistance to care. It also has not mentioned behaviors of outbursts/irrational behaviors.	F 758		

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A review of Resident #72 ' s medical from admission (12/23/19) through 4/5/21 revealed she had not been seen by a psychiatric provider during her stay at the facility.

On 4/5/21 at 1:30 PM Resident #72 observed in room with no behavioral issues noted. She was alert and oriented to self, pleasantly confused, and was able to respond to simple questions.

During an interview with Nurse #5 on 4/8/21 at 11:48 AM she reported that she was familiar with Resident #72 and that she had no behavioral issues other than wandering into other resident rooms on occasion.

A phone interview was conducted with the Pharmacy Consultant on 4/8/21 at 1:20 PM. He stated that he began working with this facility in February 2021. The monthly MRRs and communication to nursing forms for Resident #72 from February 2021 and March 2021 were reviewed. He stated that February 2021 was his first review of Resident #72 and he identified that there were no target behaviors specified for the use of Seroquel therapy prescribed for dementia. He reported that during his March 2021 MRR he saw that the facility initiated a target behavior of "decreased outburst/irrational behavior" in response to his February 2021 recommendation. The Pharmacy Consultant revealed that this was not an appropriate target behavior for the use of an antipsychotic (Seroquel) prescribed for dementia. He indicated that this was why he repeated the recommendation in March. He stated that he just completed his April 2021 review this week and he again repeated the recommendation for need of an appropriate

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target behavior for the use of Seroquel therapy for dementia and that if a target behavior that met CMS standards was unable to be identified that he would recommend a GDR during his May 2021 review. The Pharmacy Consultant spoke about examples of behavioral symptoms that would require the use of antipsychotic therapy for the treatment of dementia. He explained that these behavioral symptoms were difficult to define, but that the main concept was that the behaviors needed to cause an imminent danger to the resident and/or frightful and acute distress for the resident.

During an interview with the NP on 4/8/21 at 11:20 AM the 1/17/20 NP note that indicated Resident #72 failed a GDR of Seroquel was reviewed. She stated that staff wrote notes for her and the Medical Director on the hard copy communication to physician forms and that was what precipitated a PRN (as needed) visit such as with this 1/17/20 visit. She was unable to recall the specifics about the behaviors that were reported for Resident #72 and the resulting GDR failure in January 2020. The 1/17/20 nursing note that indicated the NP was made aware of Resident #72 ' s family ' s request to restart Seroquel was reviewed. The NP was asked if a family request to restart an antipsychotic medication was a sufficient reason to reinitiate antipsychotic therapy. She stated that all she could say was that she went by the communication forms and what was reported to her by staff and that her 1/17/20 note said that the behaviors of anxiety, agitation, and resistance to care were demonstrated with the staff and family. The NP revealed that a GDR had not been reattempted because the January 2020 GDR was

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considered a failure. She was asked what the target behaviors were for Resident #72 that required the use of Seroquel. The NP indicated that based on her 1/17/20 note they were anxiety, agitation, and resistance to care. She was asked why Resident #72 had not been referred to psychiatric services and she indicated this was because Resident #72 had no further behavioral issues since the Seroquel was reinitiated on 1/17/20.

An interview was conducted with the Medical Director on 4/8/21 at 10:45 AM. The 1/17/20 nursing note that indicated the NP was made aware of Resident #72 ' s family ' s request to restart Seroquel was reviewed with the Medical Director. The 1/17/20 NP note that indicated Resident #72 failed a GDR of Seroquel based on an increase in agitation, anxiety, and resistance to care as demonstrated with the staff as well as with her family was reviewed with Medical Director. The nursing behavioral documentation that revealed no indication of anxiety, agitation, and/or resistance to care during the time period when Seroquel was discontinued (1/15/20 - 1/17/20) were reviewed with the Medical Director. The target behavior of decreased outbursts/irrational behaviors were reviewed with the Medical Director. He revealed that family request was not an adequate reason to reinitiate antipsychotic therapy and that outbursts and irrational behaviors were not an adequate target behavioral symptom for the use of antipsychotic therapy. He stated that the use of antipsychotic therapy needed to be based on a clinical assessment. The Medical Director reported that examples of target behavioral symptoms for the use of antipsychotic therapy for the treatment of dementia would be delusions, hallucinations, or

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F 758	Continued From page 93 other behavioral symptoms that caused the resident acute/frightful distress. He revealed that based on this information the use of Seroquel for Resident #72 needed to be revisited and re-evaluated for the possibility of a GDR attempt. During an interview with the Director of Nursing (DON) on 4/8/21 at 2:40 PM she stated that she expected a clinical indication to be identified to justify the use of an antipsychotic medication.	F 758		
F 761 SS=D	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.	F 761		4/12/21

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	345429	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEAK RESOURCES - PINELAKE	801 PINEHURST AVENUE CARTHAGE, NC 28327

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F 761	Continued From page 94 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to date multi dose medication when opened and failed to discard expired medications in 3 of 3 medication carts observed (100, 200 and upper 300 hall medication carts). Findings included: The manufacturer's instruction written on the box of the Breo Ellipta (used to treat chronic obstruction pulmonary disease) read, "discard 6 weeks after opening the moisture protective foil tray or when the counter reads "0", whichever comes first." 1. The upper 300 hall medication cart was observed on 4/7/21 at 3:40 PM. The following were observed: 1 bottle of Simethicone (used to relieve symptoms of extra gas in the gastrointestinal tract) 80 milligrams (mgs.) tablet with an expiration date of 3/21 1 bottle of Multivitamin with iron tablet with an expiration date of 3/21 1 Breo Ellipta inhaler that was opened and undated. The counter of the inhaler read "4". Nurse #6 was interviewed on 4/7/21 at 3:50 PM. She stated that nurses were responsible for checking the medication carts for expired and undated medications. Nurse #6 reported that she had checked the upper 300 hall medication cart this morning and she might have missed the expired Simethicone and Multivitamin and the undated Breo Ellipta inhaler.	F 761	Filing of this plan of correction does not constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F761 Affected Resident The expired Simethicone and Multivitamin bottles and the undated Breo Elipta inhaler from 300 Hall medication cart was removed and discarded on 4/7/21 by the Director of Nursing. The two undated Breo Elipta inhalers from 200 hall medication cart were removed and discarded on 4/7/21 by the Director of Nursing. The undated Prostat bottle from the 100 hall medication cart was removed and discarded on 4/7/21 by the Director of Nursing. There were no adverse effects to any resident from the alleged deficient practice. Residents with potential to be affected An audit was completed by the Director of nursing (DON), RN Nurse Supervisor, Minimum Data Set (MDS) nurses #1 and #2, the Treatment Nurse and the Staff Development Coordinator on 4-9-21 on all medication carts in the facility. No other expired and/or opened, undated medications were found. No other	

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F 761	Continued From page 95 The Director of Nursing (DON) was interviewed on 4/8/21 at 2:46 PM. The DON stated that she expected the nurses to check the medication carts weekly and the pharmacist to check monthly for expired and undated medications. The DON indicated that she expected the facility's policy on medication storage and the manufacturer's instruction to be followed with regards to the expiration/discard dates of the medications. 2. The 200-hall medication cart was observed on 4/7/21 at 3:20 PM. There were 2 Breo Ellipta inhalers observed that were opened and undated. One of the inhalers, the counter read "4" and the other inhaler, the counter read "9". Nurse #3 was interviewed on 4/7/21 at 3:25 PM. She stated that she didn't know if the Breo Ellipta inhalers needed to be dated when opened. Nurse #3 added that she had not been writing the date when she opened the moisture protective foil tray of the Breo Ellipta inhaler. The Director of Nursing (DON) was interviewed on 4/8/21 at 2:46 PM. The DON stated that she expected the nurses to check the medication carts weekly and the pharmacist monthly for expired and undated medications. The DON indicated that she expected the facility's policy on medication storage and the manufacturer's instruction to be followed with regards to the expiration/discard dates of the medications. 3. The manufacturer's instruction written on the bottle of the Prostat (a protein supplement) read, "discard 3 months after opening."	F 761	residents were adversely affected by the alleged deficient practice. Systemic Changes All licensed nursing staff were educated on 4-21-21 by the Staff Development Coordinator on the following items. 1.All inhalers, nebulizers, eye drops, insulins, liquids, and nitroglycerin must be dated when open. 2.All medications must be disposed of prior to their expiration date. 3.Nurses must inspect medications for expiration date prior to giving medication. Any licensed nursing staff out on leave or PRN status will be educated prior to returning to duty by the SDC. Newly hired licensed nursing staff will be educated during orientation by the SDC. Monitoring The DON and RN Supervisor will audit 100% of all medication carts weekly for four weeks, then monthly for 2 months audits will begin on 4-12-21. The results of the audits will determine the need for further monitoring. The following items will be included in the audit. 1.Are there any expired medications on the medication cart. 2.Are there any open medications without a date on the medication cart. All audit information will be brought to the QAPI meeting monthly by DON to be analyzed and reviewed by the QAPI Committee meeting.	

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F 761	Continued From page 96 The 100-hall medication cart was observed on 4/7/21 at 3:30 PM. There was a bottle of Prostat that was opened and undated. Nurse #7 was interviewed on 4/7/21 at 3:32 PM. She verified that the opened bottle of Prostat was undated and indicated that it should have been dated when opened. The Director of Nursing (DON) was interviewed on 4/8/21 at 2:46 PM. The DON stated that she expected the nurses to check the medication carts weekly and the pharmacist monthly for expired and undated medications. The DON indicated that she expected the facility's policy on medication storage and the manufacturer's instruction to be followed with regards to the expiration/discard dates of the medications.	F 761		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes	F 883		4/21/21

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F 883	Continued From page 97 documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 883	Filing of this plan of correction does not	

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F 883	Continued From page 98 facility failed to provide education regarding the benefits and potential side effects of the influenza immunization with documentation in the medical record and failed to offer the influenza immunization during the influenza season (October - March) (Resident #20). This was for 1 of 5 residents reviewed for immunizations. The findings included: The facility's policy and procedure on immunizations dated 10/2019 was reviewed. The policy stated, in part, all residents would be offered an influenza vaccine beginning in October of each year, unless medically contraindicated or the resident had already been vaccinated. The policy further indicated that before receiving the influenza vaccination, the resident or representative would be provided education regarding the benefits and potential side effects of the vaccine with documentation in the medical record. Resident #20 had a readmission date of 12/21/19. The quarterly Minimum Data Set assessment dated 1/1/21, indicated Resident #20 was cognitively intact. The Influenza vaccine question regarding whether Resident #20 received the vaccine in the facility was marked no and the reason was coded as not offered. Resident #20's medical record revealed there was no documentation in the Electronic Medical Record (EMR) system or hard chart, to indicate whether Resident #20 or her responsible party (RP) had received education regarding the benefits and the potential side effects of the	F 883	constitute admission that the deficiencies alleged did in fact exist. The plan of correction is filed in evidence of the facilities desire to comply with the requirements and to continue to provide high quality care. F883 Resident affected The flu vaccine was offered to resident #20 on 4-16-21. The resident refused to take the vaccine. Residents with the potential to be affected An audit was completed by the Director of nursing (DON) and the Staff Development Coordinator (SDC) on 4-9-21 on all residents in the facility to ensure that all other residents were offered required vaccinations. No additional residents were identified as having been adversely affected by the alleged deficient practice. Systemic Changes All licensed nursing staff were educated on 4-21-21 by the Staff Development Coordinator on the following items. 1.All residents will be offered the flu vaccine and the pneumonia vaccine annually, if indicated 2.Documentation regarding education on risks/benefits of vaccine and resident response will be documented in the preventative health record of every resident Monitoring	

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F 883	Continued From page 99 influenza vaccine. In addition, there was no documentation to indicate whether Resident #20 received or refused the influenza vaccine. An interview occurred with the Director of Nursing (DON) on 4/8/21 at 8:45 AM. She was acting as the facility's Infection Control Preventionist (ICP) as the prior ICP had exited the position 3 to 4 weeks ago and a new ICP was in orientation. The DON explained influenza vaccine letters were provided to residents and mailed to resident RP's in October 2020. She felt it was an oversight that follow-up had not been made and documented for Resident #20's influenza vaccine status. The DON further stated it was her expectation that immunization education be provided, immunizations be administered as stated in their policy after consent was obtained, and documentation to be present in the medical record.	F 883	The DON and RN Supervisor will audit 25% of all residents admitted to the facility weekly for four weeks, then monthly for 2 months, audit started 4-12-21. The following items will be included in the audit. 1.Has the resident received the flu and pneumonia vaccine as indicated? 2.Is there documentation in the preventative health record regarding the education of risks/benefits of vaccine and the residents' response All audit information will be brought to the QAPI meeting monthly by the DON to be analyzed and reviewed by the QAPI Committee.	