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	345307	A. BUILDING _____ B. WING _____	C 04/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted 04/20/2021 through 04/21/2021. Additional information was obtained offsite on 04/22/2021; therefore the exit date was changed to 04/22/2021. Substandard Quality of Care was identified at: CFR 483.24 at tag F679 at a scope and severity (F) The tag F679 constituted Substandard Quality of Care An extended survey was conducted. A total of 13 allegations were investigated and 4 of the 13 allegations were substantiated and cited. Event ID# ISNR11.	F 000		
F 561 SS=E	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make	F 561		5/29/21

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

Electronically Signed | 05/17/2021

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F 561	Continued From page 1 choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to allow residents the ability to smoke more than 2 times a day and more than 2 cigarettes per smoking time due to the facility policy requiring all residents to be supervised during smoking activities for 5 of 5 residents assessed for preferences (Resident #1, #2, #3, #4 and #5) and failed to accommodate a request of room change for 1 of 1 resident reviewed for preferences (Resident #4). Findings included: 1. A review of the facility document titled "Smoking Policy" dated 08/01/2020 indicated on page 1 of 2 "Smoking will be permitted in designated areas only. Patients who choose to smoke will have a smoking assessment completed to determine if safe to smoke. If deemed safe patient will smoke if supervised. Supervised smoking is defined as the observer must be in the direct area of the smoker(s) and able to respond to emergency situations." On page 1 of 2 under the title "Process 1.1.1	F 561	F561 Self Determination 1. Concerns listed in tag F561 has the potential to cause concern with residents living in the facility. On April 20, 2021, All residents were included in a resident council meeting and based on their feedback and requests the smoking schedule was amended to provide additional smoking times. Resident #1-has a diagnosis of traumatic brain injury therefore resident is unsafe to smoke without supervision due to poor safety awareness. Resident #2- has a diagnosis of paraplegia with limitations. Resident #2 also make unsafe decisions for other residents. Resident #2 assisted resident #1 with smoking without supervision. Resident # 2 requires supervision due to poor safety awareness.	

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F 561	Continued From page 2 Smoking will only be allowed in designated areas at designated times." Under section "1.1.2. Resident must be able to take themselves down to the smoking area without staff assistance." Under section "1.2. The patient will be allowed to smoke only with supervision." Under section "1.4. Smoking apron will be worn during supervised smoking as deemed necessary by the assessment." On page 2 of 2 under section "3.1. If there is a "willful" disregard for safety to self or others or the Center is jeopardized by a patient's disregard for the smoking policy, termination of smoking privileges or initiation of a discharge plan will occur." Under section "3.1.1. First violation will result in the termination of smoking privileges for remainder of stay at the center. An observation on 04/20/2021 at 10:49AM revealed Resident's #1, #2, #3 and #4 in the wheelchairs in a small hallway leading out to the courtyard waiting to go out to smoke at the designated time of 10:45AM to 11:45AM. Resident #5 who was ambulatory was standing in the hallway with his walker waiting to go out to smoke. Smoking times were posted on the doorway leading out to the courtyard and the times were recorded as "10:45 - 11:45AM and 3:30 - 4:30PM." The residents were overheard complaining among themselves they were late going out to smoke. At 10:54AM the Director of Nursing (DON) was observed going down the hallway to take the smokers out and requested Nurse Aide (NA) #1 come out and stay with the smokers during their break. Interviews on 04/20/2021 at 11:00AM with Resident #'s 2, 3, 4, and 5 revealed they had been restricted since COVID-19 to smoking 2 times a day. They stated it happened in October	F 561	Resident #3- has a diagnosis of unspecified dementia which requires supervision due to safety awareness. Resident #4-has a diagnosis spinal stenosis with limitations, major depression, poly neuropathy which requires him supervision when smoking. Resident #5-has a diagnosis of paranoid schizophrenia and Parkinson disease which requires supervision due to poor safety awareness. 2. Residents who smoke was given a copy of the smoking policy and signed acknowledgement of policy on May 10, 2021. Upon admission residents who smoke will be given a copy of the smoking policy and sign acknowledgement of policy. 3. All Staff was educated on the smoking schedule on May 12,2021 by the Staff Development Coordinator and/or Designee. All Staff education was provided by the Staff Development Coordinator and/or Designee on 5/29/2021 on the Grievance and Concern Reporting Process and to report concerns to the facility Grievance officer which is the Social Service Director. 4. Smoking assessments were completed on all residents that smoke by May 12, 2021 and Care Plans were	

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F 561	Continued From page 3 of 2020 without any discussion with them. Resident #3 stated he used to be able to come out any time he wanted and smoke and stated he would come out at 4:00AM if he wanted but stated that all stopped in October of 2020. Resident #3 stated he was not given any information. nor had he signed any document informing him of the change and further stated now he had to be supervised while he smoked. Resident #2 stated the Director of Nursing (DON) had also told them they could only smoke 2 cigarettes while out on their smoke break and all the residents chimed in the rule was against their rights as residents at the facility. Resident #2 indicated that all the staff seem to disappear when it was time to take them out to smoke and they were almost always late going out but always had to come in on time. Resident #2 further indicated they frequently waited for someone to go out with them and once out most of the time they were hurried because the person out with them told them she had to get back because she had work that had to be done. The smokers were observed to be back in the building at 11:45AM. An interview on 04/20/2021 at 11:45AM with Resident #2 revealed there had been no communication between Administration and the residents at the facility. He stated the Administrative staff had been "a revolving door" and the staff did not seem to care about the residents. Resident #2 further stated they were one day restricted to smoking 2 times a day without any warning or communication from anyone and were told they could only smoke 2 cigarettes while they were out for their smoke break because the staff out with them had to get back in the building to perform other duties. He indicated they always had to wait to go out and	F 561	updated. Smoking assessments will be completed quarterly through the Minimum Data Set process and/or change of condition. Resident #4 has been offered several room changes and has refused to move. Facility has prepared a room acceptable to resident and he will be moved on 5/21/2021. Resident self-determination interview□s will be conducted by Social Services Director or designee, 5 interviews per week for four weeks, then 5 interviews monthly for three months. Resident self-determination interviews will also be conducted during resident council meetings monthly. 5. Results of the above audit will be reviewed and discussed in the Quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 5/29/2021	

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F 561	Continued From page 4	F 561		

then they were rushed by staff to come back in. Resident #2 further indicated "smoking is my activity and I enjoy it and I don't like to be rushed or told like I am a child that I can only smoke 2 cigarettes while I am out. This is my home and I should be able to smoke as many cigarettes as I want while I am out during smoke breaks." Resident #2 stated they had come in today at 11:45AM because their time was up according to NA #1 even though there were not out there for their full hour.

Review of Resident #1's Smoking Assessment dated 02/15/2021 revealed he had no cognitive loss, no visual deficits but did have dexterity problems, could not light his own cigarette, required an apron for safety and required supervision with smoking. The resident liked to smoke morning and afternoon. The note further stated he needed supervision with smoking at all times. Review of his care plan dated 04/19/21 revealed he was a supervised smoker that required a smoking apron.

Review of Resident #2's Smoking Assessment dated 02/18/2021 revealed he had no cognitive loss, no visual deficits and no dexterity problems, could light his own cigarette but required supervision with smoking. The resident liked to smoke morning and afternoon. The note further stated he needed supervision with smoking at all times. Review of his care plan dated 04/19/2021 revealed he was a safe smoker but required supervision.

Review of Resident #3's Smoking Assessment dated 06/29/2020 revealed he had no cognitive loss, no visual deficits, no dexterity problems and could light his own cigarette. The resident liked

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F 561	Continued From page 5	F 561		

to smoke morning, afternoon, and evening. The note further stated the resident was safe to smoke without supervision. Review of his care plan dated 04/19/2021 revealed he was a safe smoker but required supervision.

Review of Resident #4's Smoking Assessment dated 02/18/21 revealed he had no cognitive loss, no visual deficits but did have dexterity problem, could light his own cigarette but required supervision with smoking. The resident liked to smoke morning and afternoon. The note further indicated the resident needed supervision with smoking. A review of his care plan dated 04/20/2021 revealed he was a safe smoker with supervision.

Review of Resident #5's Smoking Assessment dated 02/18/2021 revealed he had no cognitive loss, no visual deficits and no dexterity problem, could light his own cigarette but required supervision with smoking. The resident liked to smoke morning and afternoon. The note further indicated the resident needed supervision at all times. A review of his care plan dated 04/11/2021 revealed he was a safe smoker.

An interview on 04/20/2021 at 11:55AM with NA #1 revealed she had been told by the DON the residents were only allowed to smoke 2 cigarettes while out for smoke break but stated when she went out with them she let them smoke as many as they wanted within their allotted time. NA #1 stated the smokers were all upset they could only go out twice a day to smoke.

An observation and interviews on 04/21/2021 at 11:00AM with Residents #1, #2, #3, #4 and #5 revealed all but Resident #1 could get their

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cigarettes out of their locker, light their cigarette, put their ashes in the ashtray and put their cigarette out. Resident #3 stated prior to October of 2020 he was an independent smoker and could come out any time he wanted to smoke but stated after COVID none of them had been allowed to come out without supervision. Residents #2, #3, #4 and #5 all stated they could smoke without supervision but stated the facility no longer allowed them to do so. They all stated they were not informed in writing of the new rule and had not signed any document informing them of the new rule.

An interview on 04/21/2021 at 4:45PM with the Director of Nursing (DON) revealed when she came to the facility she was told by the previous Administration the smokers had 2 smoke breaks per day and were only allowed to smoke 2 cigarettes during that smoke break. She stated she had not wanted to change the times and amount they could smoke because she knew a new Administrator was coming and she wanted to wait and make the decision with her so additional changes would not have to be made. The DON indicated she had told the NAs and staff going out with the smokers they were limited to 2 cigarettes at each smoke break because that was what she had been told. She further indicated in hindsight she probably should have made some changes to accommodate the residents who smoked. The DON further indicated all the residents were currently only allowed to smoke with supervision because she had been informed by the previous Administration residents had had behaviors of assisting Resident #1 who required an apron and supervision out to smoke with no supervising staff in the designated area, were lighting cigarettes for each other, and providing cigarettes to one

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another. She stated she was not sure why the Smoking Assessments and the individual care plans for Residents #2, #3, #4, and #5 did not match but stated her plan was to re-assess everyone with the assistance of therapy staff and update all their care plans. The DON further stated they were to continue with supervised smoking no matter what because that was their policy for smoking and because of the smoker's behaviors.

An interview on 04/21/2021 at 5:09PM with the Administrator revealed this was her 2nd day at the facility and stated she was surprised when she saw the smokers were limited to 2 smoke breaks per day and limited to 2 cigarettes per smoke break. She further stated she had been in the long-term care business for a long time and had never encountered these types of restrictions on smokers. The Administrator indicated she expected the smokers to be able to smoke as many cigarettes as they wanted during their smoke break and stated they were going to make some changes to the smoking schedule today. She further indicated they would be assessing the smoking residents and updating their care plans according to their assessments.

2. Resident #4 was admitted to the facility on 01/04/17 and readmitted on 10/27/2020. His admitting diagnoses included spinal stenosis, anxiety disorder, and insomnia.

Review of his most recent annual Minimum Data Set (MDS) dated 03/31/2021 revealed he was cognitively intact for daily decision making and required extensive to total care with most activities of daily living (ADL) except eating and locomotion in his wheelchair.

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An interview on 04/20/2021 at 3:50PM with Resident #4 revealed he had requested a room change because his roommate screamed at all hours of the day and night and he could not rest during the day or sleep at night without being awakened by the roommate. He stated his roommate would usually calm down if someone gave him a piece of chocolate but said the nurses just ignored him and he just continued to scream until someone finally gave him a piece of chocolate. Resident #4 further stated he had been offered one room with a resident who had a cluttered room and played music all the time and stated he nor the other resident wanted to live together. According to Resident #4 he had not been offered any other options for a room change.

An interview on 04/20/2021 at 4:22PM with the Unit Manager revealed she was aware Resident #4 had requested a room change. She stated he had been offered to move into another room but he nor the other gentleman wanted to room together. The Unit Manager stated the other gentleman had a cluttered room and liked to play music all the time and stated Resident #4 did not want to room with him. She further stated he had not been offered any other rooms because there had not been any other semi-private male rooms available. The Unit Manager indicated she was not sure why he had not been offered another room that was empty at the time.

An interview on 04/21/2021 at 4:45PM with the Director of Nursing (DON) revealed she was not aware Resident #4 had requested a room change until today when he mentioned it during their Resident Council meeting. She stated he should

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F 561	Continued From page 9 have been offered an alternative room that was suitable for he and the new roommate. The DON further stated they would work on getting him transferred to a compatible room. An interview on 04/21/2021 at 5:09PM revealed the Administrator was not aware Resident #4 had requested a room change until today when he mentioned it during the Resident Council meeting. She stated she would have expected him to have been moved from his current room to another room that was suitable for he and the new roommate. The Administrator further stated she would work on getting Resident #4 moved to another room.	F 561		
F 602 SS=E	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with residents, staff, police officer and pharmacist, the facility failed to prevent medication diversion for 4 of 4 residents sampled for misappropriation of property (Resident #12, Resident #13, Resident #3, and Resident #14). The findings included: 1. a. Resident #12 was admitted to the facility on	F 602	F602 Free from Misappropriation/ Exploitation 1. Concerns listed in tag F602 has the potential to cause concern with residents living in the facility. The interdisciplinary team has met and determined the best course of action going forward.	5/29/21

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F 602	Continued From page 10 3/17/20 with diagnoses that included traumatic spinal cord dysfunction and chronic pain syndrome. The Quarterly Minimum Data Set (MDS) assessment dated 4/3/21 indicated Resident #12 was moderately cognitively impaired, complained of frequent pain at level 5 out of 10 and received scheduled pain medication regimen and prn (as necessary) pain medications. Resident #12's care plan dated 10/16/20 indicated Resident #12 had occasional chronic pain in his lower legs. The care plan had measured goals and interventions that included the administration of pain medication. A review of Resident #12's Medication Administration Record (MAR) for November 2020 indicated an order for Hydrocodone-Acetaminophen 5-325 mg (milligrams) 1 tablet by mouth four times a day for chronic pain as well as an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 4 hours as needed for pain in addition to scheduled doses for breakthrough pain. Nurse #3 documented on 11/21/20 that she gave both the scheduled and prn doses of Hydrocodone to Resident #12 with a pain level of 4 out of 10 at 9:00 AM. On 11/21/20 at 11:00 AM, she gave another prn dose of Hydrocodone to Resident #12 and his scheduled dose at 12:00 PM for the same day. On 11/25/20, Nurse #3 documented that she gave Resident #12 a scheduled dose of Hydrocodone at 12:00 PM, a prn dose of Hydrocodone at 3:00 PM, a scheduled dose of Hydrocodone at 5:00 PM and another prn dose of Hydrocodone at 6:00 PM. A review of Resident #12's MAR for December	F 602	" Resident # 12, Resident # 13, Resident # 3 and Resident #14 have no adverse reactions or effects noted. MD notified and interventions. 2. On May 10,2021 the Narcotic-Controlled Medication policy has been revised. Policy includes receipt of controlled medications, record keeping, change of shift verification, discrepancies, proper practice for wasting controlled medication and controlled medication storage training will be done by Director of Nursing or designee by May 21, 2021. All licensed nursing staff that was not educated by 5/21/2021 will be educated prior to their next shift of working by the Staff Development coordinator or designee. The Staff Development Coordinator or designee will track all licensed nursing staff who have received the training/education on the controlled medication policy. 3. Audits of Controlled medication receipts, change of shift verification, discrepancies, proper practice for wasting controlled medication and controlled medication storage audits for all narcotics were completed on May 14,2021. Facility will audit 3 residents controlled narcotic count per shift weekly times 4 weeks. Facility will audit 3 residents controlled narcotic count per shift then monthly times 3 months. Audits will be performed by Director of Nursing or designee. Director of nursing or designee will monitor the medication controlled count sheet on anything unusual as an example;	

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F 602	Continued From page 11 2020 indicated an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth four times a day for chronic pain as well as an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 4 hours as needed for pain in addition to scheduled doses for breakthrough pain. Nurse #3 documented on 12/2/20 that she gave both the scheduled and prn doses of Hydrocodone to Resident #12 with a pain level of 4 out of 10 at 12:00 PM. Nurse #3 also documented on 12/14/20 at 5:00 PM that she gave Resident #12 two tablets of Hydrocodone (both scheduled and prn dose) for a pain level of 5 out of 10. A review of Resident #12's MAR for January 2021 indicated an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth four times a day for chronic pain as well as an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth every 4 hours as needed for pain in addition to scheduled doses for breakthrough pain. On 1/17/21, Nurse #3 gave Resident #12 a prn dose of Hydrocodone at 11:00 AM and then a scheduled dose of Hydrocodone at 12:00 PM. On 1/18/21, Nurse #3 gave Resident #12 a prn dose of Hydrocodone at 11:00 AM, a scheduled dose of Hydrocodone at 12:00 PM, another prn dose of Hydrocodone at 3:00 PM and then a scheduled dose of Hydrocodone at 5:00 PM. An interview with Resident #12 on 4/20/21 at 5:10 PM revealed he received his pain medication on time, and it was scheduled to be given four times a day. Resident #12 stated that he rarely asked for his prn dose of Hydrocodone because the scheduled doses were enough to relieve his pain. Resident #12 stated he knew what his	F 602	as needed medications or wasting of controlled medications. 4. Medication observations were performed on May 11, 2021. Polaris pharmacy Registered Nurse consultant will conduct independent medication observations of staff as availability allows. Copy of observation□s will be given to Staff Development Coordinator or designee. Staff Development Coordinator or designee will perform 2 medication observations of Licensed Nurses per shift, on each shift which includes day shift 7a to 7p and night shift 7p to 7a.x 4 weeks. Then, Staff Development Coordinator or designee will perform 2 medication observations per shift per month for 3 months. If any discrepancies occurred during observation, licensed nurse will be re-educated immediately by Director of Nursing or designee. 5. If an error is observed during audits, the Director of Nursing and Administrator will be notified immediately. Investigation will be started immediately by the Director of Nursing and Administrator. Facility will notify Medical Director and Resident's Responsible Party through the investigation process, if the facility identifies resolution no further action needed. If unable to resolve discrepancy through the investigation process, facility will notify proper authorities; such as police and Department of Health and Human Services. Licensed Nurses will be re-educated by Director of Nursing or designee as appropriately needed.	

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Hydrocodone looked like and he did not accept if the nurse tried to give him something else instead of his Hydrocodone.

A phone interview with Nurse #4 on 4/21/21 at 9:13 AM revealed she remembered being oriented by Nurse #3 and working with Resident #12 in November 2020. Nurse #4 stated she was about to give Resident #12 his scheduled dose of Hydrocodone when she noticed that one pill was missing. So, she asked Nurse #3 and Nurse #5 who was working on the other medication cart where the missing pill was, and Nurse #5 stated that it might have been wasted. Nurse #3 and Nurse #5 proceeded to sign the narcotic count sheet for Resident #12's Hydrocodone that one pill had been wasted. Nurse #4 stated she did not question what both nurses had done and did not think to report it to the unit manager or the previous DON (Director of Nursing). After this incident, Nurse #4 continued to notice discrepancies on the narcotic sign-out sheets for Resident #12. Nurse #4 disclosed that she noticed Nurse #3 signing out Resident #12's Hydrocodone at least every two hours and sometimes giving him double doses at the scheduled times. Nurse #3 also sometimes documented on Resident #12's narcotic sign-out sheet for Hydrocodone that she pulled the medication at 10:00 PM when she only worked from 7:00 AM to 7:00 PM. After noticing these discrepancies, Nurse #4 decided to notify the unit manager and the previous DON.

A phone interview with Nurse #5 on 4/21/21 at 2:26 PM revealed she had worked with Nurse #3 twice and remembered having had to call Nurse #3 to come back to the facility to sign out for a narcotic. Nurse #5 stated at first, she did not pay

5. Results of the above audits will be reviewed and discussed in the Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance.

Completion date 5/29/2021

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attention to it and thought that Nurse #3 might have just forgotten to sign the narcotic sign-out sheet. Nurse #5 stated she usually worked on the days after Nurse #3 worked and noticed that Nurse #3 had been giving Resident #12 two doses (scheduled and prn dose) of his Hydrocodone at the same time. Nurse #5 stated she thought it was odd because Nurse #3 was the only one signing out for Resident #12's prn doses of Hydrocodone and Nurse #5 never had to give him any prn dose of Hydrocodone whenever she worked. Nurse #5 also admitted that she had signed for a missing pill that belonged to Resident #12 as being wasted with Nurse #3 without witnessing Nurse #3 waste the pill and said she realized she shouldn't have done that.

b. Resident #13 was admitted to the facility on 11/26/19 with diagnoses that included traumatic brain injury and dorsalgia (back pain). The Quarterly Minimum Data Set (MDS) assessment dated 2/18/21 indicated Resident #13 was severely cognitively impaired, did not receive any pain medication and did not exhibit any indicator of pain. The Quarterly MDS assessment dated 11/18/20 indicated Resident #13 had occasional pain at level 4 out of 10 and received scheduled pain medication regimen and prn (as necessary) pain medications.

Resident #13's care plan dated 10/1/20 indicated Resident #13 had chronic pain related to knee and back pain. Resident #13 had difficulty communicating her needs. The care plan had measured goals and interventions that included the administration of pain medication.

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A review of Resident #13's Medication Administration Record (MAR) for November 2020 indicated an order for Hydrocodone-Acetaminophen 5-325 mg (milligrams) 1 tablet by mouth four times a day for pain as well as Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth as needed (prn) for pain daily. Resident #13 received her scheduled doses of Hydrocodone at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. Nurse #3 documented that she gave Resident #13 a prn dose of Hydrocodone on 11/8/20 at 10:00 AM, 11/19/20 at 6:00 PM, 11/21/20 at 9:45 AM and 1:00 PM, 11/22/20 at 10:00 AM, 11/23/20 at 11:23 AM and 3:00 PM, and 11/25/20 at 2:00 PM and 6:01 PM. No other nurse documented they gave Resident #13 a prn dose of Hydrocodone.

A review of Resident #13's MAR for December 2020 indicated an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth four times a day for pain as well as Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth prn for pain daily. Resident #13 received her scheduled doses of Hydrocodone at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. Nurse #3 documented that she gave Resident #13 a prn dose of Hydrocodone on 12/15/20 at 2:00 PM, 12/23/20 at 11:00 AM and 5:25 PM and 12/30/20 at 2:00 PM. No other nurse documented they gave Resident #13 a prn dose of Hydrocodone.

A review of Resident #13's MAR for January 2021 indicated an order for Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth four times a day for pain as well as Hydrocodone-Acetaminophen 5-325 mg 1 tablet by mouth prn for pain daily. Resident #13

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received her scheduled doses of Hydrocodone at 9:00 AM, 12:00 PM, 5:00 PM and 9:00 PM. Nurse #3 documented that she gave Resident #13 a prn dose of Hydrocodone on 1/5/21 at 2:48 PM, 1/6/21 at 3:00 PM, 1/11/21 at 5:00 PM, 1/13/21 at 2:00 PM and 8:30 PM, 1/14/21 at 3:00 PM and 1/19/21 at 7:30 AM. No other nurse documented they gave Resident #13 a prn dose of Hydrocodone.

A phone interview with Nurse #7 on 4/21/21 at 10:26 AM revealed she worked on the evening and night shift and had followed Nurse #3. Nurse #7 stated she had noticed Nurse #3 documenting giving Resident #13 prn doses of Hydrocodone and she was the only nurse who gave it. Nurse #7 stated Resident #13 had never shown any signs of discomfort or pain whenever she worked, and Resident #13 did not know to ask for any pain medication. Nurse #7 also noticed that Nurse #3 signed out a lot of narcotics back to back and were too close to give to a resident in the narcotic countdown sheets.

A phone interview with Nurse #8 on 4/21/21 at 10:56 AM revealed she worked on the night shift and often followed Nurse #3. Nurse #8 stated she noticed Nurse #3's signature on the narcotic count sheets. Nurse #3 signed out narcotics excessively and was the only nurse signing them out. Nurse #8 said it didn't make sense because it seemed like the residents were in so much pain when Nurse #3 worked but not when Nurse #8 took over. Nurse #8 also noticed that her residents were not tired, were alert and wide awake when she came on her shift. Nurse #8 decided to report Nurse #3 to the Administrator when she noticed Nurse #3 signing out Resident #13's Hydrocodone an hour or two apart. On

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some days, Resident #13's MAR looked like she had already received four or five doses of her Hydrocodone even before her scheduled dose at 9:00 PM. Nurse #8 also thought it was odd that Nurse #3 was the only one giving prn Hydrocodone to Resident #13 because Resident #13 did not talk and could not ask for her pain medication and did not usually show signs of pain or discomfort.

A phone interview with Nurse Aide (NA) #8 on 4/21/21 at 10:39 AM revealed she had noticed Nurse #3 signing out a lot of Hydrocodone for Resident #13 and she was the only one giving her a prn dose. NA #8 said she found it odd because Resident #13 never looked like she was in pain and could not talk and let staff know if she needed an extra pain medication.

A phone interview with the pharmacist on 4/21/21 at 3:07 PM revealed they had been dispensing 30 tablets of Resident #13's Hydrocodone to the facility every week to cover both her scheduled and prn doses. The pharmacist stated they did not receive any early refill request for Resident #13's Hydrocodone.

c. Resident #3 was admitted to the facility on 11/13/20 with diagnoses that included left femoral fracture, arthritis, and chronic pain. The Quarterly Minimum Data Set (MDS) assessment dated 2/19/21 indicated Resident #3 was cognitively intact, complained of occasional pain at level 3 out of 10 and received scheduled pain medication regimen and prn (as necessary) pain medications.

Resident #3's care plan dated 11/14/20 indicated

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Resident #3 had pain related to arthritis and left femoral fracture. The care plan had measured goals and interventions that included the administration of pain medication.

A review of Resident #3's Medication Administration Record (MAR) for January 2021 indicated an order for Hydrocodone-Acetaminophen 7.5-325 mg (milligrams) 2 tablets by mouth one time a day every Monday, Tuesday, Wednesday, Thursday, Friday before therapy for pain. Resident #3 also had a prn order for Hydrocodone-Acetaminophen 7.5-325 mg 1 tablet by mouth every 6 hours as needed for pain. On 1/19/21, Nurse #3 documented that she gave Resident #3 his scheduled dose of Hydrocodone at 8:00 AM and then his prn dose of Hydrocodone at 10:00 AM with a pain level of 3 out of 10.

An interview with Resident #3 on 4/21/21 at 2:00 PM revealed he broke his hip in November 2020 and the nurses gave him his scheduled dose of Hydrocodone which helped his pain. Resident #3 stated he did not usually ask for a prn dose of Hydrocodone except right after he had a hip fracture. Resident #3 added that he knew what his Hydrocodone looked like and was sure that he got it instead of some other pill.

A phone interview with Nurse #8 on 4/21/21 at 10:56 AM revealed she noticed Nurse #3 signing out Resident #3's Hydrocodone only two hours apart on 1/19/21 with him having received 3 tablets of Hydrocodone 7.5 in a span of two hours. Nurse #8 said it didn't make sense for Resident #3 to be in so much pain two months after he had a hip fracture. When Nurse #8 questioned Nurse #3 about this, Nurse #3 just

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changed the time on the narcotic countdown sheet for Resident #3.

d. Resident #14 was admitted to the facility on 5/5/20 with diagnoses that included osteoarthritis, cervicalgia (neck pain) and chronic pain. The Quarterly Minimum Data Set (MDS) assessment dated 12/3/20 indicated Resident #14 was severely cognitively impaired and did not exhibit any indicator of pain but received scheduled pain medication regimen and prn (as necessary) pain medications.

Resident #14's care plan dated 12/8/20 indicated Resident #14 had chronic pain related to osteoarthritis. The care plan had measured goals and interventions that included the administration of pain medication.

A review of Resident #14's Medication Administration Record from November 2020 to February 2021 indicated that she received a Fentanyl patch 72 hour - 12 mcg (micrograms)/hour, 1 patch transdermally every 72 hours for pain.

A phone interview with Nurse #4 on 4/21/21 at 9:13 AM revealed she had noticed whenever she was supposed to put on a new Fentanyl patch on Resident #14, the old patch would no longer be on Resident #14 for her to remove. Nurse #4 stated she thought it was odd because the Fentanyl patch was supposed to stay on Resident #14 for three days before it was changed out. She also covered the Fentanyl patch with a transparent film dressing to secure it better to the resident. Nurse #4 stated she noticed this happening at least three times when Nurse #3

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was still working at the facility. Nurse #4 stated she reported this to the unit manager who just brushed it off and told her that the Fentanyl patch might have fallen off during resident care. Nurse #4 added that none of the nurse aides had reported that Resident #14's Fentanyl patch had fallen off her body. Nurse #4 said she was surprised by the practice at the facility because the nurses were not required to check the Fentanyl patches every shift and a witness was not required when taking off old Fentanyl patches from residents prior to disposing them.

A phone interview with Nurse #5 on 4/21/21 at 2:26 PM revealed she had noticed Resident #14 ran out of her Fentanyl patches quickly. Nurse #5 stated she noticed whenever she came to work with Resident #14, she only had one or two patches left in the narcotic box. She also noticed that the old Fentanyl patch that she was supposed to remove would already be gone. Nurse #5 noticed this happening at least three times when Nurse #3 was still working at the facility. She was not sure if somebody had been taking off Resident #14's Fentanyl patch after it had been applied to her and Resident #14 would not be able to tell if someone took off her Fentanyl patch.

A phone interview with Nurse #6 on 4/21/21 at 11:22 AM revealed she did not notice anything strange regarding Resident #14's Fentanyl patch because it was usually changed by the day shift nurses. Nurse #6 also did not check routinely if Resident #14's Fentanyl patch was still on during her shift because they were never instructed to do so.

A phone interview with the pharmacist on 4/21/21

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at 3:07 PM revealed they had filled Resident #14's prescription for Fentanyl patches once a month since it was first ordered on 7/23/20 and they had sent the facility 10 patches with each refill which was enough to last for a whole month. The pharmacist stated they never received any request for refill that was earlier than when it was supposed to be refilled.

Multiple unsuccessful attempts were made to contact Nurse #3.

A phone interview with NA #7 on 4/21/21 at 9:15 AM revealed she was trained as a medication aide and started working at the facility in December 2020. NA #7 stated Nurse #3 worked as a charge nurse, but she never gave NA #7 the keys to her medication cart. NA #7 said Nurse #3 told her that she was not allowed to handle narcotics which was why during medication pass, Nurse #3 always pulled the medications and then handed them to NA #7 to give to the residents. NA #7 disclosed that she did not know if she was giving the residents the right medications because Nurse #3 was pulling them off the medication cart. NA #7 talked to the previous Administrator and asked if she was allowed to give medications on her own without Nurse #3 and the Administrator told her that she could and that Nurse #3 was not supposed to keep NA #7's keys to the medication cart.

A phone interview with Nurse #6 on 4/21/21 at 11:22 AM revealed she had noticed Nurse #3 signing out a lot of the prn doses for Hydrocodone for at least three residents that included Resident #12, Resident #13, and Resident #3. Nurse #6 also noticed that the times that Nurse #3 documented that she gave

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Hydrocodone to Resident #12, Resident #13 and Resident #3 did not look right because she was signing them out more frequently than what had been ordered for these residents. Nurse #6 reported this issue to the previous Administrator who told her that she would investigate it.

A review of a Facility-Reported Incident dated 1/21/21 to 1/26/21 and signed by the previous Administrator revealed an allegation of medication diversion for potentially three residents was substantiated. The report indicated that Nurse #3 was suspended on 1/21/21 pending the outcome of the investigation. The local police department was notified on 1/21/21. The previous Administrator also notified the state board of nursing and the drug enforcement administration. The investigation revealed Nurse #3 had narcotic documentation inaccuracies including wasting of narcotics that were ordered as prn from the attending physician. The facility began in-servicing all staff on abuse, neglect, and misappropriation to include resident interviews to determine if any underlying systematic issues were identified on 1/22/21. No other medication delivery issues were identified from the resident interviews as of 1/26/21. The facility also began in-servicing the licensed nurses on receiving medication, securing, and storing medication and administering medications on 1/21/21. The outcome of the in-servicing would ensure the resident narcotic drugs were received, secured, and always accounted for by the nursing department.

A phone interview with the previous Administrator on 4/21/21 at 8:52 AM revealed she had received multiple reports from several nurses and medication aides that they had been noticing

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discrepancies with the narcotic documentation that involved Nurse #3. NA #7 had reported to her that Nurse #3 would not let her handle the narcotics in her medication cart. When the previous Administrator inspected the sign-out sheets for narcotics, she noticed that Nurse #3 often signed out narcotics and then noted that she had wasted them but there was no second nurse's signature as witness. The previous Administrator stated she started an investigation related to suspicion that Nurse #3 had been obtaining resident drugs. On 1/26/21, she decided to terminate Nurse #3 due to mismanagement of resident medications. The previous Administrator added that they educated all nurses about receiving medications, securing, storing and administering medications and started scanning all narcotic countdown sheets into the computer system to keep documentation of the narcotics that the nurses signed out and administered to the residents.

An interview with the Director of Quality/Compliance (DQC) Officer on 4/20/21 at 3:40 PM revealed she was asked to come to the facility on 1/22/21 to investigate Nurse #3's alleged diversion of resident drugs. She stated that she reviewed the narcotic delivery slips from the pharmacy, the MAR and prn administration records and counted the narcotics that they had on hand. She noted that Nurse #3 had changed the count on the individual narcotic count sheets on at least three residents that she had reviewed. The DQC Officer could not remember which residents were affected and did not keep copies of the narcotic countdown sheets. She added that they found one pill that was missing and unaccounted for which belonged to Resident #12. They decided to terminate Nurse #3 due to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 602	Continued From page 23 inaccurate narcotic documentation and not following the correct count procedure. A phone interview with the Regional Director of Operations (RDO) on 4/21/21 at 9:45 AM revealed he had overseen the investigation regarding Nurse #3's alleged diversion of resident drugs. The RDO stated he had reviewed the Facility Reported Incident (FRI) report that the previous Administrator sent to the state and agreed with the results of the investigation. He also stated that based on the information they had gathered; they could not fully determine if Nurse #3 had taken the resident drugs but there were drugs that were missing and unaccounted for. Nurse #3 was responsible as a nurse for the resident medications and she failed to ensure the safety of the narcotics that she handled. A phone interview with the police officer on 4/21/21 at 12:00 PM revealed that the local police department had been notified of Nurse #3's alleged diversion of medications. The police officer stated he had spoken with the previous Administrator about the case, but there was not enough evidence to charge Nurse #3. The facility also conducted its own investigation and he was notified that they had terminated Nurse #3, so he did not pursue further investigation into the case. An interview with the interim Administrator on 4/21/21 at 5:09 PM revealed she had just found out about Nurse #3's diversion of resident drugs.	F 602		
F 679 SS=F	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on	F 679		5/29/21

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F 679	Continued From page 24 the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interviews, and record review, the facility failed to provide an ongoing resident centered activities program for 3 of 3 sampled cognitively intact residents reviewed for activities (Resident #2, #4, #7). Findings Included: 1. Resident #2 was admitted to the facility on 10/14/20 with diagnoses which included atrial fibrillation, peripheral vascular disease, and hyperlipidemia. Resident #2's quarterly Minimum Data Set (MDS) dated 4/17/21 revealed he was cognitively intact for daily decision making and required extensive assistance with most activities of daily living (ADL) skills but was independent for locomotion in his wheelchair. It was further revealed Resident #2's MDS was coded very important for resident to complete activities of his liking and going outside. Review of a progress note dated 3/22/21 revealed Resident #2 had the potential for altered activity pattern. The goal for Resident #2 was to participate in two group activities in a week and	F 679	F679 Activities Meet Interest/Needs Each Resident 1. Concerns listed in tag F679 has the potential to cause concern with multiple other residents living in the facility. An emergency Resident Council meeting was called by the Administrator with all residents on 4/20/2021 to discuss Activities concerns as well as interests. Resident #2- attended the ad hoc resident council meeting on 4/20/2021 and expressed an interest in playing BINGO and card games. BINGO was added and implemented 3 days a week and card games 2 days a week starting May 1, 2021. Resident #4- attended the ad hoc resident council meeting on 4/20/2021 and expressed an interest in card games. Card games was added and implemented on the calendar of Activities starting May 1, 2021. Resident #7-attended the ad hoc resident council meeting on 4/20/2021 and expressed her concerns of other residents not having activities. Resident #7 stated she prefers not to attend any activities.	

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F 679	Continued From page 25 participate in self-directed activities. An interview conducted with Resident #2 on 4/21/21 at 3:15 PM revealed activities had not been offered to him since the last Activity Director (AD) was present back in March. Resident #2 further revealed he had shown up to activities on the activity schedule and multiple times the activity had been canceled with no notification. Resident # 2 revealed he was bored most days and had expressed to staff that activities need to be offered but felt that staff did not care about the residents. An observation made on 4/21/21 at 9:45 AM revealed 6 residents who were already present in the dining room being invited by staff to watch a movie. It was further revealed staff did not go each resident's room or make any kind of announcement to invite Resident #2 or any other residents to participate. An interview conducted with Nurse Aide (NA) #3 On 4/21/21 at 1:55 PM revealed she had been leading activities for the past month due to the facility not having an AD. It was further revealed she created the activity schedule and lead activities on days when she was not on the floor assisting residents. NA #3 stated she was appointed by the previous Administrator and had not received training or any certification to lead activities. NA #3 revealed the days she was working the floor providing resident care, activities were canceled, and this happened often. An interview conducted with direct care Nurse #1 on 4/21/21 at 9:07 AM revealed the only activity she knew the residents were currently	F 679	Administrator shared the May calendar of ideas with all in attendance and posted calendars throughout the facility and in every resident□s room. 2. The Activities Director or designee will do an assessment/interview of all alert residents and update care plans with preferences of each resident by 5/21/2021. Cognitively impaired residents: families and/or Power of Attorney will be interviewed for resident preferences and update care plans by 5/21/2021. 3. The facility will provide ongoing resident-centered activities programming to support residents in their choice of activities, that have been designed to meet the individual interests of the resident while encouraging both independence and interaction in the community. Administrator in-serviced Activities Director on 5/12/2021 on developing activities that are meaningful and incorporating the resident□s interests, hobbies and cultural preferences. Director of Nursing and/or Administrator will in-service all staff by 5/21/2021 on resident engagement and staff participation from all departments. 4. Activities Director and/or Administrator will hold weekly resident council meetings for 4 weeks, starting 5/19/2021 then 2 times a month for 1 month to monitor performance and to make sure solutions are sustained. Facility will then resume	

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F 679	Continued From page 26 participating in were movies in the dining room. Nurse #1 further revealed only a few residents could attend due to social distancing. Nurse #1 stated residents had complained about not having activities and felt they should be receiving more. An interview conducted with the Director of Nursing (DON) revealed she had been in the facility for two weeks and recognized activities was an issue when she entered the facility. The DON indicated she had been pulling nurse aids when they were not busy on the floor to assist with activities. The DON further revealed she expected the activity schedule to be followed and the residents to be notified of changes. An interview conducted with the Interim Administrator on 4/21/21 at 5:20 PM revealed she had been working in the facility for two days. It was further revealed the Administrator expected residents to be notified of the activity schedule changes and for the activity event schedule to be followed. 2. Resident #4 was admitted to the facility on 10/27/20 with diagnoses which included anxiety disorder, mood disorder, and polyneuropathy. Resident #4's quarterly Minimum Data Set (MDS) dated 3/31/21 revealed Resident #4 was cognitively intact for daily decision making and was extensive assistance to totally dependent on staff assistance for most activities of daily living (ADL) but was independent for locomotion in his wheelchair. It was further revealed Resident #4's MDS was coded very important for resident to complete activities of his liking, attending group activities, and going outside.	F 679	the regular once-a-month meeting schedule. All residents which includes cognitively impaired residents will be assessed through the Minimum Data Set process. Activities Director and/or Administrator will document attendance to all Resident Council Meetings in the meeting minutes. Activities Director and/or Designee will document attendance to planned/scheduled activities programs in Point Click Care notes to be reviewed to ensure residents are meeting activity goals. Results of the above audit will be reviewed and discussed in the Quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date- 5/29/2021	

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Review of a progress note dated 3/22/21 revealed Resident #4 attended a group outdoor relaxation activity. This was the last activity progress note documented.

Review of Residents #4's care plan dated 4/20/21 revealed Resident #4 will continue current level of involvement in activities. The care plan further indicated Resident #4 attends 2-3 group activities per week and enjoys bingo, snack carts, outdoor relaxation, and card games. The goal revealed Resident #4 will attend group activities 3 times a week and participate in self-directed activities.

An interview conducted with Resident #4 on 4/21/21 at 3:20 PM revealed he had not been offered any activities since the last Activity Director (AD) left. Resident #4 indicated he had expressed to the facility he liked to play cards and games, but the facility had not offered these activities to him. Resident #4 further revealed he had received an activity schedule but had showed up for activities and no staff were present and the activity was canceled. Resident #4 stated he felt the staff did not care about the residents and he was just trying to live his best life.

An observation made on 4/21/21 at 9:45 AM revealed 6 residents who were already present in the dining room being invited by staff to watch a movie. It was further revealed staff did not go each resident's room or make any kind of announcement to invite Resident #4 or any other residents to participate.

An interview conducted with Nurse Aide (NA) #3 On 4/21/21 at 1:55 PM revealed she had been leading activities for the past month due to the facility not having an AD. It was further revealed

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F 679	Continued From page 28	F 679		

she created the activity schedule and lead activities on days when she was not on the floor assisting residents. NA #3 stated she was appointed by the previous administrator and had not received training or any certification to lead activities. NA #3 revealed the days she was working the floor providing resident care, activities were canceled, and this happened often.

An interview conducted with direct care Nurse #1 on 4/21/21 at 9:07 AM revealed the only activity she knew the residents were currently participating in were movies in the dining room. Nurse #1 further revealed only a few residents could attend due to social distancing. Nurse #1 stated residents have complained about not having activities and feels they should be receiving more.

An interview conducted with the Director of Nursing (DON) revealed she had been in the facility for two weeks and recognized activities was an issue when she entered the facility. The DON indicated she had been pulling nurse aids when they were not busy on the floor to assist with activities. The DON further revealed she expected the activity schedule to be followed and the residents to be notified of changes.

An interview conducted with the Interim Administrator on 4/21/21 at 5:20 PM revealed she had been working in the facility for two days. It was further revealed the Administrator expected residents to be notified of the activity schedule changes and for the activity event schedule to be followed.

3. Resident #7 was admitted to the facility on

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F 679	Continued From page 29	F 679		

2/13/19 with diagnosis of cerebrovascular disease, major depressive disorder, delusional disorder, and anxiety disorder.

Resident #7's quarterly Minimum Data Set (MDS) dated 3/23/21 revealed Resident #7 was cognitively intact and was independent of all activities of daily living (ADL) skills except for needing supervision with toilet use and personal hygiene.

Review of a progress note dated 3/19/22 revealed Resident #7 was offered resident shopping. This was the last activity progress note documented.

Review of Residents #7's care plan dated 4/18/21 revealed Resident #7 attended 1-2 out of room group activities per week and liked to open her window to feed the birds. The care plan goal indicated Resident #7 will participate in activities of choice 3 times a week.

An interview conducted with Resident #7 on 4/21/21 at 9:13 AM revealed there had been no activities since the previous Activity Director (AD) left a month and a half ago. It was further revealed the facility put a movie on in the dining room and did yoga but allowed residents to attend who would yell and scream and did not remove them, which caused multiple residents to leave. Resident #7 stated she received an activity schedule, but it was a joke because the facility did not follow the schedule or ask residents if they would like any activities to do in their rooms. It was further stated by Resident #7 that she felt the facility did not care the residents had nothing to do.

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F 679	Continued From page 30	F 679		

An observation made on 4/21/21 at 9:45 AM revealed 6 residents who were already present in the dining room being invited by staff to watch a movie. It was further revealed staff did not go each resident's room or make any kind of announcement to invite Resident #7 or any other residents to participate.

An interview conducted with Nurse Aide (NA) #3 On 4/21/21 at 1:55 PM revealed she had been leading activities for the past month due to the facility not having an AD. It was further revealed she created the activity schedule and lead activities on days when she was not on the floor assisting residents. NA #3 stated she was appointed by the previous administrator and had not received training or any certification to lead activities. NA #3 revealed the days she was working the floor providing resident care, activities were canceled, and this happened often.

An interview conducted with direct care Nurse #1 on 4/21/21 at 9:07 AM revealed the only activity she knew the residents were currently participating in were movies in the dining room. Nurse #1 further revealed only a few residents could attend due to social distancing. Nurse #1 stated residents have complained about not having activities and feels they should be receiving more.

An interview conducted with the Director of Nursing (DON) revealed she had been in the facility for two weeks and recognized activities was an issue when she entered the facility. The DON indicated she had been pulling nurse aids when they were not busy on the floor to assist with activities. The DON further revealed she

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F 679	Continued From page 31 expected the activity schedule to be followed and the residents to be notified of changes. An interview conducted with the Interim Administrator on 4/21/21 at 5:20 PM revealed she had been working in the facility for two days. It was further revealed the Administrator expected residents to be notified of the activity schedule changes and for the activity event schedule to be followed.	F 679		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with staff, resident, Nurse Practitioner and physician, the facility failed to maintain a medication error rate of less than 5% as evidenced by wrong dose given for 3 medications and failure to follow a physician order to have the resident rinse their mouth after being given a steroid inhaler (4 medication errors out of 28 opportunities), resulting in a medication error rate of 14.3% for 2 of 9 residents (Residents #7 and #11) observed during medication administration. The findings included: 1.a. Resident #7 was admitted to the facility on 2/3/19 with diagnoses that included epilepsy and chronic pain.	F 759	F759 Free of Medication Error 1. Concerns listed in tag F759 has the potential to cause concern with residents living in the facility. The interdisciplinary team has met and determined the best course of action is the following: Residents #7 & #11 had no adverse reaction or effects noted. Resident did receive the right medication and dosage. Medical Director, Responsible Party and/or Power of Attorney were notified. 2. Staff Development Coordinator or designee will have educated all staff that pass medications on the following 7	5/29/21

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F 759	Continued From page 32 The Physician's Orders in Resident #7's electronic medical record indicated an active order for Gabapentin 100 mg (milligrams) by mouth one time a day for neuropathy and Gabapentin 300 mg 1 capsule by mouth at bedtime for nerve pain. On 4/20/20 at 8:45 AM, Nurse #2 was observed as she prepared and administered Resident #7's medications. Nurse #2 administered Gabapentin 300 mg 1 capsule by mouth to Resident #7. On 4/20/20 at 12:58 PM, an interview with Nurse #2 revealed she did not read the directions in Resident #7's Gabapentin 300 mg medication card and did not catch that it was supposed to be given at bedtime. She also did not read the directions in Resident #7's Medication Administration Record (MAR) and failed to identify that Resident #7 was supposed to receive Gabapentin 100 mg instead of 300 mg. An interview with the physician on 4/21/21 at 10:31 AM revealed Resident #7 having received 300 mg instead of 100 mg of her Gabapentin did not really bring her harm because she had already been on this medication. The Gabapentin 300 mg might have made her sleepier than usual, but he thought it was appropriate to have just monitored Resident #7 for any changes after the medication error. The physician stated he had expected the nurses to give medications as ordered and give the appropriate dose at the right time. An interview with the Director of Nursing (DON) on 4/21/21 at 4:45 PM revealed she expected the nurses to read the labels and follow the medication orders as prescribed by the physician.	F 759	Rights of a Medication Pass: right resident, right dose, right time, right route, right reason, right documentation by 5/21/2021. For all staff that pass medication that are not educated by 5/21/2021 will be educated prior to their next shift they work by the Staff Development Coordinator or designee. 3. Staff Development Coordinator or Designee will conduct 3 medication pass observations per shift weekly x 4 weeks. Then 3 observations per shift monthly x 3 months. During observations should an error occur the Staff Development Coordinator or Designee will stop the medication pass immediately, re-educate and the observation process will continue. Should an adverse reaction occur the Medical Director, Responsible Party and/or Power of Attorney will be notified immediately. Reporting to the Department of Health and Human Services will be completed if deemed necessary. 4. Polaris Pharmacy Registered Nurse Consultant will complete independent medication pass observations. Results of the observations will be reviewed and given to the Director of Nursing or Designee. Results of the above audits will be reviewed and discussed in the Quality Assurance Performance Improvement	

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F 759	Continued From page 33 On 4/21/21 at 5:09 PM, an interview with the Administrator revealed that she expected the nurses to follow the physician's orders and administer the right dosage of medications at the right time. b. Resident #7 was admitted to the facility on 2/3/19 with diagnoses that included chronic obstructive pulmonary disease (COPD) and asthma. The Quarterly Minimum Data Set (MDS) assessment dated 3/23/21 indicated Resident #7 was cognitively intact. A review of the Physician's Orders in Resident #7's electronic medical record indicated an active order for Breo Ellipta Aerosol Powder Breath Activated 200-25 mcg (micrograms)/inhalation 1 puff inhale orally one time a day for COPD (rinse mouth with water and spit after use). This medication was used to prevent and decrease symptoms (wheezing and trouble breathing) caused by asthma and ongoing lung disease (COPD). This inhaler contained a combination of an inhaled corticosteroid and long-acting beta agonist. During an observation of Nurse #2 administering medications to Resident #7 on 4/20/21 at 8:45 AM, she was seen activating Resident #7's Breo Ellipta inhaler and giving it to Resident #7. Nurse #2 instructed Resident #7 to take a deep breath while putting the mouthpiece of the inhaler in her mouth. After Resident #7 removed the inhaler from her mouth, she handed the inhaler to Nurse #2 who proceeded to walk back to the medication cart.	F 759	Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date 05/29/2021	

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An interview with Nurse #2 on 4/20/21 at 8:55 AM revealed she did not read the label on the inhaler before she gave Resident #7's Breo Ellipta. Nurse #2 did not see the direction to have resident rinse her mouth with water and spit after using her Breo Ellipta. During the interview, Nurse #2 went back into Resident #7's room and handed her a cup of water and instructed her to rinse her mouth and spit into an empty cup. Resident #7 stated she was surprised that she was being instructed by Nurse #2 to rinse her mouth with water and spit it out. Resident #7 disclosed that she had not been doing this ever since she had started receiving her Breo Ellipta.

An interview with the Nurse Practitioner (NP) on 4/20/21 at 9:27 AM revealed inhalers were more likely to cause oral thrush which was they usually recommended for residents to clean their mouth after using their inhalers. The NP stated Nurse #2's failure to have Resident #7 rinse her mouth after using her inhaler did not present a danger to Resident #7 but not rinsing her mouth would increase her chances of getting oral thrush. The NP added that she recommended Resident #7 to rinse her mouth with water and spit it out after each use of her Breo inhaler.

An interview with the physician on 4/21/21 at 10:31 AM revealed almost all inhalers except Albuterol inhalers tended to cause oral thrush which was why they recommended for the residents to rinse their mouth with water after using their inhaler. The physician stated he did not think Nurse #2's failure to instruct Resident #7 to rinse her mouth after using her inhaler presented a clinical harm to Resident #7 but it could cause oral thrush which would have been a

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THE IVY AT GASTONIA LLC	4414 WILKINSON BLVD GASTONIA, NC 28056

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F 759	Continued From page 35	F 759		

nuisance to Resident #7.

An interview with the Director of Nursing (DON) on 4/21/21 at 4:45 PM revealed Nurse #2 should have followed the physician's orders regarding rinsing of mouth after administering Resident #7's Breo inhaler.

An interview with the Administrator on 4/21/21 at 5:09 PM revealed she expected the nurses to follow the physician's orders and directions with regards to inhaler administration.

2. Resident #11 was admitted to the facility on 7/15/20 with diagnoses that included gastroesophageal reflux disease (GERD).

The Physician's Orders in Resident #11's electronic medical record indicated an active order for Omeprazole 40 mg (milligrams) by mouth one time a day for GERD. There was also an active order dated 4/20/21 for Doxycycline 100 mg by mouth two times a day for infected boil for 10 days.

On 4/21/21 at 8:07 AM, Nurse #2 was observed as she prepared and administered Resident #11's medications. Nurse #2 administered Omeprazole 20 mg 1 tablet by mouth and Doxycycline 50 mg 1 tablet by mouth to Resident #11.

On 4/21/21 at 10:20 AM, an interview with Nurse #2 revealed she had missed that the Medication Administration Record (MAR) indicated for Resident #11 to receive 40 mg instead of 20 mg of Omeprazole and that she should have given him 2 tablets instead of 1 tablet because the stock came in 20 mg tablets. Nurse #2 also missed that the MAR indicated Doxycycline 100

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F 759	Continued From page 36 mg to be given by mouth twice a day to Resident #11 and that the MAR indicated the medication card sent by the pharmacy came in 50 mg tablets so she should have given 2 tablets instead of 1 tablet. Nurse #2 stated she should have paid more attention to the MAR, medication cards and bottle labels and should have read the medication order more carefully. An interview with the physician on 4/21/21 at 10:31 AM revealed he did not think Resident #11 not getting the right dosage of Omeprazole and Doxycycline did any harm to him. The physician stated he thought it was odd that the pharmacy had sent 50 mg tablets of Doxycycline instead of 100 mg because they liked to lessen the number of pills that the residents took as much as possible. The physician stated he had expected the nurses to give medications as ordered and give the appropriate dose at the right time. An interview with the Director of Nursing (DON) on 4/21/21 at 4:45 PM revealed she expected the nurses to read the labels and follow the medication orders as prescribed by the physician. On 4/21/21 at 5:09 PM, an interview with the Administrator revealed that she expected the nurses to follow the physician's orders and administer the right dosage of medications at the right time.	F 759		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		5/29/21

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F 880	Continued From page 37	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 38 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to follow guidance provided by the Centers for Disease Control and Prevention (CDC) by not socially distancing 5 residents observed smoking in the courtyard adjacent to the facility for 5 of 5 residents (Residents #1, #2, #3, #4 and #5), all reviewed for infection control. Findings included: According to the CDC guidelines titled, "Additional Strategies Depending on the Facility's reopening status" dated 11/20/2020 indicated facilities must implement "aggressive social distancing measures (remaining at least 6 feet apart from	F 880	F880 Infection Prevention and Control Concerns listed in F880 has the potential to cause concerns with residents who smoke at the facility. Staff Development Coordinator/Infection Preventionist will educate staff on social distancing guidelines per Center of Disease and Prevention guidelines while residents smoke. Residents are to remain six feet apart. However, residents have the right to exercise their preferences of not social distancing. Documentation of training 5-29-2021	

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F 880	Continued From page 39 others)." A review of the facility's "COVID-19 Policy/Plan for Facilities" last updated on 12/04/2020 under the heading of "Operational Considerations" read in part: "Prevent large gatherings. Choose small, well spread out group activities to take place in well ventilated areas. Gatherings for meals and activities are banned at this time and until further notice unless the social distancing rules of 6 feet distance between persons and ample fresh air can be employed. Groups should not exceed 10 with careful spacing and outside if possible." An observation on 04/20/2021 at 10:45AM revealed 4 male residents (Residents #1, #2, #3 and #4) all in wheelchairs sitting in a small hallway leading out to the smoking area waiting for someone to go out to smoke with them. The residents were positioned so closely together they could touch each other's wheelchair and there was not 6 feet between any of the residents. There was another male resident who was ambulating with a walker waiting in the hallway to go out to smoke (Resident #5). He was positioned closely to the other residents sitting in their wheelchairs. The Director of Nursing (DON) was observed at 10:54AM coming down the hallway and assisting the residents out to smoke. There was a picnic table situated on a concrete pad that all the smokers gathered around to smoke. Four of the five residents were in their wheelchairs and one of the five was seated in a chair at the table. Resident #4 and Resident #2 were on the right-hand side of the table and Resident #3 and Resident #5 (who were roommates) were on the left-hand side of the table and Resident #1 was at the far end of the table. There was approximately 1 foot between	F 880	Timeline for completion 5-29-2021 Root Cause for noncompliance with 6-feet distancing of residents that smoke: Problem: 1. Residents were observed sitting around a picnic table while smoking; residents were not 6 feet apart. Therefore, Center for Disease Control and Prevention guidelines were not followed. 2. No defined marked areas for social distancing identifying six- feet spacing. 3. Resident's preferences is to be around the table. 4. Residents do not make safe decisions. Action: 1. Removed the picnic table 2. Purchased free standing ash trays 3. Mark sitting area with duct tape to maintain 6 feet of distance. 4. Educated residents on importance of social distancing. 5. Document when resident exercise their rights to not follow social distancing guidelines. Team members: Angela Hooper, Administrator, Delma Hearting, Director of Nursing, Janie Fulton, Staff Development Coordinator/Infection Preventionist, Runa Tolbott, RN Unit Manager, Christy Proulx, Certified Nursing Assistant, Sierra	

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F 880	Continued From page 40 Resident #4 and Resident #2 on the right-hand side of the table and approximately 3 feet from Resident #4 was Resident #3 on the left-hand side of the table. There was approximately 3 feet between Resident #5 and Resident #1 who was positioned at the end of the table. There was approximately 4 feet between Resident #1 at the end of the table and Resident #2 on the right-hand side of the table. NA #1 came out to sit with the smokers and assist them as needed. She stated the residents were always positioned around the table and stated the Director of Nursing (DON) had positioned them today prior to her coming out to supervise the smokers. All 5 residents were not roommates were not seated the recommended distance of 6 feet apart to maintain a safe social distancing practice. An observation on 04/20/2021 at 3:30PM revealed the smokers were again noted to be in the small hallway in their wheelchairs waiting to go out to smoke. The residents were positioned so closely together they could touch each other's wheelchairs. An observation on 04/20/2021 at 3:50PM revealed the 5 male residents again positioned around the picnic table and there was not 6 feet between any of the residents and the two residents who were roommates were not sitting beside each other. NA #6 was observed out supervising, socializing, and smoking with the residents and she was positioned between 2 of the residents and was not 6 feet from either of the residents on each side of her. None of the residents (Residents #1, #2, #3, #4, and #5) were positioned 6 feet apart from the resident on each side of them.	F 880	Mazurkiewicz, Activities Director, Lisa Harper, Social Worker and Denny Bridges, Director of Rehabilitation. Staff Development Coordinator or designee will complete audits during smoke times will be 3 times a week times 4, then weekly times 3 months. Results of the audits will be reviewed and discussed in the Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date-5/29/2021	

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F 880	Continued From page 41	F 880		

An observation on 04/21/2021 at 11:00AM revealed the 5 male residents again positioned around the picnic table and the two who were roommates were not positioned beside each other and there was not 6 feet between any of the residents. NA #1 was observed out supervising the residents and stated she had been told by the DON the smokers did not have to be positioned 6 feet apart because they were fully vaccinated.

An observation on 04/21/2021 at 3:45PM of the 5 male smokers revealed them out in the courtyard smoking around the picnic table and the 2 roommates were not beside one another and the residents were not spaced 6 feet apart. NA #6 was observed out with the smokers and was smoking and socializing with them and she was not 6 feet apart from either resident on each side of her.

Review of the medical records revealed the following:
Resident #1 refused the 1st and 2nd COVID vaccines.
Resident #2 refused the 1st and 2nd COVID vaccines.
Resident #3 was fully vaccinated.
Resident #4 was fully vaccinated.
Resident #5 refused the 1st and 2nd COVID vaccines.

An interview on 04/21/2021 at 4:30PM with NA #6 revealed she was not aware the residents needed to be spaced 6 feet apart and stated it would be impossible to space them that far apart with only 3 ashtrays that sit on the table.

An interview on 04/21/2021 at 4:45PM with the interim Director of Nursing (DON) they had limited

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F 880	Continued From page 42 space in the courtyard for the smokers and would have to get supplies to accommodate their being spaced 6 feet apart while out smoking An interview on 04/21/2021 with the interim Administrator revealed she expected the smokers to be spaced 6 feet apart while smoking in the courtyard and stated they would need to provide additional equipment in the courtyard to accommodate the required spacing.	F 880		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations, staff, Plumber and facility owner interviews, the facility failed to maintain a safe and sanitary environment in the kitchen as evidenced by buckling, broken and uneven tiles on the floor and a clogged drain seeping water and food debris in the floor beside the stream table and causing the floor to buckle around the drain. Findings included: Interview on 04/20/2021 at 4:22PM with the Maintenance Director revealed there were some issues in the kitchen that needed repair and were supposed to be corrected with the kitchen remodel but stated the remodel had not taken place yet. He stated he was not sure what had happened but there had been a crew out to the facility ready to begin the demolition and remodel	F 921	F921- Safe/Functional/Sanitary/Comfortable Environment 1. Concerns listed in tag F921 has the potential to cause concern with multiple residents and staff in the facility. To address the kitchen, drain and clogs, the Maintenance Director scheduled the first available appointment with Roto Rooter Plumbing who completed kitchen drain repairs on 4/26/2021. To address the Kitchen floor tiles, the Area Director of Maintenance will assess the integrity of the pipes below the flooring to determine extent of repair by 5/19/2021. All final repairs will include proper pitch and taper with flooring as to avoid tripping	5/21/21

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F 921	Continued From page 43 of the kitchen but the project had been cancelled and he was not sure why that had happened. The Maintenance Director stated there was an issue with a drain backing up and water puddling in the floor causing the floor to buckle around the drain. He further stated there had been a plumber out to the facility to run a camara in the pipes to find the problem and had provided an estimate for repairs to the drain. The Maintenance Director indicated the estimate provided by the plumber had been rejected. He further indicated he was not sure why the estimate had been rejected and the drain not repaired. An observation on 04/20/2021 at 5:00PM of the kitchen revealed a drain on the floor next to the steam table that had water and food debris puddling and the surrounding tiles buckling due to the standing water. The drain continued to back up with water and food debris as the dishwasher was running to clean the dishes used to prep the dinner meal. The floor in front of the 2-compartment sink was slanting down and was uneven. The tile floor approximately 3 feet in front of the freezer was cracked, buckling and uneven. There was another drain beside the freezer with PVC pipe open and draining into another drain in the floor that had some type of debris in it. An interview on 04/20/2021 at 5:10PM with the Dietary Manager (DM) revealed today was his first day at the facility and his understanding was he was coming to work off a food truck while the kitchen was being demoed and remodeled. He stated instead he had come into a kitchen with some issues that needed repair. The DM stated it looked as though the drain was backing up from	F 921	hazards or water from pooling and meet to meet code. 2. Maintenance Director and/or Designee will round and assess all floors for cracked or damaged tiles and clogged drains throughout the facility by 5/21/2021. Maintenance Director and/ or designee will start repairs by 5/19/2021. 3. Maintenance Director will monitor kitchen floors and drains weekly for 4 weeks, then 2 times a month for 1 month then will add to the preventive maintenance schedule in TELS for monthly assessments thereafter to monitor performance and to make sure solutions are sustained. Results of the above audit will be reviewed and discussed in the Quarterly Quality Assurance Performance Improvement Committee meetings. The Quality Assurance Committee will assess and modify the action plan as needed to ensure continued compliance. Completion Date-5/21/2021	

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F 921	Continued From page 44	F 921		

the dishwasher. He further stated he had noticed the floor being slanted, uneven, buckling in places and broken and uneven in others and felt it was a hazard to the employees working in the kitchen.

An interview on 04/20/2021 at 6:45PM with the Administrator revealed she had been told by corporate the drain in the kitchen had been repaired; however when she observed the drain and saw the backed up and pooling water with food debris in it she agreed it had not been fixed. She stated she was told there was a plumber out last week that had repaired the drain and asked the Maintenance Director why it had not been repaired and he told her the estimate for the repairs had been rejected.

An interview on 04/21/2021 at 9:40AM with the Plumber revealed he had been called to come to the facility last week and run his camara in the pipes and give the facility an estimate for fixing the pipe. He stated he had provided his estimate for repairing the pipes, so the drain was not backed up and pooled with water but stated the estimate had been rejected and he had not repaired the pipe or drain.

A follow up interview on 04/21/2021 at 5:09PM with the Administrator revealed she had been told by upper management the drain in the kitchen had been repaired last week and stated she had found out that was not the case. She requested to contact the owner by phone so he could answer questions and explain why the kitchen remodel had been delayed. She contacted the owner by phone, and he stated he had just received 3 bids on the remodel of the kitchen, and said they were moving forward with one of

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F 921	Continued From page 45 the companies. The owner stated the original bid was way too high and so the work by that company crew had been cancelled. He further stated he had contacted a plumbing company to fix the issues with the kitchen drain that was puddling water and once that was completed, they were moving forward with the demolition of the kitchen. The owner indicated he was unsure how long the pipe in the kitchen had been backing up into the drain but stated they were moving forward with the repairs. The owner further indicated he was not sure when the work would begin.	F 921		