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| F 000 | INITIAL COMMENTS<br><br>A complaint investigation was conducted from 9/3/2021 to 9/23/2021. Immediate Jeopardy was identified at:<br><br>CFR 483.12 at tag F 600 at a scope and severity of K<br>CFR 483.45 at tag F 756 at a scope and severity of J<br>CFR 483.45 at tag F 757 at a scope and severity of K<br>CFR 483.70 at tag F 835 at a scope and severity of K<br><br>The tag F 600 and F 757 constituted Substandard Quality of Care.<br><br>For tag F600 Immediate Jeopardy began on 8/14/2021 and was removed on 9/12/2021.<br>For tag F756 Immediate Jeopardy began on 8/17/2021 and was removed on 9/11/2021.<br>For tag F757 Immediate Jeopardy began on 8/14/2021 and was removed on 9/11/2021.<br>For tag F835 Immediate Jeopardy began on 8/14/2021 and was removed on 9/12/2021.<br><br>A partial extended was conducted.<br><br>Seventeen of the forty-one complaint allegations were substantiated. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- | F 580 | | 10/25/21 |

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

Electronically Signed | 10/15/2021

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| F 580 | Continued From page 1 | F 580 | | |

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).
(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various

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| F 580 | Continued From page 2<br>locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff and physician interviews the facility failed to notify the physician when a resident refused two consecutive hemodialysis procedures for 1 resident; failed to notify the physician when medication was unavailable for administration for 4 days, for 1 resident, who missed 13 doses of medication. The failure of notification occurred for 2 of 3 residents reviewed for notification (Resident #10 and 14).<br><br>Findings included:<br><br>1. Resident #10 was re-admitted to the facility on 4/20/21 and had a diagnosis of end-stage renal disease (ESRD) with dependence on hemodialysis.<br><br>A review of Resident 10 ' s recent Quarterly Minimum Data Set (MDS) Assessment, dated 4/26/21, revealed that Resident #10 was severe cognitively impaired, received hemodialysis three times a week and hospice care.<br><br>A review of the physician ' s order for Resident #10, dated 4/21/21, revealed the order for hemodialysis outside of the facility on Tuesday, Thursday, and Saturday.<br><br>Records review of the multiple Dialysis Post Treatment reports for July 2021 revealed that Resident #10 last time completed the hemodialysis procedure on 7/15/21. | F 580 | The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.<br><br>F580<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident number 10 refused to go to dialysis 2 times and medical provider was not notified<br>Resident number 14 missed opioid pain medication was reported to physician extender as missed<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All residents who receive opioid pain | |

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| F 580 | Continued From page 3<br><br>A review of the Communication to Physician book for July 2021 revealed no physician notification about Resident #10, who missed two consecutive hemodialysis procedures on 7/17/21 and 7/20/21.<br><br>On 9/20/21 at 12:30 PM, during an interview, the Assistant Director of Nursing (ADON) was not aware of two consecutive missing hemodialysis procedures for Resident #10. She expected the staff to notify the physician if the resident did not receive hemodialysis. The staff was trained to use different ways of notification: Communication to Physician book, phone call, or in-person conversation if the healthcare provider was in the building.<br><br>On 9/21/21 at 10:15 AM, during an interview, the Physician Assistant (PA #1) indicated that he was not aware of missing hemodialysis procedures for Resident #10. PA #1 expected the staff to notify the healthcare provider if the resident did not receive two consecutive hemodialysis procedures. He would accept the notification via Communication to Physician book/ by the phone and was available in person on the week of 7/20/21.<br><br>On 9/21/21 at 2:00 PM, during the phone interview, the Resident 10 ' s responsible party indicated on 7/21/21. The Dialysis Center notified him that Resident #10 did not come for the hemodialysis procedures on 7/17/21 and 7/21/21. The Resident 10 ' s responsible revealed from the communication with nursing home staff, that Resident #10 refused her hemodialysis on both days, mentioned above. On 7/21/21, per family request, the Resident #10 was sent to the hospital. | F 580 | medication will be audited to validate current supply of medication<br>All resident who receives hemodialysis will be audited for last 2 weeks to ensure no dialysis refusals and compliance with dialysis. If a resident refused dialysis MD will be notified.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated that all opioid pain meds will be administered as ordered; if unable to administer pharmacy and physician will be notified for further direction<br>All licensed nurses will be educated to notify physician or physician extender for any missed hemodialysis treatments<br>DON or designee will audit 24 hours summary to ensure notifications have been made to MD of any missed pain medications and any missed hemodialysis treatments. Audits will be done 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation on pain medication administration process and missed dialysis process.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance | |

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| F 580 | Continued From page 4<br><br>On 9/21/21 at 2:10 PM, during the phone interview, Nurse #31, who worked with Resident #10 on 7/20/21, indicated that in the morning of 7/20/21, Resident #10 refused to go to the dialysis center. Nurse #31 left the message for the resident ' s responsible party but was unsure if she wrote the notification in the Communication to Physician book. Nurse #31 confirmed that the staff always notified the physician and family if the resident refused to go to the hemodialysis.<br><br>2. Resident #14 was readmitted to the facility on 7/30/21 with diagnosis that included chronic respiratory failure, presence of left artificial shoulder joint, lower back pain, acute kidney failure, chronic pain syndrome and heart failure.<br><br>Review of Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 8/13/21, revealed the resident was cognitively intact. The assessment indicated the resident needed one-to-two-person physical assistance with activity of daily living. The resident was coded as having pain with a pain scale of 10 and was on scheduled and as needed (PRN) pain medications. Resident received opioids for 7 of the 7 days during the look back period.<br><br>Review of the nursing note, dated 9/16/21, revealed the facility received orders for Resident #14 for pain control medication. Note also indicated methadone 10 mg (milligram) by mouth every 8 hours was ordered.<br><br>Review of the medication order summary report for September 2021 revealed Methadone HCl Tablet 10 MG 1 tablet by mouth every 8 hours related to lower back pain was ordered on | F 580 | Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| F 580 | Continued From page 5<br>9/16/21.<br><br>Review of the Medication Administration record (MAR) for Resident #14 for September 2021 revealed, Methadone HCl 10 MG was not administered from 9/16/21 to 9/20/21. A total of 13 doses were not administered.<br><br>During an interview on 9/20/21 at 3:00 PM, Nurse #35 stated she did not notify the physician that the resident did not receive his medication.<br><br>During an interview on 9/21/21 at 9:25 AM, Nurse# 36 confirmed she did not notify the physician about the medication unavailability.<br><br>During a telephone interview on 9/21/21 at 11:44 AM, the Assistant Director of Nursing (ADON) stated she did not notify the physician that the resident did not receive his medication.<br><br>During an interview on 9/21/21 at 11:26 AM, Physician Assistant (PA) #3 stated she was on vacation during the week of 9/13/21. PA#3 further stated the facility staff were aware to call the on-call person in her absence if they had a medication related issue or any medical emergency. PA#3 indicated upon her return she checked the on-call telephone log and did not notice anything related to Resident #14 not receiving his medication. PA #3 indicated she was unaware the resident had not received his medication for 4 days. | F 580 | | |
| F 600 SS=K | Free from Abuse and Neglect<br>CFR(s): 483.12(a)(1)<br><br>§483.12 Freedom from Abuse, Neglect, and Exploitation | F 600 | | 10/25/21 |

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| F 600 | Continued From page 6<br>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.<br><br>§483.12(a) The facility must-<br><br>§483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interviews, Physician Assistant (PA) interviews, Physician interviews, Administrator interview, Interim Director of Nursing (DON) interview, and previous Director of Nursing interview the facility neglected to provide necessary care and services by failing to administer the correct medication; failing to provide effective and ongoing nursing and medical assessments and medical interventions for a resident with an acute/significant change in condition; and failing to implement effective medical intervention for a resident with signs of dehydration for one (Resident #1) of one resident reviewed for neglect. Resident #1 received 29 incorrect medications for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on | F 600 | F600<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident #1 experienced change of condition without intervention<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current residents were reviewed for changes in condition on 09/09/2021<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All nursing staff and rehab staff were educated by SDC or designee on 09/10/2021 on identification, reporting, and documenting of acute/significant changes in condition.<br>All licensed nurses were educated by SDC or designee to notify administrator if | |

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| F 600 | Continued From page 7<br>9/1/2021. The cause of death of Resident #1 was determined to be septic shock.<br><br>Immediate Jeopardy began on 08/14/2021 when Resident #1 entered the facility and the facility failed to have effective systems in place to order and administer correct medications, and to effectively address a decline and change in condition. The immediate jeopardy was removed on 9/12/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Example C. is a scope and severity level of a "D" (Isolated -No actual harm with potential for more than minimal harm that is not immediate jeopardy.)<br><br>Findings included:<br><br>A. Cross Refer to F757: Based on record review, staff interview, Administrator interview, physician assistant interview, and physician interview the facility failed to administer the correct medications and administered medications without supporting diagnoses for one (Resident #1) of three residents reviewed for unnecessary drugs. The facility failed to recognize the incorrect medications were entered into the electronic medical record system upon admission for Resident #1 resulting in the resident receiving 29 incorrect medications for a period of 8 days. These medications included in part antipsychotics, seizure medication, pain medication, insomnia medication, hypertension medication, diabetic medication, glaucoma | F 600 | they disagree with he MD/PA or DON<br>All staff will receive abuse/neglect education using Relias learning system<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing during orientation<br>DON or designee will audit 24-hour summary to monitor for acute changes in condition and follow up 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br>DON will meet with medical director and PA weekly on the status of acute significant changes in condition.<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| F 600 | Continued From page 8 | F 600 | | |

medication, and smoking cessation. Resident #1 was admitted to the hospital on 8/30/2021 and expired on 9/1/2021.

B. Resident #1 was admitted from the hospital emergency room to the facility on 8/14/2021.

A North Carolina FL-2 form for Resident #1, dated as completed on 8/13/2021 at 1:45 PM was sent to the facility from the hospital. A FL-2 is a North Carolina form that describes a patient's medical condition and the amount of care they need when placed in a facility.

Resident #1 had diagnoses listed on the FL-2 form dated 8/13/2021 from the emergency room of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, prostate cancer (2018), esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission complaint of Resident #1 was weakness and failure to thrive.

The FL-2 form dated 8/13/2021 included documentation attested to by the physician stating Resident #1 was oriented to self, place, time, and situation as well as continent of bowel and bladder. He was also described on the documentation as requiring limited assistance with bathing, feeding, and dressing. A physical therapy evaluation included in the FL-2 dated 8/13/2021 revealed Resident #1 required maximum assistance with getting into the sitting position from laying flat but required minimum assistance from sitting to standing. The hospital physical therapy evaluation noted Resident #1

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| F 600 | Continued From page 9 | F 600 | | |

was able to walk 85 feet with a rolling walker.

Documentation in the facility electronic record listed the Resident's diagnoses as being cerebral infarction, Parkinson's disease, adult failure to thrive, muscle weakness, chronic obstructive pulmonary disease, gastro-esophageal reflux disease, hyperlipidemia, and Hypertension.

The Rehabilitation Manager was interviewed on 9/7/2021 at 2:18 PM and revealed Resident #1 received both occupational and physical therapy assessments on 8/16/2021 revealing the resident was a typical rehabilitation patient and had good potential for therapy improvement. The Rehabilitation Manager stated Resident #1 scored as being severely dependent on the assessment tools they used but he was able on 8/16/2021 to walk 50 feet with a rolling walker. The Rehabilitation Manager added on 8/17/2021 Resident #1 was able to walk 175 feet with the rolling walker.

On 8/18/2021 at 4:21 PM Resident #1 was noted in the nursing notes to have had a change in condition. Nurse #12 documented in the nursing note the blood pressure of Resident #1 had dropped, oxygen saturation levels went to 88%, and PA #1 was contacted. Resident #1 was placed on 2 Liters of oxygen and blood pressure medication was ordered to be put on hold. The Director of Nursing was contacted, vital signs were rechecked, and stabilized within the hour.

Nurse #12 was interviewed on 9/7/2021 at 1:58 PM and confirmed she was assigned to care for Resident #1 on 8/18/2021 for the 7:00 AM to 7:00 PM shift. Nurse #12 stated Resident #1 was sluggish the whole day, but his blood pressure

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| F 600 | Continued From page 10 | F 600 | | |

improved after the blood pressure medications were put on hold. Nurse #12 stated she was concerned about Resident #1 because he was on seizure medication as well as the multiple blood pressure medications and she felt he needed to be monitored closely.

On 8/19/2021 at 7:33 AM Resident #1 was noted in the nursing notes to have had a change in condition where he was noted to be lethargic. The nursing note revealed the Director of Nursing was made aware of the change in condition for Resident #1.

Nurse #17, who wrote the nursing note for Resident #1 on 8/19/2021 at 7:33 AM, was interviewed on 9/5/2021 at 7:15 AM and she stated she did not recall the resident or his condition on 8/19/2021.

On 8/19/2021 at 11:17 AM PA #1 wrote a progress note where documentation stated under history of present illness, "Per nursing complaint of patient slightly more lethargic than baseline, hypotensive, and decreased O2 (oxygen) sats (saturation levels). On exam the patient was arousable, will hold BP (blood pressure) medication and start O2, monitor for improvement or worsening condition. I have ordered labs (laboratory tests) and CXR (chest x-ray) to check for any infectious process or metabolic disturbance causing the symptoms." No medication abnormalities were noted.

Documentation in the progress notes entitled "Orders-Administration note" on 8/19/2021 at 3:09 PM, 3:11 PM, and 3:12 PM revealed Resident #1 was unable to swallow.

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Documentation in the nursing notes for Resident #1entitled "Change in Condition" dated 8/19/2021 at 3:27 PM revealed, "Resident appears [asleep] with respirations even and nonlabored. [Vital Signs] stable. [PA #1] assessed resident this shift and gave new orders to obtain [Urgent] labs & Chest x-ray [due to] health decline. [Emergency Contact #1] was on site and made aware of change of condition & new orders. Currently awaiting results."

A basic metabolic panel results for Resident #1 came back on 8/19/2021 at 6:29 PM with the abnormalities of a high BUN (Blood Urea Nitrogen) of 37.8 mg (milligrams)/dl (deciliters) (normal values are 6.0-20.0 mg/dl) and BUN/Creatinine ratio of 44.0 (normal values are 6.0-25.0). PA #1 signed the laboratory results as reviewed on 8/24/2021 at 8:23 AM.

The chest x-ray results for Resident #1were ordered on 8/19/2021 at 2:00 PM were reported on 8/19/2021 at 8:10 PM. The chest x-ray impression was bilateral basilar atelectasis and left effusion. Bilateral basilar atelectasis is defined as both sides of the lowermost lobes of the lungs are collapsed entirely or partially. Left effusion is defined as a build-up of fluid in the area between the layers of tissue that line the lungs and the chest wall. The chest x-ray results were signed as reviewed by PA #1 on 8/24/2021 at 8:17 AM.

Documentation in the nursing notes for Resident #1 entitled "Change in Condition" dated 8/20/2021 at 12:12 AM revealed the physician for Resident #1 (MD #1) was notified of the chest x-ray results with no new orders given.

Documentation in the progress notes entitled

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"Orders-Administration note" on 8/20/2021 at 9:48 AM revealed Resident #1 was unable to take medication due to difficulty breathing.

On 8/20/2021 at 11:16 AM a nursing note written by Nurse #21 stated, "Resident (#1) is currently resting in bed. Resident is not alert and oriented. Vitals are within normal range at (Blood pressure) 119/74, [Pulse] 82, O2 99 %, [Temperature] 97.4, [Respirations] 22 Resident is abdominal breathing with mouth open. Resident on 3.5 Liters of oxygen. [Capillary Blood Glucose] 174 no insulin needed. Resident consumed 0 percent of breakfast. Medication on hold due to resident not being alert. ADON (Assistant Director of Nursing) and doctor is aware of resident's condition. Will continue to monitor resident's vitals."

Nurse #21, wrote the progress note on 8/20/2021 at 11:16 AM, was interviewed on 9/7/2021 at 1:43 PM. Nurse #21 stated she had concern for Resident #1 on 8/20/2021. Nurse #21 described Resident #1 on 8/20/2021 as not being able to swallow and he did not have a feeding tube to obtain nutrition or hydration. Nurse #21 explained this was her first time caring for Resident #1 and his baseline was unknown to her. Nurse #21 stated she notified the physician and her Director of Nursing. Nurse #21 indicated her nursing judgement told her Resident #1 needed to go to the hospital. Nurse #21 explained she noted he was his own responsible party, but she saw he was not arousable indicating he had a major change in condition from his arrival at the facility. Nurse #21 stated her concern grew when she spoke with the family of Resident #1 to update them on the resident's condition. Nurse #21 stated the DON and the ADON went to assess Resident #1 but did not want him sent to the

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hospital. Nurse #21 stated PA #1 also did not want him sent to the hospital but for her to continue to monitor his condition.

An interview with the ADON was conducted on 9/3/2021 at 4:00 PM. The ADON stated she did an assessment on 8/20/2021 to determine if Resident #1 had another stroke but after an assessment he did not seem critical enough to send to the hospital. The ADON explained her assessment was focused on assessing if he had any deficits to indicate he had another stroke such as inability to speak or weakness in his extremities. The ADON explained she thought the resident was at his baseline.

An admission minimum data set (MDS) assessment dated 8/20/2021 coded Resident #1 was having moderately impaired cognition and feeling tired 7 to 11 days of the assessment period. He was coded as requiring extensive assistance with bed mobility and toilet use. He was independent with feeding himself after set-up. He did not transfer, ambulate, or perform locomotion during the assessment period. He was coded as always incontinent of bowel and bladder. He was coded as receiving 5 days of antipsychotics, 3 days of antibiotics, oxygen therapy in the facility, and intravenous medications during the assessment period.

There were no nursing notes or documentation in the medical record on the condition of Resident #1 on Saturday, 8/21/2021 or Sunday, 8/22/2021.

On 8/24/2021 at 9:41 AM the progress notes entitled "Orders- Administration note" for Resident #1 stated, "Unable to swallow."

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An interview was conducted on 9/7/2021 with Nurse #22, who wrote the 8/24/2021 administration note at 9:41 AM. Nurse #22 stated she contacted PA #1 because she had great concern for Resident #1, and she wanted to know what was going on. Nurse #22 described Resident #1 as "really passed out" and "not responding at all." Nurse #22 said she was told by PA #1 he was aware of the condition of the resident, he had ordered laboratory tests, and she was told to continue to monitor the resident.

On 8/24/2021 an initial physician visit progress note was written by the Physician for Resident #1 (MD #1). The impression portion of the note stated, "New recent problem. Has improvement with changes in medication. Continue to [rule out] other etiologies with urine and blood work testing."

Review of the physician orders revealed on 8/26/2021 the Physician (MD #1) for Resident #1 gave a verbal order for one liter of sodium chloride solution 0.9% to be administered intravenously at a rate of 75 cc (cubic centimeters)/hour until 8/27/2021 for dehydration.

On 8/26/2021 at 11:30 AM nursing notes revealed peripheral intravenous fluids were started for Resident #1.

On 8/27/2021 at 1:14 PM nursing progress notes revealed Resident #1 had a blood pressure of 90/75 and the ADON advised for oxygen levels to be increased. The documentation in the note also revealed PA #2 was called and additional laboratory tests were ordered to include a complete blood count, basic metabolic panel, and a chest x-ray.

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An interview was conducted on 9/4/2021 at 12:30 PM with Nurse #9, who wrote the 8/27/2021 1:14 PM nursing note. Nurse #9 stated when she came into to work on 8/27/2021 she was told in report Resident #1 had overdosed on blood pressure medication and was no longer able to stand or feed himself. Nurse #9 stated she really thought Resident #1 needed to be sent to the hospital because of the low blood pressure and a rectal temperature of 99.9 degrees. Nurse #9 confirmed she also worked on the 7:00 AM to 7:00 PM shift caring for Resident #1 on 8/28/2021. Nurse #9 stated she continued to have concern for Resident #1 because he was very confused and "out of it." Nurse #9 stated her nursing judgement told her he needed to be sent out to the hospital. Nurse #9 stated she relayed her concerns to the DON and the PA but neither felt it was necessary to send Resident #1 to the hospital. Nurse #9 stated she knew that if she sent Resident #1 to the hospital, she would be disciplined like some of the other nurses had been who sent residents to the hospital.

An interview was conducted with PA #2 on 9/7/2021 at 11:15 AM. PA #2 revealed Resident #1 appeared to have altered mental status and drowsy but was not lethargic. PA #2 stated she was not as familiar with this resident and thought blood tests and a repeat chest x-ray were ordered. PA #2 did not recall a request being made to send the resident to the hospital.

On 8/27/2021 at 3:23 PM an order note documented an order for saline to be administered intravenously was clarified by PA #2 to provide one liter of saline for this shift only (7:00 AM to 7:00 PM) and then discontinued.

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Laboratory results reported on 8/27/2021 at 4:46 PM flagged at low hemoglobin 13.8 g (grams)/dl (normal range of 14.0-18.0 g/dl), high glucose 118 (normal range of 70-99 mg/dl), low calcium 8.5 (normal range of 8.6-10.2), a high BUN of 65.5 (normal range of 6.0-20.0 mg/dl), a BUN/Creatine ratio of 54.6, and a sodium of 147 (normal range is 136-145 mmol (millimole)/L (liter).

A physical therapy progress note dated 8/27/2021 for Resident #1 stated, "Did well the first two days (in facility) but has struggled to perform interventions without considerable assistance."

The chest x-ray results ordered on 8/27/2021 for Resident #1 were dated as reported on 8/29/2021 at 1:15 PM. The results stated in part under the impression, "There are mild patchy bibasilar densities compatible with pneumonia or less likely atelectasis."

An interview was conducted on 9/7/2021 at 6:48 PM with Nurse #19, who cared for Resident #1 on the 7:00 PM to 7:00 AM shift on 8/27/2021. Nurse #19 recalled Resident #1 was very sedated when she started her shift on 8/27/2021. Nurse #19 stated she was told just to monitor him. Nurse #19 further stated the only thing she remembered was Resident #1 slept her entire shift.

An interview was conducted on 9/4/2021 at 2:45 PM with Nurse #10. Nurse #10 revealed she was not assigned to care for Resident #1 on the 7:00 PM to 7:00 AM shift on 8/28/2021. Nurse #10 explained she took over two medications carts because the agency nurse for one of the medication carts could not get log in information

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to access the electronic records despite numerous attempts to get help from the information technology team.

An interview was conducted on 9/7/2021 at 6:51 PM with Nurse #24, who was assigned to care for Resident #1 on the 7:00 PM to 7:00 AM shift on 8/28/2021. Nurse #24 confirmed she received report from Nurse #9 on 8/28/2021 and did not recall any concerns regarding Resident #1 being given to her. Nurse #9 stated her major concern was she did not have access to the electronic medical records despite numerous attempts to obtain information technology assistance. Nurse #24 stated she was not familiar with any of the residents and stated none of the residents were unresponsive with most of them sleeping on the shift.

An interview was conducted on 9/3/2021 at 1:51 PM with Nurse #4, who cared for Resident #1 on the 7:00 AM to 7:00 PM shift on 8/29/2021. Nurse #4 revealed 8/29/2021 was the first time she had ever cared for Resident #1. Nurse #4 did not recall if he was receiving intravenous fluids on her shift or not. Nurse #4 did not recall being told to monitor Resident #1, but she recalled being told by the nurse aide he slept all day.

An interview was conducted on 9/4/2021 at 6:43 AM with Nurse #8, who cared for Resident #1 on the 7:00 PM to 7:00 AM shift on 8/29/2021. Nurse #8 stated Resident #1 had low oxygen level on his shift, and he heard in report from the previous nurse the resident had pneumonia, but he was to only monitor him and not send him out. Nurse #8 stated he gave Resident #1 continuous oxygen and he improved by the end of his shift. Nurse #8 stated he had to leave his shift early at 6:30 PM

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and he gave a nursing report to Nurse #10, who was on another hall on his shift.

An interview was conducted on 9/3/2021 at 1:29 PM with Nurse #3, who was assigned to care for Resident #1 beginning on 8/30/2021. Nurse #3 recalled when Resident #1 was first admitted to the facility he was up with physical and occupational therapy walking and talking. Nurse #3 explained that by the time he was moved to another hallway he was just not the same. Nurse #3 stated she heard from occupational therapy Resident #1 could no longer walk, eat on his own, or sit on the edge of the bed. Nurse #3 also stated she heard from occupational therapy Resident #1 received three blood pressure pills he was not supposed to get. Nurse #3 stated she did not work on 8/27/2021 through 8/29/2021 and when she came back Resident #1 had really changed. Nurse #3 stated she received no information regarding Resident #1 in report on the morning of 8/30/2021. Nurse #3 stated Resident #1 was unresponsive and didn't look right so she called PA #1 who told her he would see the resident as soon as he arrived at the facility. Nurse #1 stated when PA #1 arrived he told her to hold all his medications. Nurse #3 stated she started her nursing duties which involved first getting blood sugars, blood pressures, vital signs and then passing out morning medications. Nurse #3 stated she also had skin assessments she needed to do after the medication pass. In addition, she explained she was on the behavior unit, so she needed to watch out for wandering residents. Nurse #3 also explained she started giving out the medications to the residents who were known to her and then the new residents, Resident #1 was going to be last because his medications were on hold. Nurse #3 stated she

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did not recall what time she sent Resident #1 to the hospital.

There were no documented vitals in the medical record for Resident #1 on 8/30/2021 prior to 2:33 PM.

Documentation in the nursing notes written by Nurse #3 on 8/30/2021 at 2:33 PM stated, "Resident unresponsive to voice and painful stimuli. PA (#1) and ADON notified of declining status and vitals (Temperature) 99.3, (Pulse) 65, (Blood pressure) 69/46, (O2) 89 % on 4 [Liters] of O2. No urine output in foley. PA [#1] ordered resident to be sent to [Emergency Department] for further evaluation, [Emergency contact #1] resident emergency contact also notified of the changes."

The emergency room report dated 8/30/2021 stated in the narrative in part, "[Resident #1] laying supine in his bed unresponsive but breathing. Nurse in room advised he has been unresponsive since at least 7 AM when she began shift this morning. Nurse also stated that he is normally alert and talking. Noted [patient's] skin was hot to touch, and radial pulses were absent."

The hospital discharge summary dated 9/1/2021 at 4:28 AM revealed Resident #1 expired due to septic shock.

Review of the death certificate dated 9/1/2021 revealed the immediate cause of death for Resident #1 was septic shock with contributing diagnoses of pneumonia, sacral decubitus ulcer, and possible meningitis.

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An interview was conducted on 9/3/2021 at 4:00 PM with the ADON. The ADON stated on 8/30/2021 she arrived at the facility around 2:00 PM because she was going to be supervising the night shift that day. The ADON stated shortly after she arrived PA #1 arrived to assess Resident #1, who the facility staff had been working all weekend to stabilize. The ADON stated she saw Resident #1 on 8/26/2021 and he was "okay." The ADON revealed when she did her assessment at 2:00 PM on 8/30/2021 Resident #1 was not responding to painful stimuli.

An interview was conducted with PA #1 on 9/7/2021 at 8:15 AM. PA #1 revealed on 8/30/2021 he was on his way to the facility when he received a phone call notifying him of the chest x-ray results for Resident #1. PA #1 indicated he told the nurse he would assess Resident #1 as soon as he arrived at the facility and gave a verbal order for an antibiotic for the resident. PA #1 recalled he told the nurse to send the resident out as soon as he saw him in the facility that morning. PA #1 stated Resident #1 was debilitated upon admission and did not think the medication errors necessarily contributed to his decline.

A subsequent interview was conducted on 9/8/2021 at 2:07 PM with PA #1. PA #1 corrected his version of the events of 8/30/2021 during which Resident #1 was sent to the hospital. PA #1 confirmed he saw Resident #1 on the morning of 8/30/2021 and he appeared lethargic, so he ordered more laboratory tests and continued monitoring. PA #1 stated Resident #1 had no signs of infection and his vital signs were good. PA #1 stated he had left for another facility when he received a phone call around 1:00 PM

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informing him Resident #1 was unresponsive and needed to be sent to the hospital.

An interview was conducted on 9/7/2021 at 10:08 AM with the Physician (MD #1) for Resident #1. MD #1 explained if the facility nurses had a resident concern and wanted someone evaluated to be sent to the emergency room it was facility policy to reach out to the Director of Nursing or a Physician. MD #1 explained, previously the nurses were sending residents to the hospital without letting anybody in administration know. MD #1 stated there was a chain of command and the nurses can certainly send a resident to the hospital if needed but someone on the administrative level needed to know. MD #1 stated it was critical the nurses in the facility reach out if he or she has a concern for a resident.

C. Cross refer to F692: Based on record review, staff interview, Physician Assistant interview, and Medical Doctor interview the facility failed to take immediate measures to prevent dehydration for one (Resident #1) of one resident reviewed for dehydration.

On 9/9/2021 at 12:30 PM, the administrator was informed of the immediate jeopardy.

The allegation of immediate jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy removal:

F600 - Abuse and Neglect
" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome

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as a result of the noncompliance

Synopsis: Resident was admitted 8/14/21. Upon admission, a charge nurse entered inaccurate admission orders and did not confirm the orders. The resident did not receive ordered medications for two days until they were confirmed by the nurse on 8/16. On 8/18, resident exhibited a change in status and PA placed blood pressure medication on hold and resident on oxygen. On 8/19, resident was noted to be lethargic and the PA ordered a chest x-ray and lab tests. On 8/19, abnormal lab results returned with elevated BUN and creatinine levels. On 8/20, the resident was observed to be not alert, had abdominal breathing, and not eating or taking meds. Resident was assessed by DON and ADON and no new orders were received at that time in response to resident's change in condition. No additional assessment or documentation was present on 8/21 or 8/22. Then, on 8/23, PA examined the patient and indicated mild dehydration and ordered to increase PO fluids. On 8/24, it was discovered in the IDT meeting that medication diagnosis codes were missing. Upon review of the patient's discharge summary, it was discovered that his current meds did not match the discharge summary. The resident did not receive the medications that he should have received until 8/24. An attempt to discover the source of these orders was unsuccessful at the time. PA and medical director were notified. Medications were reconciled and corrected. Later (9/9), the ADON, while auditing new admissions since 8/13, discovered the discharge summary for a different patient that matched what had originally been entered for the resident. If the charge nurse disagrees with the decision from physician extenders, DON and/or attending

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physician for need for higher level of care, notify administrator who will notify medical director to make the call. Administrator notified nursing leadership of this on 9/11. SDC or designee will notify all nurses working currently and the remainder before their next shift.

On 9/9, DON spoke with every charge nurse and instructed each charge nurse to observe and assess each patient for any signs of acute change of condition. A census sheet was used to ensure each current resident was observed. DON reviewed this list once it was complete to ensure residents had been observed. Based on this, two acute changes were identified. One resident had refused dialysis. Nurse assessed patient for signs of fluid overload, educated patient on importance of receiving dialysis, and MD and RP were notified. Care plan was updated to include refusal of dialysis. The second patient was noted to have decreased intake. NP was informed and gave verbal order to increase oral intake of fluids, and RP was notified.

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

Facility Action: Current licensed nursing (nurses and CNAs) and rehab staff were educated by the staff development coordinator or designee regarding identification, reporting, and documentation of acute/significant changes in condition to be completed by 9/10/21.
The staff development coordinator or designee will educate licensed nurses to notify Administrator if they disagree with the decisions

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from PA/NP, attending physician, and/or DON starting 9/11/21 to be completed for additional nurses before their next scheduled shift. Any agency staff will be educated before their next scheduled shift. The staff development coordinator will communicate the scheduler to identify when agency staff are scheduled and educate them before their shift. All staff will receive abuse/neglect education via our SDC using the Relias learning system during their next scheduled shift. Any who have not received this by 9/14 will be taken off the schedule until they do. Our SDC is notifying staff and presenting the Relias presentation to them. Nurse aides will notify charge nurses verbally for any observed change in resident status. Charge nurses will observe/assess patient. If any acute significant change is observed, charge nurse will notify physician. Recommendations will be implemented, and nursing leadership will be notified. If the charge nurse disagrees with the decision from physician extenders (PAs, NPs), DON, and/or attending physician for need for higher level of care, the Administrator will be notified who will then notify the Medical Director to make the call.

Patient will be observed, and a progress note will be written every shift until the situation is resolved. Shift reports (24 hour/72 hour) will be reviewed by nursing leadership daily 5 X weekly to identify and follow up acute/significant changes in condition. PA will assess patients who have had a change of condition and provide a list of these patients to nursing leadership. Nursing leadership will verify that orders were implemented and report any questions or concerns to the PA. The DON will meet with the Medical Director and PA weekly on the status of

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Residents with acute significant changes in condition. Medical director will meet with physician assistants to discuss any concerns coming from the weekly meeting with the DON. Nursing leadership will review Residents experiencing changes in condition during daily (5 X weekly) morning IDT meetings. Medical director has been in contact with administrator, nurse consultant, DON, and ADON during this process and is committed to these weekly meetings moving forward.

Medical director will meet with physician assistants weekly to discuss patients. This will include patients with acute changes, new patients, patients who are recently had major changes in treatment plans, and any other topics that need to be addressed. During weekly meeting between medical director and director of nursing, any questions or concerns about treatment decisions will be discussed.
The Director of Nursing or designee will ensure implementation of the plan.

Planned removal of IJ: 9/12/21

Attending physician provided coaching to PA on 9/9 regarding appropriate management and management of significant changes and med reconciliation. After meds were corrected, patient's lethargy improved. MD saw patient on 8/24 after meds had been corrected.

The credible allegation was verified on 9/17/21 as evidenced by interviews with staff both nursing assistants and nurses. Nursing staff, nursing assistants reported receiving education on regarding preventing abuse and neglect and recognizing a change in condition and medical

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| F 600 | Continued From page 26<br>provider notification of change. Per review of documentation all residents with change in condition were reviewed in daily IDT meetings and the DON meet weekly with the MD since alleged compliance date of 9/12/21. The facility's credible allegation of immediate jeopardy removal was verified as having been implemented on 9/12/21. | F 600 | | |
| F 609 SS=D | Reporting of Alleged Violations<br>CFR(s): 483.12(c)(1)(4)<br><br>§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:<br><br>§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.<br><br>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified | F 609 | | 10/25/21 |

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| F 609 | Continued From page 27<br>appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:<br>Based on Administrator interview and record review the facility failed to report neglect to the state agency upon notification of neglect for one (Resident #1) of one resident reviewed for neglect.<br><br>Findings included:<br><br>On 9/9/2021 at 12:30 PM the facility Administrator was notified via an immediate jeopardy template of neglect which occurred to Resident #1. The template informed the Administrator of the following neglectful care provided to Resident #1. The facility failed to administer correct medications to a new admission. The facility failed to provide effective analysis and medical intervention for a resident with acute/significant change in condition. The facility failed to provide ongoing assessments for a resident with acute/significant change in condition on 8/21/2021 and 8/22/2021. The facility failed to implement effective medical interventions for a resident with signs of dehydration.<br><br>An interview was conducted with the facility Administrator on 9/13/2021 at 4:40 PM. The facility Administrator stated he sent a 24-hour report to the state offices for Resident #1 on 8/31/2021 after he received notice from the hospital alleged abuse had occurred. The Administrator stated a 5-day report was sent to the state offices on 9/7/2021, unsubstantiating the allegation.<br><br>Review of the initial allegation report dated 8/31/2021 revealed the facility became aware on | F 609 | F609<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Allegation of neglect for resident #1 was reported before the survey. When the surveyor notified the DON and administrator that we were being put in immediate jeopardy, the administrator should have then been reported for a second time.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>Administrator was educated by regional nurse consultant to report allegation of neglect when receiving notification of immediate jeopardy for neglect<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All FRIs will be audited by regional nurse consultant 3x weekly x 4 weeks, then weekly x 8weeks, then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| F 609 | Continued From page 28<br>8/31/2021 at 11:00 AM of resident abuse and resident neglect. The form stated Resident #1, who was in the hospital, had an allegation of abuse/neglect filed by hospital staff due to pressure wounds. The local police had been notified on 8/31/2021 at 11:21 AM.<br><br>Review of the investigation report dated 9/7/2021 revealed the updated information from the medical director and nursing confirmed the wound on Resident #1 was a Kennedy ulcer, not pressure related. The facility staff were able to confirm that it was not present shortly before Resident #1 went to the hospital. The summary of the investigation concluded the allegation was unsubstantiated due to the wound being a Kennedy ulcer (indicative of end of life) versus a pressure ulcer. Additionally, it was confirmed the wound was not present shortly before the patient went to the hospital.<br><br>The investigation of the alleged neglect submitted to the facility Administrator on 9/9/2021 as an immediate jeopardy template was not included in the 9/7/2021 documentation sent to the state offices. | F 609 | | |
| F 641 SS=D | Accuracy of Assessments<br>CFR(s): 483.20(g)<br><br>§483.20(g) Accuracy of Assessments.<br>The assessment must accurately reflect the resident's status.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and staff interview, the facility failed to accurately code Activities of Daily Living (ADL) on the Minimum Data Set (MDS) assessment for 1 of 14 residents reviewed for | F 641 | F641<br><br>1. How corrective action will be accomplished for each resident found to | 10/25/21 |

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| F 641 | Continued From page 29<br>ADL's (Resident # 14).<br><br>Findings included:<br><br>Resident # 14 was admitted to the facility on 7/30/21 with multiple diagnoses, some of which included chronic respiratory failure, presence of left artificial shoulder joint, lower back pain and heart failure<br><br>Review of the quarterly MDS assessment dated 8/13/21 revealed Resident #14 was assessed as cognitively intact and all ADLs were coded as occurring only once or twice during the look back period.<br><br>During an interview on 9/20/21 at 10:30 AM, Nurse Aide (NA) #10 stated resident #14 needs limited to extensive one-person physical assistance for ADL's except for eating as the resident can self-feed with set up assistance.<br><br>During an interview on 9/20/21 at 1:45 PM, Nurse # 21 stated Resident # 14 required limited to extensive assistance with one-person physical assist for ADLs and was able to eat independently with set up help.<br><br>During a telephone interview on 9/22/21 at 12:28 PM, the MDS coordinator stated the resident's MDS assessment was incorrectly coded for ADLs. The MDS coordinator indicated the resident's MDS assessment was completed by an offsite MDS staff who did not complete the interviews with the resident, staff, nurse aides and therapy. An in-room assessment was not completed prior to coding of the ADL's.<br><br>During a telephone interview on 9/23/21 at 1:30 | F 641 | have been affected by the deficient practice:<br>MDS coordinator will assess resident, interview staff to include CNA and Nurses to gather the information needed to document ADLS and continence accurately on MDS. The coordinator will then complete the MDS assessment in nurse assessments and do a detailed nursing note under progress notes. A 10/1/21 Quarterly MDS was scheduled for resident #14 to accurately code resident□s ADL actual self performance and staff support.<br><br>2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>MDS coordinator checks the in-progress schedule daily and ensures interviews and staff observations are used to create ADL reconciliation progress notes are completed for all residents with a MDS dated for that date.<br><br>3. Measures to be put in place or systemic changes made to ensure practice will not re-occur: MDSCs were trained on 9/22/21 and 10/7/21 to accurately code ADLs on MDS per RAI Manual Guidelines. MDSC in facility will complete staff interviews and documentation to support the MDS coding of ADLS and continence.<br><br>4. How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Regional MDS Consultant | |

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| F 641 | Continued From page 30<br>PM, the Administrator indicated it was his expectation that the resident assessments were completed accurately. | F 641 | or designee will audit 5 MDS for weekly for 4 weeks, next twice a month for one month, and then monthly until QAPI determines substantial compliance has been met.<br>5. Completion 10/25/2021 | |
| F 684 SS=E | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, resident interview, staff interview, previous Director of Nursing interview, Interim Director of Nursing interview, and Physician interview the facility failed to change treatment orders after a podiatry visit, consistently provide wound care, and provide consistent wound care assessments for one (Resident #3) of one resident reviewed for a non-pressure wound.<br><br>Findings included:<br><br>Resident #3 was admitted to the facility on 5/26/2021 with diagnoses of acute osteomyelitis of the left foot and ankle, cellulitis of left lower limb, and a non-pressure chronic ulcer of left lower limb. | F 684 | F684<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 3 received orders from podiatry consult that was not completed<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current residents who have been to an outside appointment in the last 14 days were audited for any changes in orders. All orders will be updated in PCC. This was completed 10/18/2021.<br>Measures to be put in place or systemic | 10/25/21 |

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| F 684 | Continued From page 31<br>Review of the physician discharge summary dated 5/26/2021 from the hospital revealed Resident #3 required outpatient follow up for a chronic nonhealing left heel wound with acute infection. The discharge summary requested the wound vac dressing changes be completed three times per week and a for Resident #3 to follow up with podiatry.<br><br>The most recent significant change minimum data set assessment dated 7/27/2021 coded Resident #3 as cognitively intact but with the mood of feeling tired or little energy for two to six days of the assessment period. Resident #3 had not coded as having any pressure sores but was receiving applications of dressing to feet.<br><br>The care plan for Resident #3, dated as created on 5/30/2021, had a focus area for a left heel pressure ulcer and at risk for potential for pressure ulcer development relative to a history of ulcers limited range of motion/mobility. One of the interventions was to administer treatments as ordered and monitor for effectiveness. An additional intervention was to report dressing if not intact during care to nurse.<br><br>Documentation in the physician orders for Resident #1 revealed an order dated as initiated on 5/26/2021 stating, "Wound Vac changed to left heel every evening shift every Monday, Wednesday, and Friday for wound care." (Wound VAC is a vacuum-assisted closure of a wound used as a type of therapy to help wounds heal. During the treatment, a device decreases air pressure on the wound, helping the wound heal more quickly.)<br><br>a. Review of a nursing note dated 5/26/2021 for | F 684 | changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated by DON or designee to review any outside consults for changes in orders and transcribe as ordered.<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of transcribing orders from consults<br>DON or designee will audit all outside consults to ensure follow through of order changes 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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Resident #3 revealed the wound vac was to be delivered the next day and a wet to dry dressing was to be applied until the wound vac arrived.

Documentation on a nursing note for Resident #3 dated 5/30/2021 revealed the wound vac was applied to the left heel and working well.

Documentation in the nursing notes for Resident #3 dated 7/6/2021 revealed she was out of the facility at an appointment.

Review of the electronic medical record for Resident #3 under the miscellaneous section revealed an order from the podiatrist office dated 7/6/2021 under order information "Dressing-Apply."

Review of podiatry progress notes from the 7/6/2021 visit, not included in the electronic medical record, revealed Resident #3 was seen for a follow up of a left heel ulceration. It was noted she had severe peripheral vascular disease with heel ulceration with neuropathy. The instructions in the podiatry progress notes stated, "I have written orders for dressing changes to be performed with calcium alginate with silver 3 times a week. Please cleanse wound with soap and water with dressing changes." The podiatrist orders dated 7/6/2021 did not include the use of a wound vac in treatment for the left heel of Resident #3.

Review of the physician orders, nursing progress notes, and physician progress notes revealed the facility did not contact the podiatrist to update the wound care orders or to clarify wound care orders from the podiatrist on 7/6/2021.

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A physician progress note written by Physician Assistant (PA) #1 on 7/19/2021 at 10:31 AM revealed under assessment and plan, "Non-pressure chronic ulcer of left heel and midfoot with unspecified severity." Under the same progress note PA #1 wrote, "Still working with Physical therapy, has to be following up with podiatry for foot wound."

An interview was conducted with the interim Director of Nursing (DON) on 9/13/2021 at 4:30 PM. The interim DON confirmed Resident #3 went to a podiatrist appointment on 7/6/2021 for which orders were received for a dressing to be applied. The interim DON also confirmed these orders should have been clarified on 7/6/2021 to find out if the wound vac was still to be used in wound care.

An interview was conducted on 9/7/2021 at 10:08 AM with the physician (MD #1) for Resident #3. MD #1 stated the orders on the discharge summary of a resident need to be followed when the resident was admitted. MD #1 stated the wound care orders for Resident #3 should probably later had been verified but that right now with the nurses sometimes things don't get done. MD #1 confirmed that when the wound vac was discontinued for Resident #3 it should have been documented.

b. Review of the documentation on the June Treatment Administration Record (TAR) revealed Resident #3 was documented as having received the wound vac dressing change treatment on 6/2/2021, 6/4/2021, 6/7/2021, 6/11/2021, 6/14/2021, and 6/18/2021. The June TAR had a blank space for treatments for Resident #3 on 6/16/2021, 6/21/2021, 6/23/2021, 6/25/2021, and

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6/28/2021. On 6/30/2021 the TAR had a code 9 documented indicating a progress note was written.

Review of a 6/30/2021 Orders- Administration Note revealed a note text stating, "No wound vac in place at this time."

An interview was conducted on 9/14/2021 at 3:49 PM with Nurse #5. Nurse #5 recalled going into the room of Resident #3 on 6/30/2021 and the wound vac was not in the room, so she documented this in a note. Nurse #5 could not recall any other information about that day or Resident #3.

Review of the documentation on the July TAR revealed Resident #3 was documented as having received the wound vac dressing change treatment on 7/3/2021, 7/7/2021, 7/23/2021, 7/26/2021, and 7/28/2021. The July TAR had a blank space for treatments on 7/5/2021, 7/9/2021, 7/12/2021, 7/16/2021, 7/19/2021, and 7/21/2021. On 7/30/2021 the TAR had a code 9 documented indicating a progress note was written. There was no corresponding note dated 7/30/2021 in the Orders- Administration Notes.

Review of the documentation on the August TAR revealed Resident #3 was documented as having received the wound vac dressing change treatment on 8/2/2021, 8/4/2021, and 8/13/2021. The August TAR had a blank space for Resident #3 on 8/6/2021, 8/9/2021, 8/11/2021, 8/18/2021, 8/20/2021, 8/23/2021, and 8/30/2021. On 8/16/2021, 8/25/2021, and 8/27/2021 the TAR had a code 9 documented indicating a progress note was written.

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An interview was conducted on 9/3/2021 at 5:20 PM with Nurse #2 who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 8/6/2021, 8/11/2021, and 8/23/2021. Nurse #2 stated she always completed the dressing changes assigned to her on her shift. Nurse #2 revealed Resident #3 did not have a wound vac in August but on the days, she was assigned to do wound care for Resident #3 she did a "wet to dry dressing change." Nurse #2 explained a wet to dry dressing change was completed by cleaning the wound with normal saline, putting saline on gauze, and wrapping the wound with Kerlix. Nurse #2 stated she must have forgot to document the dressing changes on 8/6/2021, 8/11/2021, and 8/23/2021.

An interview was conducted on 9/3/2021 at 5:54 PM with Nurse #7, who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 8/9/2021. Nurse #7 did not recall doing a wound vac dressing change or doing any treatment for Resident #3 on 8/9/2021.

An interview was conducted on 9/4/2021 at 4:53 PM with Nurse #15, who was assigned to care for Resident #3 on the 7:00 PM to 7:00 AM shift on 8/9/2021. Nurse #15 stated that all the dressing changes were the responsibility of the day shift (7:00 AM to 7:00 PM) and she did not recall Resident #3 having a wound vac. Nurse #15 could not specifically recall 8/9/2021 and the dressing change order for Resident #3.

An interview was conducted on 9/4/2021 at 3:16 PM with Nurse #12, who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 8/18/2021. Nurse #12 stated she never changed the wound vac dressing for Resident #3 because

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it was never assigned to be competed on her shift.

An interview was conducted on 9/5/2021 at 7:15 AM with Nurse #17, who was assigned to care for Resident #3 on the 7:00 PM to 7:00 AM shift on 8/16/2021 and 8/18/2021. Nurse #17 remembered on 8/16/2021 she put a code 9 on the TAR for the heel treatment of Resident #3 because she was told by another nurse the wound vac had been discontinued so a wet to dry dressing was to be completed. Nurse #17 stated she did do a wet to dry dressing on 8/16/2021 but she did not recall doing a dressing change for Resident #3 on 8/18/2021.

An interview was conducted on 9/7/2021 at 6:01 PM with Nurse #22, who was assigned to care for Resident #3 on the 7:00 AM to 7:00 PM shift on 8/20/2021. Nurse #22 stated on 8/20/2021 she did not do wound care because the facility had an extra nurse doing wound care. Nurse #22 stated she did not do a wet to dry dressing for Resident #3 or a wound vac dressing change.

An interview was conducted on 9/4/2021 at 6:38 PM with Nurse #16, who was assigned to care for Resident #3 on the 7:00 PM to 7:00 AM shift on 8/20/2021. Nurse #16 stated she did not recall Resident #3 and she did not do a wound vac dressing change on 8/20/2021.

An interview was conducted on 9/3/2021 at 5:21 PM with Nurse #6, who wrote progress notes on 8/25/2021 and 8/27/2021 indicating Resident #3 did not have a wound vac. Nurse #6 stated she did not recall Resident #3 ever having a wound vac and the wound vac had been discontinued a long time ago. Nurse #6 stated it was best

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practice to do a wet to dry dressing if a wound vac was not available. Nurse #6 revealed she did a wet to dry dressing change on 8/25/2021 and 8/27/2021 because she always did her assigned dressing changes.

An interview was conducted on 9/4/2021 at 3:25 PM with Nurse #13, who was assigned to care for Resident 3 on the 7:00 AM to 7:00 PM shift on 8/30/2021. Nurse #13 stated she remembered 8/30/2021 and she did not do a dressing change for Resident #3. Nurse #13 explained the following situation. Nurse #13 was assigned the Covid-19 unit with 12 residents with one resident who was discharging. There was a situation going on where she needed to type in medications for another resident into the electronic record urgently. Nurse #13 stated she was overwhelmed with trying to administer medications, call the pharmacy, and get hard scripts for the physician assistant to sign. Nurse #13 revealed she was not able to get the wound treatments completed for her hall. The nurse who was supposed to relieve her at the end of her shift did not arrive and Nurse #13 could not stay due to a family emergency. Nurse #13 stated she wrote out a detailed accounting for her report for the next nurse on a writing tablet to include the information that wound care had not been completed. Nurse #13 stated she gave the keys to her medication cart to the Assistant Director of Nursing, who then exited the Covid-19 Unit while Nurse #13 left the nursing unit at approximately 8:30 to 8:40 PM.

An interview was conducted on 9/7/2021 at 7:04 AM with Nurse #20, who was assigned to care for Resident #3 on the 7:00 PM to 7:00 AM shift on 8/30/2021. Nurse #20 stated she could not recall what she did or did not do on 8/30/2021. Nurse

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#20 stated Resident #1 probably needed a wet to dry dressing because she did not have a wound vac.

Review of the documentation on the September TAR revealed Resident #3 had a Code 7 for sleeping on 9/1/2021 for the wound vac dressing change treatment.

An interview was conducted on 9/5/2021 at 9:57 AM with Nurse #18, who documented the Code 7 on 9/1/2021 on the TAR of Resident #3. Nurse #18 stated he did not recall Resident #3. Nurse #18 did not recall if he completed the treatment for Resident #3 or if he passed it onto the next nursing shift.

An observation of wound care and an interview was conducted with Resident #3 on 9/3/2021 beginning at 10:48 AM. Resident #3 stated wound care dressing changes to her heel had not been done in several days. Nurse #1 removed a black medical boot and sock for Resident #3. The sock of Resident #3 was observed to be saturated with reddish brown drainage at the heel. The dressing under the sock was also saturated with reddish brown drainage.

An interview was conducted with Nurse #1 after the dressing change for Resident #3. Nurse #1 revealed that a lot of residents told her their dressing changes are not getting done. Nurse #1 also revealed she could not find an order for a dressing change for Resident #3, so she brought dressing change supplies in the room in order to copy what she saw when she removed the old dressing.

An interview was conducted on 9/3/2021 at 5:25

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PM with the corporate nurse consultant and the interim Director of Nursing. Both the corporate nurse consultant and the interim Director of Nursing did not know when the wound vac for Resident #3 was removed but it was good nursing practice to in the absence of a wound vac, to use a wet to dry dressing change as replacement care.

An interview was conducted with the previous Director of Nursing (DON) on 9/4/2021 at 1:45 PM. The previous DON revealed the facility had an agency wound care nurse who was doing treatments and assessments, but the facility terminated her services in the middle of July 2021 putting this responsibility on the hall nurses.

The interim DON was interviewed again on 9/13/2021 at 4:10 PM. The interim DON confirmed the treatments should have been consistently completed for Resident #3, but she did not think her wound deteriorated in the facility.

c. A weekly skin evaluation was completed on 6/8/2021 for Resident #3 for her left heel. The wound was assessed as a Stage 3 measuring 4.0 centimeters (cm) in length, 3.5 cm in width, and 0.5 cm in depth. The wound was assessed as present on admission, moist tissue, 100% wound involvement, a small amount of serous drainage. The wound edges were described as well defined. The treatment being used was a wound vac dressing change every Monday, Wednesday, and Friday.

The next wound assessment for Resident #3 was dated 6/25/2021, 17 days later. The documentation revealed Resident #3 had a heel pressure wound at a Stage 3. No other

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assessment information was documented.

On 7/3/2021 a weekly skin evaluation for Resident #3 documented her skin was intact with no impairment.

On 7/6/2021 a weekly skin evaluation for Resident #3 documented her skin was intact with no impairment.

On 7/14/2021 a weekly skin evaluation for Resident #3 documented her skin was intact with no impairment. The evaluation also documented she had a wound present on the left heel. There was no other assessment information.

On 7/20/2021 a weekly skin evaluation for Resident #3 documented she had a Stage 3 left heel pressure wound measuring 4.3 cm in length, 3.4 cm in width, no depth. The wound tissue was described as moist with no drainage. The wound edges were described as well defined. The current treatment was, "clean dressing on." The wound was described as improving.

The next weekly skin evaluation for Resident #3 was on 8/3/2021, 14 days later. Documentation on the 8/3/2021 skin evaluation revealed Resident #3 had a left heel pressure ulcer that was unstageable with no assessment measurements. Resident #3 was also assessed to have left lower leg edema. The only other information provided were the notes stating, "Resident has wound noted on left heel with a dry dressing intact and edema 2+ noted on LLE (left lower extremity) front."

The last documented skin assessment in the electronic medical record for Resident #3 was

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| F 684 | Continued From page 41<br>dated 8/19/2021. The documentation revealed Resident #3 had a wound impairment site on her left lower leg (rear) and left heel, with no measurements taken. The documentation notes stated, "Open area to left leg. Open area and discoloration to left foot." No other information was provided on the skin assessment other than the date acquired for the left foot and left leg wounds was 8/13/2021.<br><br>Resident #3 was discharged from the facility to home on 9/3/2021.<br><br>An interview was conducted with the interim Director of Nursing (DON) on 9/13/2021 at 4:30 PM. The DON stated the facility staff should have been doing more tracking of wounds through consistent assessments and documentation. The DON stated the podiatrist and not the facility wound care provider was following Resident #3. The DON confirmed the facility should have been doing weekly skin assessments for Resident #3.<br><br>An interview was conducted with the facility Administrator on 8/14/2021 at 3:45 PM. The Administrator confirmed Resident #3 had only the one podiatry appointment on 7/6/2021 while she was the in the facility and the family of Resident #3 opted to take her back to the podiatrist after her discharge. | F 684 | | |
| F 686 SS=G | Treatment/Svcs to Prevent/Heal Pressure Ulcer<br>CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with | F 686 | | 10/25/21 |

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| F 686 | Continued From page 42<br>professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, and Physician interview the facility failed to perform skin assessments to monitor or identify skin concerns for 2 (Residents #1 and #2) of 3 residents reviewed for pressure ulcer/wound care.<br><br>Findings included:<br><br>1. Resident #1 was admitted from the hospital emergency room to the facility on 8/14/2021.<br><br>A North Carolina FL2 form for Resident #1, dated as completed on 8/13/2021 at 1:45 PM was sent to the facility from the hospital. A FL-2 is a North Carolina form that describes a patient's medical condition and the amount of care they need when placed in a facility.<br><br>Resident #1 had diagnoses listed on the FL-2 form dated 8/13/2021 from the emergency room of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, prostate cancer (2018), esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission | F 686 | F686<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 1 and # 2 are no longer at the facility<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current residents will have a completed skin assessment as of 10/14/2021.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated by DON or designee to complete skin assessments as scheduled<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of transcribing orders from consults | |

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| F 686 | Continued From page 43<br>complaint of Resident #1 was weakness and failure to thrive.<br><br>Documentation in an admission progress note dated 8/14/2021 at 7:10 AM as a late entry revealed Resident #1 had a laceration to his swollen red ear and his buttocks were red but blanchable. Blanchable indicates there was a temporary obstruction of blood flow to that area.<br><br>An interview was conducted on 9/7/2021 at 6:30 PM with Nurse #23, who wrote the admission progress note on 8/14/2021 for Resident #1. Nurse #23 explained she had two residents who were declining rapidly with one of those residents being about to expire as well as a resident who needed blood work on her shift 7:00 PM to 7:00 AM beginning on 8/13/2021. Nurse #23 stated she did not recall what time or what day Resident #1 was admitted to the facility. Nurse #23 stated she knew she had to additionally put into the electronic medical record admission assessments for Resident #1. Nurse #23 stated she was not able to complete the admission assessments for Resident #1 and she passed this information on to the next nursing shift.<br><br>There were no additional skin assessments for Resident #1 until 8/19/2021. The 8/19/2021 skin assessment for Resident #1 indicated his skin was intact without impairment.<br><br>An interview was conducted on 9/4/2021 at 4:46 PM with Nurse #14 who completed a skin assessment for Resident #1 on 8/19/2021. Nurse #14 stated she worked from 11:00 PM to 7:00 AM on 8/19/2021. Nurse #14 stated she recalled Resident #1 but denied she did any kind of skin assessment on Resident #1. Nurse #14 declared | F 686 | DON or designee will audit all weekly skin assessments for completion 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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another nurse must have gone into the medical record under her name and documented she did the skin assessment on Resident #1.

Resident #1 had an admission minimum data set assessment dated 8/20/2021 which coded him as having moderately impaired cognition with no behaviors or rejection of care. He was coded as always incontinent of bladder and bowel but with no pressure sores. He was coded as at risk for pressure sores and on a pressure reducing device for his bed.

Documentation on the care plan for Resident #1, dated as initiated on 8/14/2021, was a focus area for potential for skin impairment. One of the interventions was to perform a weekly skin assessment.

There was no other documentation in the medical record of skin assessments for Resident #1 after 8/19/2021.

An interview was conducted on 9/4/2021 at 1:30 PM with Nurse #9. Nurse #9 confirmed she was assigned to care for Resident #1 on 8/27/2021 from 7:00 AM to 7:00 PM as well as 8/28/2021 from 7:00 AM to 7:00 PM. Nurse #9 stated she provided incontinent care to Resident #1 around 4:00 PM or 5:00 PM on 8/27/2021. Nurse #9 stated there were no skin concerns for Resident #1 at that time and confirmed she saw no bruising or skin tears.

An interview was conducted on 9/3/2021 at 4:48 PM with Nurse Aide (NA #1), who confirmed she cared for Resident #1 on 8/28/2021 and 8/29/2021 for the 7:00 AM to 7:00 PM shift. NA #1 stated she was very busy on 8/28/2021 and only

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checked on Resident #1 one time during her shift. NA #1 stated on 8/29/2021 she provided incontinent care to Resident #1 two times during her shift. NA #1 did not recall Resident #1 having any skin issues on either day for which she would have to alert the nurse on the hall.

An interview was conducted on 9/7/2021 at 6:55 AM with NA #4, who confirmed he cared for Resident #1 on 8/28/2021 for the 7:00 PM to 7:00 AM shift. NA #4 stated he was working "short" that night with two nurse aides when there were usually three nurse aides. NA #4 stated that evening was the first time he had ever seen Resident #1 and he checked on him every two hours. Na #4 did not recall Resident #1 having any skin concerns or issues.

An interview was conducted on 9/4/2021 at 8:00 PM with NA #3, who confirmed he cared for Resident #1 on 8/29/2021 for the 7:00 PM to 7:00 AM shift. NA #3 stated he checked on Resident #1 three or four times, but he really did not need to provide incontinent care because Resident #1 had a foley catheter. NA #3 stated Resident #1 had no skin issues or any bruising.

Documentation in the nursing notes dated 8/30/2021 at 7:44 AM stated, "Called [Physician Assistant (PA) #1] in regard to [chest x-ray] results. No new orders were obtained at this time. Will f/u today when arrives to facility. Resident afebrile. [Productive] cough noted. Will follow up."

Documentation in the nursing notes dated 8/30/2021 at 2:33 PM revealed emergency medical services were called to take Resident #1 to the hospital. Resident #1 was described as unresponsive to voice and painful stimuli

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receiving 4 liters of oxygen.

An interview was conducted on 9/3/2021 at 1:29 PM with Nurse #3, who was assigned to care for Resident #1 on 8/30/2021 from 7:00 AM to 7:00 PM. Nurse #3 stated she was not told of any concerns in nursing report from the previous shift on 8/30/2021. Nurse #3 revealed the Director of Nursing told her of the skin assessments she needed to do when she arrived for her shift, and Resident #1 was one of them. Nurse #3 stated when she arrived, she notified the PA #1 of the chest x-ray results and she knew PA #1 would check on him. Nurse #3 indicated she would have to look in the medical record to confirm what time Resident #1 was sent to the emergency room. Nurse #3 stated when she sent Resident #1 to the hospital, she did a quick skin assessment and did not see anything, not even redness. Nurse #3 confirmed Resident #1 was unresponsive and on 4 liters of oxygen, but she did roll him to look at his skin prior to the arrival of the emergency medical services. Nurse #3 stated she did not document her assessment of his skin prior to his transport to the hospital.

The first documentation in the emergency room nursing notes from the hospital for Resident #1 was on 8/30/2021 at 3:13 PM. Review of the emergency room nursing notes dated 8/30/2021 at 7:15 PM revealed, "[Patient is laying in bed. [Patient] had cardiac, [blood pressure] and pulse [oximetry] monitor on and temperature foley. [Patient] responds to pain. Previous [Registered Nurse] stated skin breakdown to the back. [Registered Nurse] unable to turn [patient] at this tme, [Registered Nurse] does not have help to turn [patient]. [Patient] is on 6 [Liters per Minute] [Nasal Cannula] of oxygen."

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Review of emergency room department provider notes revealed Resident #1 was assessed by the first medical doctor in the emergency room on 8/30/2021 at 3:12 PM. The first medical doctor to assess Resident #1 requested a wound care consult for a sacral decubitus ulcer present on admission. The clinical notes of the hospital record revealed the wound care consultant requested photos of the wound be place on the electronic medical record along with the concerns for review. The death summary portion of the hospital record dated 9/1/2021 at 1:35 AM revealed the preliminary cause of death for Resident #1 was septic shock. In the brief hospital course, the medical record stated, "It was also noted [patient] had a severe unstageable spine decubitus ulcer."

The death certificate for Resident #1, dated as signed by the adult-gerontology nurse practitioner on 9/1/2021, listed the immediate cause of death as septic shock with contributing causes of pneumonia, sacral decubitus ulcer, and possible meningitis.

An interview was conducted with the previous Director of Nursing (DON) on 9/4/2021 at 1:45 PM. The previous DON stated it was facility policy for an admission skin assessment to be completed upon arrival of a new resident and then a weekly skin assessment after that. The previous DON revealed the facility had an agency wound care nurse who was doing treatments and assessments, but the facility terminated her services in the middle of July 2021 putting this responsibility on the hall nurses.

An interview was conducted on 9/7/2021 at 10:08

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AM with the physician for Resident #1 (MD #1). The MD #1 stated he had looked at the hospital records for Resident #1 when he was sent to the hospital on 8/30/2021. He acknowledged he saw the emergency room physician documentation of a "sacral wound" and he surmised the emergency room physician did not know what he was looking at. The MD #1 stated he looked at the photo of the sacral area of Resident #1 from the hospital and declared it to be a "Kennedy ulcer." The MD #1 further explained the Kennedy ulcer could have appeared in the twenty-four hours Resident #1 sat in the emergency room. The MD #1 stated the wound was clearly a Kennedy ulcer which were notoriously quick in presentation. The MD #1 further explained a Kennedy ulcer was created when blood flow was being diverted and was a part of the disease process at the end of life for some patients.

An interview was conducted on 9/13/2021 at 12:56 PM with the wound care consultant who was contacted when Resident #1 was in the emergency room. The hospital wound care consultant confirmed she was asked to provide a wound consult for Resident #1, but she did not see Resident #1 in the emergency room because she was told he was decompensating or failing in health. The wound care consultant revealed she requested photographs of the wound so she could perform a telehealth consult. The wound care consultant stated a Kennedy ulcer usually appears within 24 to 48 hours of a patient's death. The wound care consultant stated if the wound on Resident #1 was a Kennedy terminal ulcer, it would have appeared or started twenty-four to forty-eight hours prior to arrival in the emergency room. The wound care consultant stated, "Without documentation as to what his (Resident

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#1's) skin looked like prior to going to the hospital and without knowing what the sacral area looked like at the nursing home, it can not be determined if this was a deep tissue injury or a Kennedy ulcer."

2. Resident #2 was readmitted to the facility on 8/6/2021 with diagnoses of peripheral vascular disease, chronic kidney disease Stage 4, Hypertension, and surgical amputation.

The admission minimum data set assessment dated 7/1/2021 revealed Resident #2 was severely cognitively impaired with a stage two pressure wound upon admission and a surgical wound.

The care plan, dated 6/30/2021, had a focus area for Resident #2 for a pressure ulcer on her left buttock and potential for pressure ulcer development relative to immobility. One of the interventions was to administer treatments as ordered and monitor for effectiveness. An additional focus area on the care plan for Resident #2 initiated on 6/28/2021 was for the potential for further skin impairment relative to admission with a pressure ulcer and surgical site. One of the interventions was for weekly skin assessments.

Review of the electronic medical record revealed a communication with family note dated 9/1/2021 at 7:05 PM for which the responsible party for Resident #2 was informed of a pressure area on the left anterior foot.

Review of the electronic medical record for Resident #2 revealed a skin/wound note dated 9/1/2021 at 7:10 PM stating, "left anterior foot,

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pressure area, ppp (peripheral pulse palpable) 2+" Peripheral pulse palpable refers to her pulse being able to be felt in her legs and feet.

Documentation in the medical record dated 9/1/2021 for Resident #2 revealed an order for one Xeroform Petrolatum Gauze to be applied to the left anterior heel topically every day shift related to muscle weakness.

The 9/1/2021 physician's order for the left anterior heel was discontinued and corrected on 9/3/2021 for the same treatment to be applied twice daily on every day and night shift.

Review of the electronic medical record did not reveal a corresponding skin assessment for the left anterior foot for Resident #2.

The most recent skin assessment for Resident #2 was dated 8/19/2021 with documentation of a wound and treatment plan for the right knee.

The medical record of Resident #2 did not contain skin assessments for the weeks 7/25/2021 to 7/31/2021, 8/9/2021 to 8/14/2021, 8/22/2021 to 8/28/2021, 8/9/2021 to 9/4/2021, and 9/5/2021 to 9/11/2021.

An interview was conducted with the Interim Director of Nursing on 9/13/2021 at 4:30 PM. The Interim Director of Nursing confirmed there should be skin assessments completed weekly for Resident #2 as specified in the care plan. The Interim Director of Nursing also confirmed a skin assessment should have been completed on 9/1/2021 to document the pressure area on the left anterior foot of Resident #2.

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| F 690 SS=D | Bowel/Bladder Incontinence, Catheter, UTI<br>CFR(s): 483.25(e)(1)-(3)<br><br>§483.25(e) Incontinence.<br>§483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.<br><br>§483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-<br>(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;<br>(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and<br>(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.<br><br>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.<br>This REQUIREMENT is not met as evidenced by: | F 690 | | 10/25/21 |

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| F 690 | Continued From page 52<br>Based on record review, staff interviews, Physician Assistant interviews, Physician interview, and Director of Nursing interview the facility failed to obtain a physician's order and a diagnosis for the use of an indwelling urinary catheter for one (Resident #1) of one resident reviewed for catheter use.<br><br>Findings included:<br><br>Resident #1 was admitted to the facility on 8/14/2021 from the hospital emergency room.<br><br>A North Carolina FL2 form for Resident #1, dated as completed on 8/13/2021 at 1:45 PM was sent to the facility from the hospital. A FL-2 is a North Carolina form that describes a patient's medical condition and the amount of care they need when placed in a facility.<br><br>Resident #1 had diagnoses listed on the FL-2 form dated 8/13/2021 from the emergency room of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, prostate cancer (2018), esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission complaint of Resident #1 was weakness and failure to thrive.<br><br>An admission minimum data set assessment dated 8/20/2021 coded Resident #1 as having moderately impaired cognition. He was coded as requiring extensive assistance with bed mobility and toilet use. He was coded as always incontinent of bowel and bladder. He was not coded as having a catheter. | F 690 | F690<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 1 is no longer at the facility.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current resident with catheters will be audited by DON/designee for appropriate diagnosis by 10/14/2021. If no appropriate diagnosis, MD or Physician extender was notified to obtain a diagnosis or order to discontinue catheter.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated by DON or designee that all indwelling catheters required a diagnosis for use, if no diagnosis contact the physician or physician extender for diagnosis or order to discontinue.<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of transcribing orders from consults<br>DON or designee will audit all indwelling catheters for appropriate diagnosis 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3 | |

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| F 690 | Continued From page 53<br><br>Documentation on the care plan dated as initiated on 8/28/2021 had a focus area for bladder incontinence relative to impaired mobility. The interventions included cleaning of peri-area with each incontinence episode, monitor and document for signs and symptoms of urinary tract infections, and monitor and document and report as needed any possible causes of incontinence.<br><br>Documentation on an order note written by Nurse #9 on 8/27/2021 at 3:23 PM revealed PA #2 ordered a chest x-ray and a urinalysis for Resident #1. The note also revealed a condom catheter was used to collect the specimen for the urinalysis.<br><br>Review of the order recap reports in the electronic record for Resident #1 from admission to discharge did not reveal any orders for a condom catheter or an indwelling urinary catheter.<br><br>Nurse Aide Documentation in the medical record under the heading "Tasks" revealed Resident #1 did not have his continence rated due to an indwelling catheter at 3:13 AM on 8/28/2021 and 10:59 PM on 8/29/2021.<br><br>A situation, background, assessment, and recommendation nursing note dated 8/30/2021 at 2:25 PM for Resident #1 revealed he had an indwelling urinary catheter and was sent to the emergency room for a change in condition.<br><br>An interview was conducted with Nurse #9, who worked on the 8/27/2021 and 8/28/2021 7:00 AM to 7:00 PM shift, on 9/4/2021 at 12:30 PM. Nurse #9 revealed she contacted the Physician | F 690 | How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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Assistant (PA #2) who assessed the resident and gave orders for a urine analysis, complete blood count, basic metabolic panel, and a chest x-ray. Nurse #9 stated when she arrived at the start of her shift Resident #1 was wearing a brief. Nurse #9 confirmed she was not given an order from PA #2 for an indwelling urinary catheter. Nurse #9 stated she put a condom catheter on Resident #1 to obtain collect a sample for the urine analysis, but she removed the catheter after the sample was obtained.

PA #2 was interviewed on 9/7/2021 at 11:15 AM. PA #2 stated she remembered giving verbal orders for the blood tests, chest x-ray and urine analysis for Resident #1 on 8/27/2021 but did not recall giving orders for a condom catheter or an indwelling urinary catheter. PA #2 stated she knew for sure she would never had ordered a condom catheter for Resident #1 and would not have ordered an indwelling urinary catheter unless the resident had a urinary retention problem. PA #2 stated she would have to look in the electronic medical record to be certain but had no recollection of ever ordering an indwelling urinary catheter for Resident #1. PA #2 stated the risks involved with an indwelling urinary catheter included urinary tract infections and dehydration.

Nurse #19, who cared for Resident #1 on 8/27/2021 on the 7:00 PM to 7:00 AM shift, was interviewed on 9/7/2021 at 6:48 PM. Nurse #19 did not recall if Resident #1 had a catheter or not.

Nurse Aide (NA) #3, who cared for Resident #1 on 8/27/2021 on the 7:00 PM to 7:00 AM shift, was interviewed on 9/4/2021 at 8:00 PM. NA #3 stated Resident #1 already had an indwelling urinary catheter at the start of his shift. NA #3

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| F 690 | Continued From page 55<br>confirmed Resident #1 had no skin concerns or pressure sores.<br><br>NA #1, who cared for Resident #1 on 8/28/2021 and 8/29/2021 on the 7:00 AM to 7:00 PM shift, was interviewed on 9/3/2021 at 4:48 PM. NA #1 stated 8/28/2021 was the first day she had ever seen Resident #1 and she confirmed he had an indwelling urinary catheter at the start of her shift on that day as well as the next day on 8/29/2021. NA #1 stated Resident #1 had no skin concerns or pressure sores.<br><br>An interview was conducted on 9/4/2021 at 8:00 PM with NA #3, who cared for Resident #1 on the 7:00 PM to 7:00 AM shift on 8/29/2021. NA #3 stated Resident #1 already had a catheter at the start of his shift on 8/29/2021. NA #3 confirmed Resident #1 had no skin concerns or pressure sores.<br><br>An interview was conducted on 9/4/2021 at 1:12 PM with NA #2, who cared for Resident #1 on the 7:00 AM to 7:00 PM shift on 8/30/2021. NA #2 stated Resident #1 had an indwelling urinary catheter at the start of her shift and she never had to provide incontinence care to Resident #1 due to the indwelling urinary catheter. NA #2 did not recall any skin breakdown.<br><br>An interview was conducted on 9/7/2021 at 10:08 AM with the physician (MD #1) for Resident #1. MD #1 stated orders had to be obtained for an indwelling catheter. MD #1 confirmed the only reason Resident #1 would have had orders for a catheter would have been for urinary retention, which would have been on the physician order. | F 690 | | |
| F 692 SS=D | Nutrition/Hydration Status Maintenance | F 692 | | 10/25/21 |

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| F 692 | Continued From page 56<br>CFR(s): 483.25(g)(1)-(3)<br><br>§483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident-<br><br>§483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise;<br><br>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;<br><br>§483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, Physician Assistant interview, and Medical Doctor interview the facility failed to implement effective interventions at the onset of mild dehydration for one (Resident #1) of one resident reviewed for dehydration.<br><br>Findings included:<br><br>Resident #1 was admitted from the hospital emergency room to the facility on 8/14/2021.<br><br>Resident #1 had diagnoses listed on the FL-2 form dated 8/13/2021 from the emergency room | F 692 | F692<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 1 is no longer a resident of the facility<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current resident with BMP/CMP within the last 14 days will be audited by | |

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| F 692 | Continued From page 57<br>of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, prostate cancer (2018), esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission complaint of Resident #1 was weakness and failure to thrive.<br><br>On 8/14/2021 the physician ordered 8.6 mg Senna to be given as one tablet by mouth at bedtime for constipation. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, and one dose on 8/21/2021. Senna has diuretic properties.<br><br>On 8/14/2021 the physician ordered 6.25 mg Carvedilol to be given as one tablet two times a day by mouth for Hypertension. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received nine doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, two doses on 8/21/2021, one dose on 8/22/2021, one dose on 8/23/2021, and one dose on 8/24/2021. Carvedilol is a diuretic used to control high blood pressure.<br><br>Documentation in the order administration notes on 8/19/2021 at 3:09 PM, 3:11 PM, and 3:12 PM revealed Resident #1 was unable to swallow.<br><br>A basic metabolic panel results for Resident #1 came back on 8/19/2021 at 6:29 PM with the | F 692 | DON/designee for evidence of abnormal lab values indicative of dehydration; if abnormal values present MD or physician extender will be notified. If resident is unable to swallow MD will be notified and requested for orders for IV fluids or transfer acute care for treatment. This was completed 10/19/2021<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated by DON or designee on abnormal lab values and to contact the physician or physician extender for abnormal lab values; if a patient is not able to swallow fluids MD or physician extender will be notified of current condition and request orders for IV fluids or transfer to acute care for treatment.<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of transcribing orders from consults<br>DON or designee will audit all BMP/CMP lab results for abnormal values and patient swallowing function and interventions obtained 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at | |

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| F 692 | Continued From page 58<br>abnormalities of a high BUN (Blood Urea Nitrogen) of 37.8 (milligrams) mg/ (deciliter) dl (normal values are 6.0-20.0 mg/dl) and BUN/Creatinine ratio of 44.0 (normal values are 6.0-25.0). PA #1 signed the laboratory results as reviewed on 8/24/2021 at 8:23 AM.<br><br>An admission minimum data set assessment dated 8/20/2021 coded Resident #1 was having moderately impaired cognition. He was independent with feeding himself after set-up. He was not coded as having dehydration.<br><br>On 8/23/2021 PA #1 wrote a progress note because Resident #1 had a decreased food and fluid intake by mouth. PA #1 documented under history of present illness, "Per nursing complaint of patient still more lethargic than baseline. On exam the patient was arousable, will hold medications and monitor for improvement or worsening of condition. I have reviewed [laboratory data], he appears mildly dehydrated and will have nursing encourage increased PO (by mouth) fluids." An order to push fluids was not added as an order on the Medication Administration Record.<br><br>On 8/24/2021 at 9:41 AM orders- administration notes for Resident #1 stated, "Unable to swallow."<br><br>An interview was conducted on 9/7/2021 with Nurse #22, who wrote the 8/24/2021 administration note at 9:41 AM. Nurse #22 stated she contacted PA #1 because she had great concern for Resident #1, and she wanted to know what was going on. Nurse #22 described Resident #1 as "really passed out" and "not responding at all." Nurse #22 said she was told by PA #1 he was aware of the condition of the | F 692 | Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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resident, he had ordered laboratory tests, and she was told to continue to monitor the resident.

Review of the physician orders revealed on 8/26/2021 the physician (MD #1) for Resident #1 gave a verbal order for one liter of sodium chlorine solution 0.9% to be administered intravenously at a rate of 75 cubic centimeter (cc) /hour until 8/27/2021 for dehydration. This physician order for intravenous fluids was given 3 days after he was noted to be mildly dehydrated by PA #1.

On 8/26/2021 at 11:30 AM nursing notes revealed peripheral intravenous fluids were started for Resident #1.

On 8/27/2021 at 1:14 PM nursing progress notes revealed Nurse #9 contacted PA #2 to clarify an existing intravenous fluid order with the intravenous fluid order on hold until the order was clarified.

An interview was conducted with PA #2 on 9/7/2021 at 11:15 AM. PA #2 revealed Resident #1 appeared to have altered mental status and drowsy but was not lethargic. PA #2 stated she was not as familiar with this resident and thought blood tests and a repeat chest x-ray were ordered. PA #2 confirmed Resident #1 was receiving intravenous fluids.

Documentation order note dated 8/27/2021 at 3:23 PM revealed the order for saline to be administered to Resident #1 intravenously was clarified by PA #2 for the provision of 1 liter of saline for the 7:00 AM to 7:00 PM shift and then the order was to be discontinued.

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Review of the MAR for Resident #1 revealed under the order dated as initiated on 8/26/2021 for one liter of saline solution to be administered intravenously every shift for dehydration. This order was documented as administered on the day shift on 8/27/2021 and on the night shift on 8/27/2021.

Laboratory results reported on 8/27/2021 at 4:46 PM flagged a high BUN of 65.5 (normal range of 6.0-20.0 mg/dl), a BUN/Creatine ratio of 54.6, and a sodium of 147 (normal range is 136-145 millimole (mmol)/ Liter (L).

The care plan for Resident #1 had a focus area initiated on 8/28/2021 for dehydration or potential fluid deficit relative to failure to thrive. The interventions included administering medications as ordered while monitoring and documenting for side effects; lab work as ordered; and the monitoring, documenting, and reporting of signs or symptoms of dehydration. The signs and symptoms of dehydration listed on the care plan included decreased or no urine output, concentrated urine, strong odor, tenting skin, cracked lips, furrowed tongue, new onset confusion, dizziness on sitting and standing, increased pulse, headache, fatigue, weakness, dizziness, fever, thirst, recent weight loss, and dry sunken eyes.

An interview was conducted on 9/7/2021 at 8:15 AM with PA #1. PA #1 stated Resident #1 was debilitated upon admission and had a diagnosis of failure to thrive. PA #1 explained Resident #1 declined from the time he was admitted with a decreased intake of food, fluids and medications but he was at an end of life stage and did not respond. PA #1 stated attempts were made to

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| F 692 | Continued From page 61<br>keep Resident #1 hydrated with intravenous fluids to try to correct his electrolytes and the antibiotic Azithromycin was ordered on 8/30/2021, but he was sent to the hospital before he received any of the doses.<br><br>An interview was conducted on 9/7/2021 at 10:08 AM with MD #1. MD #1 indicated he felt the facility intervened with appropriately with intravenous fluids when the laboratory test results came back stating Resident #1 had a BUN of 65 on 8/27/2021. MD #1 indicated Resident #1 improved clinically once his medications had been changed but perhaps a separate medical event or infectious process had started after that. | F 692 | | |
| F 697 SS=E | Pain Management<br>CFR(s): 483.25(k)<br><br>§483.25(k) Pain Management.<br>The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, resident, staff, physician assistant and physician interviews the facility failed to provide pain medication according to physician's order for 1 of 2 resident reviewed for pain management (Resident#14). Resident did not receive 13 doses of Methadone (medication used for pain management).<br><br>Findings included:<br><br>Resident #14 was readmitted to the facility on 7/30/21 with diagnosis that included chronic | F 697 | F697<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 14 missed opioid pain medication was reported to PA<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice: | 10/25/21 |

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| F 697 | Continued From page 62<br>respiratory failure, presence of left artificial shoulder joint, lower back pain, acute kidney failure, chronic pain syndrome and heart failure.<br><br>Review of Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 8/13/21, revealed the resident was cognitively intact. The assessment indicated the resident needed one-to-two-person physical assistance with activity of daily living. The resident was coded as having pain with a pain scale of 10 and was on scheduled and as needed (PRN) pain medications. Resident received opioids for 7 of the 7 days during the look back period.<br><br>Review of the care plan for Resident #14, dated 8/13/21, revealed the resident was care planned for pain. The goal was to have no or decreased complaints of pain. Interventions were included positioning the resident for comfort, attempting non-pharmacological interventions as needed, encouraging relaxation techniques, and providing diversional activities. Interventions also included medications to be administered as ordered and notifying physician for pain not relieved with medication or with new complaints of pain.<br><br>Review of the pain clinic consultation note, dated 9/16/21, revealed the Resident #14 was alert and oriented, had no acute distress and showed no involuntary pain behavior during the physical examination. The note also indicated that methadone 10 MG thrice a day was initiated to see if it was more beneficial for pain compared to Xtampza (oxycodone-based pain medication). Note indicated oxycodone was continued for break through pain and Flexeril 10 MG thrice a day was to improve spasm control. | F 697 | All current residents that receive opioid pain medication will be reviewed to validate adequate supply<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated that all opioid pain meds will be administered as ordered; if unable to administer pharmacy and physician will be notified for further direction<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of administering pain medications<br>DON or designee will audit 24 hour summary to ensure notification of missed pain meds to MD or extender 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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Review of the nursing note, dated 9/16/21, revealed the facility received orders for Resident #14 for pain medications. Note also indicated methadone 10 mg (milligram) by mouth every 8 hours was ordered.

Review of the nursing note, dated 9/20/21, revealed the pharmacy did not receive the script on 9/17/21 which was faxed by the pain clinic on 9/16/21. The pain clinic was called on 9/17/21 but was closed. Facility spoke with the pain clinic on 9/20/21 for clarification of medications and to refax the script to the pharmacy.

Review of the medication order summary report for September 2021 revealed the following medications were ordered for Resident #14 on 9/16/21 to control / manage resident's pain:
" Oxycodone HCl capsule 5 MG (milligrams) 2 capsule by mouth every 12 hours for pain related to lower back pain
" Cyclobenzaprine HCl Tablet 10 MG 1 tablet by mouth three times a day for muscle spasm relief related to lower back pain.
" Methadone HCl Tablet 10 MG 1 tablet by mouth every 8 hours related to lower back pain.

Review of the Medication Administration record (MAR) for Resident #14 for September 2021 revealed, Methadone HCl 10 MG was not administered from 9/16/21 to 9/20/21. A total of 13 doses were not administered. Review of the pain scale from 9/16/21 to 9/20/21 revealed the pain scale was marked as 0, except on 9/20/21 morning which was marked as 7. Review of the MAR revealed resident was administered oxycodone 5 MG- 2 tablets at 9:00 AM and pain scale was noted as 4.

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During an observation and interview on 9/20/21 at 10:30 AM, Resident #14 was observed to be well groomed, sitting on his bed, watching TV. The resident did not appear to be in any distress and showed no facial signs of pain like grimacing, no moaning or crying. Resident #14 stated he was unhappy and frustrated that the staff had not provided him all his medications since Thursday (9/16/21). Resident #14 indicated the facility nurse earlier that day had communicated to him that they had not received medications from the pharmacy and needed some authorization from the facility. The resident wanted to know why the facility has not been authorizing/ signing the paper so that he can receive the medication. The resident stated he had chronic pain, which included his lower back and shoulder. Resident denied pain during the interview. Resident did indicate that he was administered pain medication and that helped. After the interview Resident #14 transferred self to his wheelchair and propelled himself in the hallway. He did not appear in any pain and was propelling self without any issue and at a decent pace.

During an interview on 9/20/21 at 3:00 PM, Nurse #35 stated she was assigned to the Resident #14 on 9/16/21 (7AM to 7 PM). Nurse confirmed Resident #14 went to an outpatient pain clinic appointment on 9/16/21. Nurse indicated she received verbal orders from the pain clinic regarding new pain medication. Nurse #35 indicated she did not receive the medication methadone from pharmacy until the end of her shift and was not administered to the resident. Nurse #35 indicated the resident was not observed in pain and his pain scale was 0.

During an interview on 9/21/21 at 9:25 AM,

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Nurse# 36 indicated she was assigned to the Resident #14 on 9/17/21 (7AM - 7 PM). She stated she noticed that the medication methadone had not yet arrived from the pharmacy. Nurse #36 stated she notified the Assistant Director of Nursing (ADON) and was informed that she was looking into the issue. Nurse indicated she did administer the other medications as ordered by the physician and the resident was not in any pain during her shift.

During a telephone interview on 9/23/21 at 9:12 AM. Nurse #37 stated she was assigned to the resident on 9/18/20 and 9/19/20 (7 AM to 7 PM). She indicated on 9/18/20 she was given a report that there was a discrepancy in the script sent in by the pain clinic. Nurse # 37 further indicated, she was told that the medication was ordered by pain clinic physician and the pain clinic was closed over the weekend. Resident #14's medication methadone was unavailable to be administered as the pharmacy needed a script from the physician. Nurse# 37 stated on 9/18/21, the resident was not observed to be in any pain but was upset and frustrated that his medication was unavailable.

Nurse # 37 stated on 9/19/21, the resident was not observed in any pain, and had not asked about the medication. There was game on the television and the resident was enjoying the game. Nurse # 37 stated resident medication methadone was unavailable for administration. All other medications were administered as ordered by the physician.

During an interview on 9/20/21 at 1:45 PM, Nurse #21 indicated she was assigned to the Resident #14 on 9/20/21 (7AM to 7 PM) and had noticed that the medication was not available to be

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administered to the resident. Nurse indicated she had administered other pain medication as ordered by the physician and resident's pain was managed.

During a telephone interview on 9/21/21 at 11:44 AM, the Assistant Director of Nursing (ADON) indicated Resident #14 had an appointment with pain clinic center on 9/16/21. ADON stated on 9/17/21 at around 4 PM, Resident #14 notified her that he did not receive his medication. The ADON stated she had called the pain center to verify the orders and get clarification as to which pharmacy number the order was faxed. ADON further indicated when she called the clinic on 9/17/21 (Friday), the clinic was closed. ADON stated on 9/20/21 (Monday), she called the clinic, and the orders were refaxed to the pharmacy. ADON further stated she did not notify the physician that the resident did not receive his medication.

During an interview on 9/21/21 at 11:26 AM, Physician Assistant (PA) #3 stated she was on vacation during the week of 9/13/21. PA#3 further stated the facility staff were aware to call the on-call person in her absence if they had a medication related issue or any medical emergency. PA#3 indicated upon her return she checked the on-call telephone log and did not notice anything related to Resident #14 not receiving his medication. PA #3 indicated she was unaware the resident had not received his medication for 4 days.

During a telephone interview on 9/23/21 at 3:10 PM, PA #4, indicated Resident #14 was seen in the pain clinic on 9/16/21. The PA #4 stated the resident was previously on long lasting pain

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| F 697 | Continued From page 67<br>medication which was discontinued on 9/16/21. PA #4 indicated that by not receiving the medication for few days the resident could possibly have withdrawal symptoms, however when the facility contacted the pain clinic on 9/20/21, PA #4 did inform the facility to continue the previous medication until methadone was available.<br><br>During an interview on 9/21/21 at 1:20 PM, the Medical Director indicated the Resident #14 was drug seeking and would constantly ask the physician to increase his pain medication. It was due to this reason the resident was referred to the pain clinic. Pain clinic was managing resident's pain medication. The physician stated Resident #14 was on pain medications like oxycodone and as needed (PRN) pain medication and his pain scale was zero. The resident did not have any withdrawal symptoms. The physician stated the resident should receive his medications as ordered, however the resident's pain was under control. | F 697 | | |
| F 726 SS=D | Competent Nursing Staff<br>CFR(s): 483.35(a)(3)(4)(c)<br><br>§483.35 Nursing Services<br>The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). | F 726 | | 10/25/21 |

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| F 726 | Continued From page 68<br><br>§483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br><br>§483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs.<br><br>§483.35(c) Proficiency of nurse aides.<br>The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, nursing interviews and a Director of Nursing interview the facility failed to train an agency nurse how to put new admission orders into the electronic medical record for 1 (Nurse #23) of 2 nurses reviewed for knowledge of the electronic medical record system.<br><br>Findings included:<br><br>Resident #1 had a late entry admission note dated 8/14/2021 at 7:10 AM written by Nurse #23. The admission note revealed an initial assessment was completed on Resident #1.<br><br>An interview was conducted on 9/7/2021 at 6:30 PM with Nurse #23, who wrote the admission progress note on 8/14/2021 for Resident #1. Nurse #23 explained she had two residents who were declining rapidly with one of those residents | F 726 | F726<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident #1 admission orders transcribed incorrectly<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>New admission orders are verified within 24 hours<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All agency licensed nurses are educated by SDC or designee on how to do orders | |

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| F 726 | Continued From page 69<br>being about to expire as well as a resident who needed blood work on her shift, 7:00 PM to 7:00 AM beginning on 8/13/2021. Nurse #23 stated she did not recall what time or what day Resident #1 was admitted to the facility. Nurse #23 stated she knew she had to additionally put admission orders into the electronic medical record for Resident #1. Nurse #23 stated she asked for help from another nurse (Nurse #11) on the other hall because she did not know how to put the medication orders for Resident #1 into the electronic medical record. Nurse #23 said she tried to get Nurse #11 to show her how to do this, but she was told it would be faster if Nurse #11 put all the medication orders into the electronic medical record. Nurse #23 revealed Nurse #11 told her all the medication orders for Resident #1 were in the electronic medical record. Nurse #23 stated when she went to look at the electronic medical administration record (eMAR) for Resident #1 the medications were not showing up as needing to be given by highlighting in yellow. Nurse #23 stated she called the Director of Nursing (DON) to let her know the medications were not showing up on the eMAR for Resident #1 and she was told by the DON it would be taken care of. Nurse #23 revealed when she returned to work several days later, she noted Resident #1 was receiving the medications Nurse #11 entered into the eMAR.<br><br>An interview was conducted with Nurse #11 on 9/4/2021 at 2:52 PM. Nurse #11 stated she was working on her nursing unit on 8/14/2021 on the 7:00 PM to 7:00 AM shift when she was approached by a nursing assistant and was asked to go to another unit to assist because another nurse was "having a hard time." Nurse #11 revealed she went to the other nursing unit | F 726 | for admissions prior to the start of their shift<br>Steps to how to put orders in to point click care are left at each unit for reference.<br>Agency staff will not be permitted start shift without acknowledgement of understanding on how to put orders into medical record.<br>DON or designee will audit admission orders within 24 hours of admission 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| F 726 | Continued From page 70<br>and found a agency nurse (Nurse #23) who did not know how to put orders into the electronic medical system. Nurse #11 indicated it was going to be faster for her to put the orders in rather than show the agency nurse how to put the orders in.<br><br>An interview was conducted on 9/4/2021 at 1:45 PM with the previous DON. The DON revealed when Resident #1 was admitted the admission orders were not transcribed correctly into the electronic medical record. The DON explained she interviewed Nurse #11 to find out what happened and where Nurse #11 obtained the incorrect admission orders from. The DON stated she found out Nurse #11 was trying to help Nurse #23 who did not know how to put admission orders into the electronic medical record, but she did not know how the wrong medications were entered. | F 726 | | |
| F 755 SS=E | Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3)<br><br>§483.45 Pharmacy Services<br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>§483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>§483.45(b) Service Consultation. The facility | F 755 | | 10/25/21 |

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| F 755 | Continued From page 71<br>must employ or obtain the services of a licensed pharmacist who-<br><br>§483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.<br><br>§483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and resident, staff, and Physician Assistant (PA) interviews the facility failed to obtain pain medication from the pharmacy which delayed medication administration for 1 of 2 residents (Resident #14) reviewed for pain.<br><br>Findings included:<br><br>Resident #14 was readmitted to the facility on 7/30/21 with diagnosis that included chronic respiratory failure, presence of left artificial shoulder joint, lower back pain, acute kidney failure, chronic pain syndrome and heart failure.<br><br>Review of Resident #14's quarterly Minimum Data Set (MDS) assessment, dated 8/13/21, revealed the resident was cognitively intact. The resident was coded as having pain with a pain scale of 10 and was on scheduled and as needed (PRN) pain medications. Resident received opioids for 7 of the 7 days during the look back | F 755 | F755<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 14 missed opioid pain medication was reported to PA<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All current residents that receive opioid pain medication will be reviewed to validate adequate supply<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated that all opioid pain meds will be administered as ordered; if unable to administer pharmacy and physician will be notified for | |

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| F 755 | Continued From page 72<br>period.<br><br>Review of the nursing note, dated 9/16/21, revealed the facility received orders for Resident #14 for pain medications. Note also indicated methadone 10 mg (milligram) by mouth every 8 hours was ordered.<br><br>Review of the medication order summary report for September 2021 revealed on 9/16/21 Methadone HCl Tablet 10 MG (milligrams) 1 tablet by mouth every 8 hours was ordered for lower back pain.<br><br>Review of the Medication Administration record (MAR) for Resident #14 for September 2021 revealed, Methadone HCl 10 MG was not administered from 9/16/21 to 9/20/21. A total of 13 doses were not administered.<br><br>During an interview on 9/20/21 at 3:00 PM, Nurse #35 stated she was assigned to the Resident #14 on 9/16/21 (7AM to 7 PM). Nurse indicated she received verbal orders from the pain clinic related to the new medication. Nurse #35 further indicated when she contacted the pharmacy for medication, they had notified her that they had not received the orders. Nurse stated she contacted the pain clinic on 9/16/21 to verify if the medications were faxed to the pharmacy. The pain clinic had faxed the medication to the wrong pharmacy. Nurse# 35 further stated the pain clinic was given the correct fax number so that the medications could be faxed to the pharmacy. Nurse # 35 indicated later that evening she did call the pharmacy to find out if they received the script. The pharmacist had informed her that they would have received it if it was faxed to them. | F 755 | further direction<br>Any Licensed Nurse who is not educated by October 18, will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation for process of administering pain medications<br>DON or designee will audit 10% of pain medications for adequate supply 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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During an interview on 9/21/21 at 9:25 AM, Nurse# 36 indicated she was assigned to the Resident #14 on 9/17/21 (7AM - 7 PM). She stated she noticed that the medication methadone had not yet arrived from the pharmacy. Nurse #36 stated she notified the Assistant Director of Nursing (ADON) and was informed that the ADON was looking into the issue. Nurse confirmed she did not call the pharmacy for the medication.

During a telephone interview on 9/23/21 at 9:12 AM. Nurse #37 stated she was assigned to the resident on 9/18/20 and 9/19/20 (7 AM to 7 PM). She indicated on 9/18/20 she was given a report that there was a discrepancy in the script sent in by the pain clinic. Nurse # 37 further indicated, she was told that the medication was ordered by pain clinic physician and the pain clinic was closed over the weekend. Nurse #37 stated she did explain to the resident that the pharmacy needed the script from the physician so that pharmacy could dispense the medication. Nurse #37 stated she did not contact the pharmacy regarding the medication.

Nurse # 37 stated on 9/19/21, she did contact the pharmacy. The pharmacy indicated that they were waiting for the script to be signed by the physician. Nurse further stated she did not contact the facility physician as the script was sent by the pain clinic and not the facility physician.

During an interview on 9/20/21 at 1:45 PM, Nurse #21 indicated she was assigned to the Resident #14 on 9/20/21 (7AM to 7 PM) and had noticed that the medication was not available to be administered to the resident. She stated she called the pharmacy and was informed that a

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| F 755 | Continued From page 74 | F 755 | | |

script needs to be signed by the provider. Nurse #21 indicated she faxed a new signed script to the pharmacy that afternoon after it was signed by the PA.

During an interview on 9/21/21 at 10:15 AM, Physician assistant (PA) #1, stated he does not recollect the name of the nurse, but on 9/20/21 a nurse assigned to the resident had asked him to sign a script for the medication to be sent to the pharmacy. This medication was ordered by the pain clinic. PA #1 stated he did sign the script.

During a telephone interview on 9/21/21 at 11:44 AM, the Assistant Director of Nursing (ADON) indicated Resident #14 had an appointment with pain clinic center on 9/16/21. ADON stated on 9/17/21 at around 4 PM Resident #14 notified her that he did not receive his medication. The ADON stated she had called the pain center to verify the orders and get clarification as to which pharmacy number the order was faxed. ADON further indicated when she called the clinic on 9/17/21 (Friday), the clinic was closed. ADON stated on 9/20/21 (Monday), she called the clinic, and the orders were refaxed to the pharmacy.

During a telephone interview on 9/23/21 at 3:10 PM, PA #4, indicated Resident #14 was seen in the pain clinic on 9/16/21. PA #4 stated the clinic faxed the script to the pharmacy on 9/16/21. On 9/20/21 the pain clinic received a call from the facility informing them that the script was faxed to a wrong pharmacy and another fax number was provided. The script was re faxed to the pharmacy.

During a telephone interview on 9/22/21 at 11:23 AM, the pharmacy staff stated the pharmacy

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| F 755 | Continued From page 75<br>received the script for methadone on 9/20/21 and the medication was immediately dispatched to the facility.<br><br>During a telephone interview on 9/23/21 at 1:30 PM, the administrator stated the facility had changed pharmacy on 9/1/21 and this would not have caused the resident not receiving his medication. He stated the residents should receive all medications as prescribed by the physician. He further stated that when medication was unavailable the physician need to be notified for new orders. | F 755 | | |
| F 756 SS=J | Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5)<br><br>§483.45(c) Drug Regimen Review.<br>§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>§483.45(c)(2) This review must include a review of the resident's medical chart.<br><br>§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. | F 756 | | 10/25/21 |

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| F 756 | Continued From page 76<br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, consultant pharmacist interview, and pharmacy manager interview, the facility consultant pharmacist failed to complete a comprehensive review of a new admission's medications for 1 (Resident #1) of 3 residents reviewed for pharmacy reviews upon admission. Resident #1 received medications ordered for another resident for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock.<br><br>Immediate Jeopardy began on 08/17/2021 when Resident #1 had an initial pharmacy review | F 756 | F756<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident # 1 admission orders transcribed incorrectly<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>Pharmacy consultant performed comprehensive review of admission orders for all residents admitted since 08/13/21.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>Pharmacy Consultant will review each new admission within 24-48 hours. The pharmacy consultant will report any time | |

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completed and the facility failed to have a system in place for the facility pharmacist to perform a comprehensive review of the medications ordered for a resident upon admission. The immediate jeopardy was removed on 9/11/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "D" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.

Findings included:

Resident #1 was admitted from the hospital emergency room to the facility on 8/14/2021.

A North Carolina FL2 form for Resident #1, dated as completed on 8/13/2021 at 1:45 PM was sent to the facility from the hospital. A FL-2 is a North Carolina form that describes a patient's medical condition and the amount of care they need when placed in a facility.

Resident #1 had diagnoses listed on the FL-2 form from the emergency room of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission complaint of Resident #1 was weakness and failure to thrive.

The FL-2 form also listed the current hospital medication orders for Resident #1 as the

sensitive recommendations or irregularities to the Director of Nursing via phone. DON will forward to physician for review and action.
Weekly meeting with medical director and PA and DON to discuss any pharmaceutical changes
DON or designee to review all pharmacy consultant new admission reviews 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3

How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.

Completion October 25, 2021

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following: 81 mg Aspirin (a blood thinner) to be given as one tablet by mouth a day; 10 mg Atorvastatin (treatment of heart disease) to be given as one tablet by mouth a day; 0.2-0.5% Brimonidine-Timolol (eye drops) to be given as one drop in each eye every 12 hours; 25-100 mg Carbidopa-levodopa (used to treat Parkinson's) to be given as one and half tablets by mouth three times a day; 500 mg Cephalexin (antibiotic) to be given as one capsule by mouth two times a day for 5 days; 1000 units Cholecalciferol (Vitamin D) to be taken as one capsule by mouth once a day; 500 mg Ciprofloxacin (antibiotic) to be taken as one tablet by mouth two times a day for 5 days; 2% Dorzolamide ophthalmic solution (eye drops) to be taken as one drop in both eyes two times a day; 20 mg Doxycycline (used to treat gum disease) to be taken as one tablet by mouth two times a day; 40 mg Famotidine to be taken as one tablet by mouth once a day; 0.005% Latanoprost ophthalmic solution (eye drops) to be taken as one drop in both eyes at bedtime; Multivitamins- Mineral to be taken as one capsule by mouth two times a day; 75 mg Sertraline (used to treat depression) to be taken as one and a half tablets (75 mg total) by mouth one time a day; and 0.4 mg Tamsulosin (used to treat frequent urination) to be taken as one capsule by mouth once a day; 50 mg Trazadone to be taken as one capsule by mouth at bedtime as needed for sleep; 80 mg Valsartan (blood pressure medication)to be taken as one tablet by mouth one time daily; and 1000 microgram (microgram) Vitamin B-12 to be taken by mouth once daily.

Documentation in the facility electronic record listed the Resident's diagnoses as being cerebral infarction (principle diagnosis), Parkinson's disease, adult failure to thrive, muscle weakness,

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chronic obstructive pulmonary disease, gastro-esophageal reflux disease, hyperlipidemia, and Hypertension.

An interview was conducted with Nurse #11 on 9/4/2021 at 2:52 PM. Nurse #11 stated she was working on her nursing unit on 8/14/2021 on the 7:00 PM to 7:00 AM shift when she was approached by a nursing assistant and was asked to go to another unit to assist because another nurse was "having a hard time." Nurse #11 revealed she went to the other nursing unit and found an agency nurse (Nurse #23) who did not know how to put orders into the electronic medical system. Nurse #11 indicated it was going to be faster for her to put the orders in rather than show the agency nurse how to put the orders in. Nurse #11 stated she took the hospital emergency room discharge orders for Resident #1 that were on the nursing unit desk and returned to her own nursing unit to put them into the electronic medical record. Nurse #11 stated she called the on-call service at approximately 3:00 AM to have the orders verified. The on-call service connected her to the phone for Physician's Assistant (PA) #1. Nurse #11 stated the phone did not answer and the voice mail box was full. Nurse #1 stated she attempted to call the on-call PA #1 four times. Nurse #11 stated it took her four hours to put the orders into the electronic medical record for Resident #1 due to multiple interruptions every 15 to 20 minutes. Nurse #11 confirmed she had gone down the list to make sure she had put the orders in correctly.

According to the medication administration record (MAR) for Resident #1, he did not receive any medications on 8/14/2021 or 8/15/2021.

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Documentation on the MAR for Resident #1 revealed he began to receive medications which had been ordered for him by Nurse #11 beginning on 8/16/2021.

Review of the physician orders and the Medication Administration Record (MAR) for Resident #1 in the electronic record revealed the following medication orders and their administration:

On 8/14/2021 the physician ordered 10 mg of Amlodipine Besylate to be given as one tablet by mouth one time a day for Hypertension and angina.

On 8/18/2021 the physician ordered 10 mg Amlodipine Besylate to be given as one tablet by mouth one time a day for Hypertension and angina to be put on hold if the blood pressure diastolic was less than 100.

On 8/21/2021 the physician ordered 10 mg Amlodipine Besylate Tablet 10 mg to be given as 1 tablet by mouth one time a day for Hypertension and angina to be put on hold if the blood pressure systolic was less than 100.

On 8/14/2021 the physician ordered 40 mg Atorvastatin Calcium to be given as one tablet by mouth at bedtime for his cholesterol level. This physician's order was for 30 mg more of Atorvastatin Calcium than was ordered on the FL-2 from the hospital for Resident #1.

On 8/14/2021 the physician ordered 1000 mg of Divalproex Sodium delayed release to be given as two tablets of 500 mg each by mouth one time a day for seizures.

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On 8/14/2021 the physician ordered 1500 mg of Divalproex Sodium Delayed Release to be given as three tablets of 500 mg each by mouth at bedtime for seizures.

On 8/14/2021 the physician ordered 30 mg Duloxetine HCL (hydrochloride) Delayed Release Particles to be given as one capsule by mouth one time a day as an antidepressant.

On 8/14/2021 the physician ordered 325 mg Ferrous Sulfate to be given as one tablet one time a day for supplementation.

On 8/14/2021 the physician ordered 10 mg Fluphenazine HCL to be given as one tablet by mouth at bedtime as an antipsychotic.

On 8/14/2021 the physician ordered two Lidocaine Patches to be applied to the skin of the affective areas topically one time a day every 12 hours then removed for treatment of pain. No strength for the Lidocaine was listed on the physician's order.

On 8/14/2021 the physician ordered 6 mg Melatonin to be given as two tablets of 3 mg each by mouth at bedtime for insomnia.

On 8/14/2021 the physician ordered 7 mg/24 hours NicoDerm CQ Patch to be applied at 8:00 AM as one patch trans dermally one time a day at for smoking and removal of the patch at 7:59 AM.

On 8/14/2021 the physician ordered 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for a psychotic disorder.

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On 8/14/2021 the physician ordered a duplicate order for 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for restlessness.

On 8/14/2021 the physician ordered a third duplicate order for 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for restlessness.

On 8/14/2021 the physician ordered 5 mg Olanzapine to be given as one tablet by mouth two times as day for insomnia.

On 8/14/2021 the physician ordered 2.5 mg Olanzapine Tablet to be given as one tablet by mouth three times a day for restlessness as needed.

On 8/14/2021 the physician ordered 17 grams Polyethylene Glycol to be given as one packet by mouth one time a day for constipation.

On 8/14/2021 the physician ordered 1 mg Prazosin HCL to be given as one capsule by mouth at bedtime for Hypertension.

On 8/14/2021 the physician ordered 40 mg Protonix Tablet Delayed Release to be given as one tablet by mouth one time a day as an acid reducer.

On 8/14/2021 the physician ordered a duplicate order for 40 mg Protonix Tablet Delayed Release to be given as one tablet by mouth one time a day as an acid reducer.

On 8/14/2021 the physician ordered 8.6 mg Senna to be given as one tablet by mouth at bedtime for constipation.

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On 8/14/2021 the physician ordered 0.5mg/ml (milliliter) Budesonide Suspension to be administered by inhaling orally two times a day for shortness of breath.

On 8/14/2021 the physician ordered 0.5 mg Carboxymethylcellulose Sodium Liquid to be administered as eye drops, two drops in each eye two times a day for treatment of glaucoma. Instill 0.5 mg in both eyes two times a day for glaucoma.

On 8/14/2021 the physician ordered 6.25 mg Carvedilol to be given as one tablet two times a day by mouth for Hypertension.

On 8/14/2021 the physician ordered 200 mg Celebrex dispensed as written to be given as one capsule by mouth two times a day for pain.

On 8/14/2021 the physician ordered 500 mg Acetaminophen to be given as one tablet by mouth every 8 hours for pain.

On 8/14/2021 the physician ordered 100 units/ml (milliliters) Insulin Aspart Solution Pen-Injector to be injected with a pen injector as per sliding scale: If 201-250 = 4 units, 251-300 6 units, 301-350 8 units, 351-400 10 units; 350-400 10 units, 400 to HI 10 units repeat in 2 hours and cover greater than 300 subcutaneously three times a day for insulin give 5 units three times a day repeat finger stick blood sugar in 2 hours and cover as per sliding scale.

On 8/14/2021 the physician ordered 2 grams of Voltran Gel 1 % to be applied to his skin topically three times a day for pain.

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On 8/14/2021 the physician ordered 18-103 microgram/ actuation Combivent Aerosol to be administered with an inhaler as 2 puffs inhaled orally four times a day every four hours for shortness of breath as needed.

On 8/14/2021 the physician ordered 0.65 mcg Sodium Chloride Solution to be administered as one spray in both nostrils four times a day for congestion.

Documentation in the medical record for Resident #1 under assessments revealed a consultant pharmacist admission medication regimen review was completed on 8/17/2021. The review stated, "See report for any noted irregularities and/or recommendations."

The facility pharmacist was interviewed on 9/7/2021 at 11:50 AM. The facility pharmacist explained when he did the Admission medication review on Resident #1 on 8/17/2021, he did so remotely and did not have access to the discharge information from the hospital in the electronic medical record. The pharmacist confirmed he did not look at the diagnoses to compare to the medications on the admission medication review. He also explained that most of the medications for Resident #1 had not been transmitted to the pharmacy on 8/17/2021 so he was not able to see them as medication orders. The facility pharmacist further explained he filled out a form in the electronic medical record to say he had noted irregularities for Resident #1, but the actual consultation reports were sent to the Director of Nursing. The pharmacist reported on the consultation report the concern the resident was on two antipsychotics and needed an AIMS

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test (abnormal involuntary movement scale). An AIMS test is used to detect abnormal movements in patients receiving antipsychotics. The consultant pharmacist stated the two antipsychotics administered to Resident #1 could have led to over sedation and falls. The pharmacist stated he sent his review to the previous DON on 8/17/2021 with the usual expectation it would be acted upon by his next review in 30 days. The pharmacist stated he would not know if his review in this case was acted upon because the facility had a new pharmacy and pharmacist effective 9/1/2021.The pharmacist stated his concerns after reviewing the medication list for Resident from 8/14/2021 to 8/24/2021 was for over sedation and falls as well as for low blood pressure episodes due to a new regimen for Hypertension.

An interview was conducted on 9/8/2021 at 9:45 AM with a pharmacy manager for the pharmacy the facility had a contract in August 2021. The Pharmacy manager stated most of the medication orders for Resident #1 were dated as being put into the electronic medical record on 8/14/2021 but were not transmitted or signed off by the physician until Monday, 8/16/2021 or later. The Pharmacy manager stated there was no way for the pharmacy to know the physician orders were for the wrong resident and the pharmacy relies on the physician and the consultant pharmacist to catch medication order errors.

On 9/9/2021 at 12:30 PM, the administrator was informed of the immediate jeopardy.
The allegation of immediate jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy

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removal:

F756 - Drug Regimen Review
" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Synopsis: Pharmacy consultant performed admission medication review for the patient on 8/17/21, but a discharge summary had not been scanned into the EMR system. This missing info allowed the resident to continue to receive incorrect medications for eight days without appropriate diagnoses.

Fourteen residents admitted on or after 8/13 had pharmacy consults with irregularities or recommendations that had not been addressed. Current consultant pharmacist was notified on 9/9/21 and completed a medication review on these Residents. The consultation report was sent to the facility and the ADON will complete on 9/10/21.

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

Facility Action: Consultant pharmacist will review each new admission within 24-48 hours. This will happen remotely with EMR access. Pharmacist will have access to PointClickCare (PCC), EMAR, and hospital discharge summary in the miscellaneous section of a patient's electronic record. Each review will be electronically documented for facility access. The consultant pharmacist will report any time sensitive recommendations or irregularities to the Director

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of Nursing via phone. Upon receipt of recommendations, the Director of Nursing will forward to the physician for review and action. The Director of Nursing will provide the Medical Director completed pharmacy recommendations weekly.

During a call with the consultant pharmacist on 9/9, pharmacist informed us she will be visiting the facility to conduct monthly medication review on 9/27/21. During the call, DON and administrator instructed consultant pharmacist of location of discharge summary in miscellaneous file in PCC on EMR. Medications will be confirmed at time of admission so that they are accessible for consultant pharmacist to review. Not having confirmed the medications in this instance led to them not being available for the pharmacist to review.

Medical director will meet with physician assistants weekly and also meet with director of nursing weekly. During weekly meeting between medical director and director of nursing, any questions or concerns about actual or proposed pharmaceutical changes will be discussed.

The Director of Nursing or designee will ensure implementation of the plan.

Planned removal of IJ: 9/11/21

The credible allegation was verified on 9/17/21. Review of medical records of new admission revealed a pharmacy review. All medications for new admissions were reviewed by the Pharmacist between 24-48 hours of facility admission. Facility staff alleged compliance as of 9/11/21. The facility's credible allegation of

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| F 756 | Continued From page 88<br>immediate jeopardy removal was verified as having been implemented on 9/11/21. | F 756 | | |
| F 757 SS=K | Drug Regimen is Free from Unnecessary Drugs<br>CFR(s): 483.45(d)(1)-(6)<br><br>§483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-<br><br>§483.45(d)(1) In excessive dose (including duplicate drug therapy); or<br><br>§483.45(d)(2) For excessive duration; or<br><br>§483.45(d)(3) Without adequate monitoring; or<br><br>§483.45(d)(4) Without adequate indications for its use; or<br><br>§483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>§483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, Administrator interview, physician assistant interview, and physician interview the facility failed to administer the correct medications and administered medications without supporting diagnoses for one (Resident #1) of three residents reviewed for unnecessary drugs. The facility failed to recognize the incorrect medications were entered into the electronic | F 757 | F757<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>Failed to administer the correct medications and administered medications without a supporting | 10/25/21 |

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| F 757 | Continued From page 89<br>medical record system upon admission for Resident #1 resulting in the resident receiving 29 incorrect medications for a period of 8 days. These medications included in part antipsychotics, seizure medication, pain medication, insomnia medication, hypertension medication, diabetic medication, glaucoma medication, and smoking cessation. Resident #1 was admitted to the hospital on 8/30/2021 and expired on 9/1/2021.<br><br>Immediate Jeopardy began on 08/14/2021 when Resident #1 entered the facility and the facility failed to have an effective system in place to order and administer the correct medications. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock. The immediate jeopardy was removed on 9/11/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective.<br><br>Findings included:<br><br>Resident #1 was admitted from the hospital emergency room to the facility on 8/14/2021. | F 757 | diagnosis for Resident #1<br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br>" All new admissions are at risk for the deficient practice.<br><br>The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br>" Director of Nursing or designee will provide education to all licensed nurses on how to admit a patient including order entry and confirming orders<br>" Any nurse who did not receive the education by the compliance date will be removed from the schedule until completed<br>" All new nurses will receive education during the orientation process.<br>" DON or designee will perform admission audits within 24 hours of admission to ensure correct transcription 5x weekly x 4 weeks, once weekly x8 weeks and monthly x 3.<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits will be reported to the QAPI committee quarterly x 2 for analysis of patterns, trends, or need for further systemic changes.<br><br>Completion October 25, 2021 | |

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A North Carolina FL-2 form for Resident #1, dated as completed on 8/13/2021 at 1:45 PM was sent to the facility from the hospital. A FL-2 is a North Carolina form that describes a patient's medical condition and the amount of care they need when placed in a facility.

Resident #1 had diagnoses listed on the FL-2 form dated 8/13/2021 from the emergency room of Parkinson's disease, chronic obstructive pulmonary disease, esophageal reflux, personal history of transit ischemic attack without residual deficits (2016), Hypertension, prostate cancer (2018), esophageal reflux, cerebral vascular disease, and hyperlipidemia. The FL-2 form also revealed the emergency room admission complaint of Resident #1 was weakness and failure to thrive.

The FL-2 form dated 8/13/2021 included documentation attested to by the physician stating Resident #1 was oriented to self, place, time, and situation as well as continent of bowel and bladder. He was also described on the documentation as requiring limited assistance with bathing, feeding, and dressing. A physical therapy evaluation included in the FL-2 dated 8/13/2021 revealed Resident #1 required maximum assistance with getting into the sitting position from laying flat but required minimum assistance from sitting to standing. The hospital physical therapy evaluation noted Resident #1 was able to walk 85 feet with a rolling walker.

The same 8/13/2021 FL-2 form also listed the current hospital medication orders for Resident #1 as the following: 81 milligrams (mg) Aspirin (a blood thinner) to be given as one tablet by mouth

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a day; 10 mg Atorvastatin (treatment of heart disease) to be given as one tablet by mouth a day; 0.2-0.5% Brimonidine-Timolol (eye drops) to be given as one drop in each eye every 12 hours; 25-100 mg Carbidopa-levodopa (used to treat Parkinson's) to be given as one and half tablets by mouth three times a day; 500 mg Cephalexin (antibiotic) to be given as one capsule by mouth two times a day for 5 days; 1000 units Cholecalciferol (Vitamin D) to be taken as one capsule by mouth once a day; 500 mg Ciprofloxacin (antibiotic) to be taken as one tablet by mouth two times a day for 5 days; 2% Dorzolamide ophthalmic solution (eye drops) to be taken as one drop in both eyes two times a day; 20 mg Doxycycline (used to treat gum disease) to be taken as one tablet by mouth two times a day; 40 mg Famotidine to be taken as one tablet by mouth once a day; 0.005% Latanoprost ophthalmic solution (eye drops) to be taken as one drop in both eyes at bedtime; Multivitamins- Mineral to be taken as one capsule by mouth two times a day; 75 mg Sertraline (used to treat depression) to be taken as one and a half tablets (75 mg total) by mouth one time a day; and 0.4 mg Tamsulosin (used to treat frequent urination) to be taken as one capsule by mouth once a day; 50 mg Trazadone to be taken as one capsule by mouth at bedtime as needed for sleep; 80 mg Valsartan (blood pressure medication)to be taken as one tablet by mouth one time daily; and 1000 microgram (mcg) Vitamin B-12 to be taken by mouth once daily.

Documentation in the facility electronic record listed the Resident's diagnoses as being cerebral infarction (principle diagnosis), Parkinson's disease, adult failure to thrive, muscle weakness, chronic obstructive pulmonary disease,

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gastro-esophageal reflux disease, hyperlipidemia, and Hypertension.

An admission nursing progress note dated 8/14/2021 at 7:10 AM as a late entry stated, "Received resident to Room [#] via stretcher with medical transport, alert and oriented x 2, skin [warm/dry] to touch denies [complaint of] pain, [abdomen] soft none distended, [Range of Motion] x4, laceration to left ear swollen and red, buttocks red but blanchable. Continent of bladder not bowel. Resident is full code, no [signs/symptoms] of distress noted. Resident in bed resting."

An interview with Nurse #23, who wrote the admission progress note on 8/14/2021 for Resident #1, was conducted on 9/7/2021 at 6:30 PM. Nurse #23 revealed Resident #1 was admitted to the facility in the late evening on 8/13/2021 or early morning hours of 8/14/2021. Nurse #23 also revealed she was very busy on the 7:00 PM to 7:00 AM shift on 8/14/2021 with several residents in distress as well as trying to figure out how to put the new orders into the record for Resident #1. Nurse #23 stated she called to the other nursing unit for assistance.

An interview was conducted with Nurse #11 on 9/4/2021 at 2:52 PM. Nurse #11 stated she was working on her nursing unit on 8/14/2021 on the 7:00 PM to 7:00 AM shift when she was approached by a nursing assistant and was asked to go to another unit to assist because another nurse was "having a hard time." Nurse #11 revealed she went to the other nursing unit and found a travel nurse (Nurse #23) who did not know how to put orders into the electronic medical system. Nurse #11 indicated it was going

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to be faster for her to put the orders in rather than show the travel nurse how to put the orders in. Nurse #11 stated she took the hospital emergency room discharge orders for Resident #1 that were on the nursing unit desk and returned to her own nursing unit to put them into the electronic medical record. Nurse #11 stated she called the on-call service at approximately 3:00 AM to have the orders verified. The on-call service connected her to the phone for Physician's Assistant (PA) #1. Nurse #11 stated the phone did not answer and the voice mail box was full. Nurse #11 stated she attempted to call the on-call PA #1 four times. Nurse #11 stated it took her four hours to put the orders into the electronic medical record for Resident #1 due to multiple interruptions every 15 to 20 minutes. Nurse #11 confirmed she had gone down the list to make sure she had put the orders in correctly.

According to the Medication Administration Record (MAR) for Resident #1, he did not receive any ordered medications on 8/14/2021 or 8/15/2021.

Documentation on the MAR for Resident #1 revealed he began to receive medications which had been ordered for him by Nurse #11 beginning on 8/16/2021.

Review of the physician orders and the MAR for Resident #1 in the electronic record revealed the following medication orders and their administration:

On 8/14/2021 the physician ordered 10 mg of Amlodipine Besylate to be given as one tablet by mouth one time a day for Hypertension and angina. Review of the MAR revealed Resident #1

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received two doses under this medication order, one dose on 8/17/2021 and one dose on 8/18/2021. The order was discontinued on 8/18/2021.

On 8/18/2021 the physician ordered 10 mg Amlodipine Besylate to be given as one tablet by mouth one time a day for Hypertension and angina to be put on hold if the blood pressure diastolic was less than 100. Review of the MAR revealed Resident #1 received one dose on 8/21/2021. This order was discontinued on 8/21/2021.

On 8/21/2021 the physician ordered 10 mg Amlodipine Besylate Tablet 10 mg to be given as 1 tablet by mouth one time a day for Hypertension and angina to be put on hold if the blood pressure systolic was less than 100. This medication was not discontinued while the resident was in the facility. Review of the MAR revealed Resident #1 received four doses under this medication order: one dose on 8/22/2021, one dose on 8/24/2021, one dose on 8/26/2021, and one dose on 8/29/2021.

On 8/14/2021 the physician ordered 40 mg Atorvastatin Calcium to be given as one tablet by mouth at bedtime for his cholesterol level. This physician's order was for 30 mg more of Atorvastatin Calcium than was ordered on the FL-2 from the hospital for Resident #1. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received six doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, one dose on 8/21/2021, and one dose on 8/23/2021.

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On 8/14/2021 the physician ordered 1000 mg of Divalproex Sodium delayed release to be given as two tablets of 500 mg each by mouth one time a day for seizures. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/21//2021, one dose on 8/22/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 1500 mg of Divalproex Sodium Delayed Release to be given as three tablets of 500 mg each by mouth at bedtime for seizures. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, one dose on 8/21/2021, and one dose on 8/23/2021.

On 8/14/2021 the physician ordered 30 mg Duloxetine HCL (hydrochloride) Delayed Release Particles to be given as one capsule by mouth one time a day as an antidepressant. This medication order was discontinued on 8/24/2021. Review of the MAR revealed Resident #1 received three doses under this medication order: one dose on 8/21/2021, one dose on 8/22/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 325 mg Ferrous Sulfate to be given as one tablet one time a day for supplementation. This medication was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/21/2021, one dose on 8/22/2021, and one dose no 8/24/2021.

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On 8/14/2021 the physician ordered 10 mg Fluphenazine HCL to be given as one tablet by mouth at bedtime as an antipsychotic. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, one dose on 8/21/2021, and one dose on 8/23/2021.

On 8/14/2021 the physician ordered two Lidocaine Patches to be applied to the skin of the affective areas topically one time a day every 12 hours then removed for treatment of pain. No strength for the Lidocaine was listed on the physician's order. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received three doses under this order: two patches on 8/21/2021, two patches on 8/23/2021, and two patches on 8/24/2021.

On 8/14/2021 the physician ordered 6 mg Melatonin to be given as two tablets of 3 mg each by mouth at bedtime for insomnia. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/19/2021, one dose on 8/20/2021, one dose on 8/21/2021, a one dose on 8/23/2021.

On 8/14/2021 the physician ordered 7 mg/24 hours NicoDerm CQ Patch to be applied at 8:00 AM as one patch trans dermally one time a day at for smoking and removal of the patch at 7:59 AM. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received one patch under this order on

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8/21/2021.

On 8/14/2021 the physician ordered 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for a psychotic disorder. This medication order was put on hold on 8/22/2021 and discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received two doses under this medication order: one dose on 8/19/2021 and one dose on 8/21/2021.

On 8/14/2021 the physician ordered a duplicate order for 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for restlessness. This medication order was put on hold on 8/22/2021 and discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received two doses under this medication order: one dose on 8/19/2021 and one dose on 8/21/2021.

On 8/14/2021 the physician ordered a third duplicate order for 15 mg Olanzapine Tablet to be given as one tablet by mouth at bedtime for restlessness. This medication order was put on hold on 8/22/2021 and discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received three doses under this medication order: one dose on 8/19/2021, one dose on 8/20/2021, and one dose on 8/21/2021.

On 8/14/2021 the physician ordered 5 mg Olanzapine to be given as one tablet by mouth two times as day for insomnia. This medication order was put on hold on 8/22/2021 and discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received eleven doses under this medication order: two doses on 8/16/2021, two doses on 8/17/2021, two doses on

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8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, two doses on 8/21/2021, and one dose on 8/22/2021.

On 8/14/2021 the physician ordered 2.5 mg Olanzapine Tablet to be given as one tablet by mouth three times a day for restlessness as needed. This medication order was put on hold on 8/22/2021 and discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received six doses under this medication order: one dose on 8/19/2021, one dose on 8/20/2021, three doses on 8/21/2021, and one dose on 8/22/2021

On 8/14/2021 the physician ordered 17 grams Polyethylene Glycol to be given as one packet by mouth one time a day for constipation. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received three doses under this medication order: one dose on 8/21/2021, one dose on 8/22/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 1 mg Prazosin HCL to be given as one capsule by mouth at bedtime for Hypertension. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received four doses under this medication order: one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, and one dose on 8/21/2021.

On 8/14/2021 the physician ordered 40 mg Protonix Tablet Delayed Release to be given as one tablet by mouth one time a day as an acid reducer. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1

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revealed he received three doses under this medication order: one dose on 8/21/2021, one dose on 8/22/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered a duplicate order for 40 mg Protonix Tablet Delayed Release to be given as one tablet by mouth one time a day as an acid reducer. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received three doses under this medication order: one dose on 8/21/2021, one dose on 8/22/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 8.6 mg Senna to be given as one tablet by mouth at bedtime for constipation. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, and one dose on 8/21/2021.

On 8/14/2021 the physician ordered 0.5mg/ml (milliliter) Budesonide Suspension to be administered by inhaling orally two times a day for shortness of breath. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received nine doses under this medication order: one dose on 8/16/2021, one dose on 8/17/2021, one dose on 8/18/2021, two doses on 8/21/2021, one dose on 8/22/2021, two doses on 8/23/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 0.5 mg Carboxymethylcellulose Sodium Liquid to be administered as eye drops, two drops in each eye two times a day for treatment of glaucoma. Instill

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0.5 mg in both eyes two times a day for glaucoma. This order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received six administrations under this medication order: one administration on 8/17/2021, one administration on 8/18/2021, two administrations on 8/21/2021, one administration on 8/22/2021, and one administration on 8/24/2021.

On 8/14/2021 the physician ordered 6.25 mg Carvedilol to be given as one tablet two times a day by mouth for Hypertension. This medication order was discontinued on 8/24/2021. Review of the MAR for Resident #1 revealed he received nine doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, two doses on 8/21/2021, one dose on 8/22/2021, one dose on 8/23/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 200 mg Celebrex dispensed as written to be given as one capsule by mouth two times a day for pain. This medication order was discontinued on 8/24/2021. The MAR for Resident #1 revealed he received five doses under this medication order: one dose on 8/17/2021, one dose on 8/18/2021, one dose on 8/21/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 500 mg Acetaminophen to be given as one tablet by mouth every 8 hours for pain. This medication order was discontinued on 8/24/21. The MAR for Resident #1 revealed he received nineteen doses under this medication order: one dose on 8/16/2021, three doses on 8/17/2021, three doses on 8/18/2021, one dose on 8/19/2021, one dose on 8/20/2021, three doses on 8/21//2021,

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three doses on 8/22/2021, two doses on 8/23/2021, and two doses on 8/24/2021.

On 8/14/2021 the physician ordered 100 units/ml (milliliters) Insulin Aspart Solution Pen-Injector to be injected with a pen injector as per sliding scale: If 201-250 = 4 units, 251-300 6 units, 301-350 8 units, 351-400 10 units; 350-400 10 units, 400 to HI 10 units repeat in 2 hours and cover greater than 300 subcutaneously three times a day for insulin give 5 units three times a day repeat finger stick blood sugar in 2 hours and cover as per sliding scale. This medication order was discontinued on 8/24/2021. The MAR for Resident #1 revealed he had been administered 4 units of insulin 8/22/21 at 2:00 PM for a blood sugar of 215.

On 8/14/2021 the physician ordered 2 grams of Voltran Gel 1 % to be applied to his skin topically three times a day for pain. This medication order was discontinued on 8/24/21. Review of the MAR revealed Resident #1 received five doses under this medication order: one dose on 8/18/2021, one dose on 8/22/2021, one dose on 8/23/2021, and one dose on 8/24/2021.

On 8/14/2021 the physician ordered 18-103 microgram/actuation Combivent Aerosol to be administered with an inhaler as 2 puffs inhaled orally four times a day every four hours for shortness of breath as needed. This medication order was discontinued on 8/24/21. Review of the MAR revealed Resident #1 received fifteen doses under this medication order: one dose on 8/19/2021, one dose on 8/20/2021, four doses on 8/21/2021, two doses on 8/22/2021, three doses on 8/22/2021 three doses on 8/23/2021, and one dose on 8/24/2021.

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On 8/14/2021 the physician ordered 0.65 mcg (microgram) Sodium Chloride Solution to be administered as one spray in both nostrils four times a day for congestion. This medication order was discontinued on 8/24/21. Review of the MAR revealed Resident #1 received twenty two doses of under this medication order: four doses on 8/16/2021, three doses on 8/17/2021, three doses on 8/18/2021, four doses on 8/21/2021, three doses on 8/22/2021, four doses on 8/23/2021, and one dose on 8/24/2021.

On 8/16/2021 at 3:02 PM Physician Assistant (PA #1) wrote an admission progress note. Documentation in the history of present illness indicated Resident #1 was up in the chair ready to eat breakfast and was at the facility for physical and occupational therapy. The documentation further stated on his exam he was slow to speech but had no other acute issues. No medication abnormalities were noted.

The care plan for Resident #1, dated 8/16/2021, had a focus area for the resident's use of psychotropic medications (antipsychotics) relative to behavior management. The one intervention was to monitor for side effects and effectiveness.

An admission minimum data set (MDS) assessment dated 8/20/2021 coded Resident #1 was having moderately impaired cognition and feeling tired 7 to 11 days of the assessment period. He was coded as requiring extensive assistance with bed mobility and toilet use. He was independent with feeding himself after set-up. He did not transfer, ambulate, or perform locomotion during the assessment period. He was coded as always incontinent of bowel and

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bladder. He was coded as receiving 5 days of antipsychotics, 3 days of antibiotics, oxygen therapy in the facility, and intravenous medications during the assessment period.

On 8/23/2021 PA #1 wrote a progress note stating under history of present illness, "Per nursing complaint of patient still more lethargic than baseline. On exam the patient was arousable, will hold medications and monitor for improvement or worsening of condition. I have reviewed labs, he appears mildly dehydrated and will have nursing encourage increased PO fluids. No acute infectious process on chest x-ray. PA #1 did not note any medication irregularities.

On 8/24/2021 at 12:19 PM a nursing progress note written by the ADON stated, "Reviewed medication list reconciled with [PA #1]. New orders obtained and updated."

An interview was conducted on 9/9/2021 at 9:27 AM with the ADON regarding the 8/24/2021 12:19 PM progress note she wrote. The ADON revealed the physician orders for Resident #1 were mis-transcribed and the physician orders were reviewed and realigned with new physician orders.

On 8/24/2021 an initial physician visit progress note was written by the Physician for Resident #1 (MD #1). The impression portion of the note stated, "New recent problem. Has improvement with changes in medication. Continue to [rule out] other etiologies with urine and blood work testing."

On 8/25/2021 at 11:09 AM nursing notes

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indicated medications were held for Resident #1.

An interview was conducted with PA #1 on 9/7/2021 at 8:15 AM. PA #1 stated he did not recall if he was on call on 8/14/2021, the day Resident #1 was admitted. PA #1 remembered signing off electronically on the medications for Resident #1 on 8/16/2021. PA #1 stated he was notified by the previous DON the medications given to Resident #1 were ordered for another resident. PA #1 stated, "As soon as the DON alerted me, I reviewed his medications and put him on the correct medications." PA #1 did not recall which day the DON notified him of the medication errors, stating it was sometime after 8/20/2021.

The emergency room report dated 8/30/2021 stated in the narrative in part, "Nurse stated as we were leaving the room that "this was caused by a medication error that put him in this state" but she had no other information, unknown where she obtained that information."

The hospital discharge summary dated 9/1/2021 at 4:28 AM revealed Resident #1 expired due to septic shock.

Review of the death certificate dated 9/1/2021 revealed the immediate cause of death for Resident #1 was septic shock with contributing diagnoses of pneumonia, sacral decubitus ulcer, and possible meningitis.

An interview was conducted with the previous Director of Nursing (previous DON) on 9/4/2021 at 1:45 PM. The Director of Nursing stated she was out on medical leave beginning on 8/16/2021 and when she returned on 8/23/2021 she went

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through to check the paperwork for the new admissions who had come in her absence. She discovered the medications for Resident #1 were transcribed incorrectly and she had no idea where the list of medications ordered for Resident #1 came from. The previous DON revealed she immediately notified her Administrator who told her he would contact the legal department of the corporation. The previous DON stated she notified PA #1 and the Medical Director of the medication errors and the seriousness of the situation on 8/23/2021. She stated PA #1 told her he would never have approved Resident #1 to be on four orders for Zyprexa. The previous DON stated PA #1 came into the facility on 8/24//2021 and went through the medication list for Resident #1 with the ADON to make sure Resident #1 was on the correct medications. She stated the medical director was very alarmed when notified of the medication errors. The previous DON stated the medication errors put him at risk for acute renal injury. The previous DON stated she called Nurse #11 into her office to explain what happened. The previous DON stated she suspended Nurse #11 for two weeks. The previous DON revealed she, herself, quit effectively immediately on the morning of 8/30/2021.

An interview was conducted on 9/9/2021 at 11:38 AM with the facility Administrator. The Administrator stated a root cause analysis was conducted by the facility on 8/24/2021 when the medication errors were discovered. The Administrator stated the previous Director of Nursing and the MDS Nurse (Current Interim DON) discovered the incorrect medications were transcribed into the electronic medical record. The Administrator stated the MDS Nurse

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recognized Resident #1 was on antipsychotics without a diagnosis for their use, and she then went to the previous DON to question why he was receiving antipsychotics. The facility Administrator stated they did not know where Nurse #11 got the medication orders from for Resident #1, but the medication orders for Resident #1 were corrected. In addition, the Administrator revealed Nurse #11 was counseled so the error would not happen again. The Administrator stated all recent new admissions were audited and no other medication errors were found.

An interview was conducted with the resident's physician (MD #1) on 9/7/2021 at 10:08 AM. MD #1 confirmed he was told by the previous DON the wrong medication list was put into the electronic medical record for Resident #1 but he was told the issue was resolved when PA #1 put the correct medications into the medical record. MD #1 was unsure how it happened. MD #1 stated it is the facility policy to have the admitting nurse put the medications from the hospital discharge summary into the electronic medical record to be ordered from the pharmacy when a resident arrives from the hospital. MD #1 explained the orders do not need to be checked or verified by a physician prior to the medications being ordered from the pharmacy. MD #1 stated a physician will reconcile the medications upon an admission assessment. MD #1 explained the physician was only looking to see if the medications logically make sense. MD #1 stated it was the job of the nurse to put the medications into the electronic medical record correctly.

On 9/9/2021 at 12:30 PM, the administrator was informed of the immediate jeopardy.

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The allegation of immediate jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy removal:

F757 - Unnecessary Drugs
" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Synopsis: Resident was admitted 8/14/21. Upon admission, a charge nurse entered inaccurate admission orders and did not confirm the orders. On 8/16, charge nurse confirmed resident's medication orders and resident began receiving medications. On 8/18, resident exhibited a change in status and PA placed blood pressure medication on hold and resident on oxygen. On 8/19, resident was noted to be lethargic and the PA ordered a chest x-ray and lab tests. On 8/20, the resident was observed to be not alert, had abdominal breathing, and not eating or taking meds. Resident was assessed by DON and ADON and no new orders were received at that time. On 8/23, PA examined the patient and indicated mild dehydration and ordered to increase PO fluids. On 8/24, it was discovered in the IDT meeting that medication diagnosis codes were missing. Upon review of the patient's discharge summary, it was discovered that his current meds did not match the discharge summary. An attempt to discover the source of these orders was unsuccessful at the time. PA and medical director were notified. Medications were reconciled and corrected. Later (9/9), the ADON, while auditing new admissions since 8/13, discovered the discharge summary for a different patient that matched what had originally been

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entered for the resident.
The assistant director of nursing (ADON) reviewed medication orders for current residents admitted after 8/13/21 and compared to the hospital discharge summary to ensure accuracy.
" Specify the action the entity will take to alter the process or system failure to prevent a serious outcome from occurring or recurring, and when the action will be complete

Facility action: Current licensed nursing staff were educated by the SDC or designee regarding procedures for admitting a Resident to include accurate order entry and confirming orders. Education started last week, however, the SDC was made aware 9/9 of the need to complete further education. Licensed nursing staff on 9/10 were educated, and all remaining licensed nursing staff will receive education before their next shift. This will be tracked by nursing leadership and administrator. Charge nurse on duty will enter medication orders electronically based on hospital discharge summary and confirm orders. Residents' physician will review and approve new admission orders. The hospital discharge summary will be scanned electronically into miscellaneous file in Resident record. This will be done by admissions or medical records. They were notified 9/11.
Nursing leadership will complete an admission audit to ensure accuracy of orders within 24 hours. Physician/PA are required to review new admissions with 48 hours of admission. This was confirmed with medical director 9/10. PA and MD will be notified of new admissions by email, phone, and/or in person.
DON or designee will inform the Medical Director of new admissions weekly to include any concerns with medication or medical status. New

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| F 757 | Continued From page 109<br>patients will also be discussed in weekly meeting between medical director and physician assistants. During weekly meeting between medical director and director of nursing, any questions or concerns about treatment decisions or medication orders will be discussed.<br><br>The Director of Nursing or designee will ensure implementation of the plan.<br><br>Planned removal of IJ: 9/11/21<br><br>The credible allegation was verified on 9/17/21. Interview with the ADON revealed that all new admission orders are reviewed by nursing administration staff and compared to the discharge summary for accuracy. All licensed staff received training on accuracy of physician orders for new admissions on 9/3/21. The facility provided evidence that the physician or PA reviews the orders of new admissions within 24-48 hours. Review of facility audit information demonstrated that the nursing audits of new admissions were being completed. MD notes were filed in the charts. Facility audit documentation demonstrated weekly meetings between the DON and MD to discuss weekly admissions. The facility alleged compliance as of 9/11/21. The facility's credible allegation of immediate jeopardy removal was verified as having been implemented on 9/11/21. | F 757 | | |
| F 835 SS=K | Administration<br>CFR(s): 483.70<br><br>§483.70 Administration.<br>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest | F 835 | | 10/25/21 |

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| F 835 | Continued From page 110<br>practicable physical, mental, and psychosocial well-being of each resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, staff interview, consultant pharmacist interview, pharmacy manager interview, Administrator interview, Physician Assistant interviews, Physician interview the facility Administration failed to provide effective leadership and oversight of processes and policies and procedures to ensure an effective system was in place to implement medication orders for new admissions for one (Resident #1) of three new admissions; failed to have an effective system in place for new admission medication reconciliation for one (Resident #1) of three new admissions; failed to have an effective system in place for comprehensive pharmacy reviews for one (Resident #1) of three residents with pharmacy reviews. The facility Administration also failed to perform a root cause analysis for the medication errors and implement systematic changes to prevent additional medication errors from occurring until immediate jeopardy was identified for one (Resident #1) of three new admissions. The facility Administration failed to have an effective, comprehensive approach to responding to acute/significant changes in condition to ensure necessary care and services were provided for 1 (Resident #1) of 1 resident reviewed for neglect. Resident #1 received 29 incorrect medications for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in | F 835 | F835<br><br>How corrective action will be accomplished for those residents found to have been affected by the deficient practice;<br>Failed to provide effective leadership and oversight of processes and policies to ensure an effective system was in place to implement medication orders for new admissions<br>How the facility will identify other residents having the potential to be affected by the same deficient practice;<br>" All new admissions are at risk for the deficient practice.<br><br>The measures that will be put into place or systemic changes made to ensure that the deficient practice will not recur.<br>" Director of Nursing or designee will provide education to all licensed nurses, CNAs, and rehab staff on identifying changes of condition<br>" Any nurse/can/rehab staff who did not receive the education by the compliance date will be removed from the schedule until completed<br>" All new nurses/cnas/rehab staff will receive education during the orientation process.<br>" IDT will meet daily to discuss issues for each department including status changes with residents<br>" DON or designee will perform | |

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| F 835 | Continued From page 111<br>transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock.<br><br>Immediate Jeopardy began on 08/14/2021 when Resident #1 entered the facility and the facility failed to have effective systems in place to order and administer correct medications; failed to have an effective system in place for new admission medication reconciliation; failed to have a system in place for comprehensive pharmacy reviews; and failed to have a system to effectively address a decline and change in condition. The immediate jeopardy was removed on 9/12/2021 when the facility implemented an acceptable credible allegation for Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity level of an "E" (no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put into place are effective. Example C. for F600 is a scope and severity level of a "D" (Isolated -No actual harm with potential for more than minimal harm that is not immediate jeopardy.)<br><br>Findings included:<br><br>A. Cross refer to F600: Based on record review, staff interviews, Physician Assistant (PA) interviews, Physician interviews, Administrator interview, Interim Director of Nursing (DON) interview, and previous Director of Nursing interview the facility neglected to provide necessary care and services by failing to administer the correct medication; failing to provide effective and ongoing nursing and | F 835 | admission audits within 24 hours of admission to ensure correct transcription 5x weekly x 4 weeks, once weekly x8 weeks and monthly x 3.<br>" DON or designee will review shift report daily to identify any changes of condition and intervene as needed 5x weekly x 4 weeks, weekly x 8 weeks and monthly x 3<br><br>How the facility plans to monitor its performance to make sure that solutions are sustained. The results of the audits will be reported to the QAPI committee quarterly x 2 for analysis of patterns, trends, or need for further systemic changes.<br><br>Completion October 25, 2021 | |

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medical assessments and medical interventions for a resident with an acute/significant change in condition; and failing to implement effective medical intervention for a resident with signs of dehydration for one (Resident #1) of one resident reviewed for neglect. Resident #1 received 29 incorrect medications for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock.

B. Cross refer to F756: Based on record review, staff interview, consultant pharmacist interview, and pharmacy manager interview, the facility consultant pharmacist failed to complete a comprehensive review of a new admission's medications for 1 (Resident #1) of 3 residents reviewed for pharmacy reviews upon admission. Resident #1 received medications ordered for another resident for a period of 8 days. Resident #1 was noted to have a change in condition beginning on 8/18/2021 with a hypotensive episode. Resident #1 continued to decline, suffering from lethargy, dehydration, hypotensive episodes, and inability to swallow until the facility recognized the error in transcription of medication on 8/24/2021. Resident #1 was sent to the hospital on 8/30/2021 and expired in the hospital on 9/1/2021. The cause of death of Resident #1 was determined to be septic shock.

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C. Cross refer to F757: Based on record review, staff interview, Administrator interview, physician assistant interview, and physician interview the facility failed to administer the correct medications and administered medications without supporting diagnoses for one (Resident #1) of three residents reviewed for unnecessary drugs. The facility failed to recognize the incorrect medications were entered into the electronic medical record system upon admission for Resident #1 resulting in the resident receiving 29 incorrect medications for a period of 8 days. These medications included in part antipsychotics, seizure medication, pain medication, insomnia medication, hypertension medication, diabetic medication, glaucoma medication, and smoking cessation. Resident #1 was admitted to the hospital on 8/30/2021 and expired on 9/1/2021.

On 9/9/2021 at 12:30 PM, the administrator was informed of the immediate jeopardy.

The allegation of immediate jeopardy removal indicated:

Credible Allegation of Immediate Jeopardy removal:

F835 - Administration
" Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance
Synopsis: Patient received incorrect medications because medications from the wrong discharge summary were entered. A root cause analysis was initiated at the time the mistake was noticed by nursing leadership and the administrator. The nurse who entered the orders was counseled and

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disciplined and education was provided. We gathered info from this nurse, but she was unable to say where she had gotten these orders. As part of the ongoing chart reviews, the ADON found where these orders originated. They were from the discharge summary of another patient who had not yet admitted but was to admit soon after this patient. The nurse who entered the orders was assisting another nurse, took the paperwork from her, and failed to verify that it was for the correct patient. A 24-hour admission audit was not completed for the patient, allowing him to continue to receive these medications.
We failed to have a comprehensive system in place for pharmacy reviews due to the pharmacist not having access to the discharge summary. Additionally, a change of condition was not responded to appropriately. MD educated PA on 9/9 about appropriate response to change of condition and med reconciliation.
The facility determined the root cause of the medication error. A charge nurse inadvertently entered medications from another Resident's discharge summary when she failed to verify that the orders were for the correct patient. Nursing leadership will complete 24-hour admission audits to ensure accuracy of orders.
Current policy and procedures will be implemented to provide care to new admissions, provide accurate medications, to identify and treat changes in condition, to provide necessary care and services, and QAPI to address situations and errors with root cause analysis. Corporate nurse consultant has been assisting and will be visiting weekly beginning 9/13 to assist with plan of correction and observation and oversight of processes. Medical director has been involved in this plan of correction and will be formally meeting with the DON and Administrator weekly

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| F 835 | Continued From page 115<br>to discuss status of plan of correction and any clinical concerns.<br>" Specify the action the entity will take to alter the process or system failure to prevent a serious outcome from occurring or recurring, and when the action will be complete<br><br>Facility Action: The Interdisciplinary team will meet daily 5 X weekly to discuss issues and plans for the day for each department to include status changes with Residents. Residents exhibiting acute changes in condition will be discussed and any identified needs will be directed to the responsible discipline for action. This was reemphasized on 9/9.<br>New admissions will be audited within 24 hours by nursing leadership to ensure accuracy of medication orders comparing to hospital discharge summary. Any discrepancies will be corrected at the time of identification.<br>Shift reports (24 hour/72 hour) will be reviewed daily 5 X weekly by nursing leadership and reviewed with the IDT in daily meeting to identify and discuss changes in condition. The DON or designee will complete facility room rounds daily 5 X weekly to ensure necessary care and services are being provided to Residents. Any issues will be corrected at the time of identification.<br>Medical director will meet with physician assistants weekly to discuss patients. This will include patients with acute changes, new patients, patients who are recently had major changes in treatment plans, and any other topics that need to be addressed. During weekly meeting between medical director and director of nursing, any questions or concerns about treatment decisions will be discussed.<br>The Administrator or designee will ensure | F 835 | | |

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| F 835 | Continued From page 116<br>implementation of the plan.<br>Corporate nurse and VP of operations will conduct weekly visits to provide oversight to administration and to assure systems and processes are in place and effectively being implemented to provide necessary care and services to residents in the facility.<br>Attending physician provided coaching to PA on 9/9 regarding appropriate management and management of significant changes and med reconciliation. After meds were corrected, patient's lethargy improved. MD saw patient on 8/24 after meds had been corrected.<br><br>Planned removal of IJ: 9/12/21<br><br>The credible allegation was verified on 9/17/21. Significant change education was provided to all staff on 9/9/21. Interview with licensed nursing staff revealed that they look for changes in behavior, eating habits, input/output, or any unusual event to determine change in condition. Evidence of new admission audits were reviewed 9/17/21. The facility's credible allegation of immediate jeopardy removal was verified as having been implemented on 9/12/21. | F 835 | | |
| F 842 SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)<br><br>§483.20(f)(5) Resident-identifiable information.<br>(i) A facility may not release information that is resident-identifiable to the public.<br>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. | F 842 | | 10/25/21 |

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| F 842 | Continued From page 117 | F 842 | | |

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

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

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

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when

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| F 842 | Continued From page 118<br>there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview, record review, and Interim Director of Nursing interview the facility failed to accurately document the provision of wound care on the Treatment Administration Record for 2 (Residents #2 and Resident #11) of 3 residents reviewed for the provision of wound care.<br><br>Findings included:<br><br>1. Resident #2 was readmitted to the facility on 8/6/2021 with diagnoses of peripheral vascular disease, chronic kidney disease Stage 4, Hypertension, and surgical amputation.<br><br>Documentation in the medical record dated 9/1/2021 for Resident #2 revealed an order for one Xeroform Petrolatum Gauze to be applied to the left anterior heel topically every day shift related to muscle weakness. | F 842 | F842<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Resident #2 is no longer at the facility and Resident #11 □s skin assessment was updated on 10/19/2021.<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All residents who receive wound care will be audited for completion of documentation by 10/14/2021. Any resident found to not have a skin assessment had one completed.<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur: | |

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| F 842 | Continued From page 119<br>The 9/1/2021 physician's order for the left anterior heel was discontinued and corrected on 9/3/2021 for the same treatment to be applied twice daily on every day and night shift.<br><br>Review of the documentation on the September Treatment Administration Record (TAR) for the treatment order for the left anterior ankle of Resident #2 revealed blank spaces for the night shift on 9/4/2021 and the day shift on 9/5/2021.<br><br>An interview was conducted on 9/13/2021 at 5:21 PM with Nurse #17, who was assigned to care for Resident #2 on 9/4/2021 on the 7:00 PM to 7:00 AM shift. Nurse #17 stated she did all of her treatments. Nurse #17 further stated she did not remember Resident #2, but she did remember being very busy on 9/4/2021 and maybe forgot to document she wound care treatments.<br><br>An interview was conducted on 9/13/2021 at 2:38 PM with Nurse #25, who cared for Resident #2 on 9/5/2021 for the 7:00 AM to 7:00 PM shift. Nurse #25 stated 9/5/2021 was a very busy day but she completed all the wound care treatments assigned to her. Nurse #25 stated she just didn't check off on the TAR she completed the wound care treatment for Resident #2.<br><br>An interview was conducted with the Interim Director of Nursing (DON) on 9/13/2021 at 4:30 PM. The interim DON confirmed the nurses should document when they provide wound care and if they do not have time to document the nurse should write a progress note or document as a late entry at another time.<br>2. Resident #11 was admitted on 06/25/21 with a diagnosis of traumatic spinal cord injury with no movement in the lower extremities and limited | F 842 | All licensed nurses will be educated on documentation of wound treatments by DON or designee<br>DON or designee will audit 10 % of ETAR completion of wound care 5x weekly x 4 weeks, then weekly x 8 weeks, then monthly x 3<br>Any Licensed Nurse who is not educated will not be allowed to work until education received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during orientation process<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur: Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| F 842 | Continued From page 120 | F 842 | | |

movement in the upper extremities.

A review of Resident #11's minimum data set (MDS) assessment dated 07/07/21 indicated he was cognitively intact and had a stage III pressure injury to the sacrum (buttocks)and required 1-person assistance with ADL's.

A review of the Physician order dated 06/24/21 revealed a treatment for Santyl Ointment 250unit/gram to be applied to Resident #11' sacrum every evening shift.

A review of the treatment administration record (TAR) for June 2021 revealed no documentation on 06/27/21 through 06/29/21 for administration of Santyl ointment.

A review of the TAR for July 2021 revealed no documentation on 07/05/21 through 07/09/21, 07/12/21, 07/14/21 and 07/16/21 for administration of Santyl ointment.

A review of the TAR for August 2021 revealed no documentation on 08/6/21 and 08/24/21 for administration of Santyl ointment.

During an interview with Nurse #21 on 09/21/21 at 3:30pm; Nurse #21 stated that when treatments are completed, they should be documented on the TAR or in a progress note. Nurse #21 stated there were occasions when she has been too busy with resident care that she had forgotten to document after providing wound care for Resident #11.

During an interview with Nurse #22 on 09/21/21 at 4:00pm; Nurse #22 stated that she had completed Resident #11's wound care and

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| F 842 | Continued From page 121<br>documented in the TAR; Nurse #22 further stated that there had been occasions when she was unable to complete documentation.<br><br>During an interview with Nurse #38 on 09/22/21 at 12:05pm; Nurse #38 recalled occasions when she completed Resident #11's wound care but forgot to complete documentation.<br><br>During an interview with Nurse #39 on 09/22/21 at 1:00pm; Nurse #39 stated she had been assigned to Resident #11 and completed his wound care but did not complete documentation.<br><br>During an interview with the interim Director of Nursing on 09/24/21 at 10:30am; the interim DON stated it is the expectation that staff complete treatments according to Physician orders and document on the TAR or in a nursing progress note. | F 842 | | |
| F 880 SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§483.80(a)(1) A system for preventing, identifying, | F 880 | | 10/25/21 |

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| F 880 | Continued From page 122 | F 880 | | |

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 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

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| F 880 | Continued From page 123<br>corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, staff interview, corporate nurse consultant interview, and Director of Nursing interview the facility failed to follow infection control procedures with the use of wound care supplies during wound care for 1 (Resident #3) of 3 residents reviewed for wound care. This occurred during a Covid-19 pandemic and a Covid-19 outbreak in the facility.<br><br>Findings included:<br><br>Documentation on the facility general wound care/dressing changes policy dated 11/01/2019 revealed in the procedure a licensed nurse would follow recognized standards of practice regarding dressing changes.<br><br>Observations of wound care began on 9/3/2021 at 10:27 AM with Resident #2. Nurse #1 brought a sealed package of Petrolatum Gauze, a box of gloves, tape container, a ready to use 110 ml (milliliter) container of saline solution, a small stack of gauze 4 x 4 squares, and 3 packages of sealed nonstick adherent pads into the room of Resident #2 and laid the supplies on her bed of Resident #2. Nurse #1 explained she had to bring the box of gloves from room to room with her | F 880 | F880<br>How corrective action will be accomplished for each resident found to have been affected by the deficient practice:<br>Proper infection control practices were not followed while wound care was performed<br><br>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:<br>All residents with wounds are at risk for being affected<br>Measures to be put in place or systemic changes made to ensure practice will not re-occur:<br>All licensed nurses will be educated by DON or designee regarding proper infection control technique while providing wound care<br>Any Licensed Nurse who is not educated will not be allowed to work until education is received.<br>Any new Licensed Nurses will be educated by Staff Development Nurse or Director of Nursing or designee during | |

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| F 880 | Continued From page 124<br>because the resident rooms did not always have gloves. Nurse #1 pointed out the room of Resident #2 did not have any gloves beside the ones she brought to the room. After removing the dirty wound bandage, disposal of the bandage, removal of gloves, hand hygiene, and the donning of a new pair of gloves, Nurse #1 began to use some of the supplies she brought into the room. During the observation of wound care to Resident #2, Nurse #1 opened the foil lid on the container of saline solution, poured some saline solution on a 4 x 4 square of gauze, and used this to clean the wound on Resident #2. Nurse #2 set the open container of saline solution on a bedside table. Nurse #2 subsequently opened the Petrolatum gauze package, cut off a piece of the Xeroform with the scissors and placed the Petrolatum gauze pad on the heel wound of Resident #2. Nurse #1 then opened a package with a gauze pad and placed the gauze pad over the Petrolatum gauze pad. Nurse #1 then wrapped the entire heel with a gauze from a gauze bandage roll. Nurse #1 cut the strip of gauze after wrapping the bandage and the resident's heel. The nurse held in the gauze wrap in place and secured it with a piece of tape removed from the tape dispenser. Nurse #2, after disposing of the dirty dressings removed from the resident's heel into a garbage bag, removed her gloves and performed hand hygiene. Nurse #1 then brought the partially used and unused supplies, from the room and placed them on top the treatment cart. Nurse #2 cleaned the scissors with antibacterial wipes. Nurse #2 put supplies to include the tape, scissors, and the 2 unused packages of gauze pads back into the treatment cart drawers leaving the opened container of saline solution, the open container of Petrolatum gauze on the top of the treatment cart. | F 880 | orientation for process of administering pain medications<br>DON or designee will audit 2 patients daily for proper technique during wound care 5x weekly x 4 weeks, then weekly x 8 weeks, and then monthly x 3<br><br>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur:<br>Results of the audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further resolution if needed.<br><br>Completion October 25, 2021 | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 880 | Continued From page 125 | F 880 | | |

Observations of wound care continued 9/3/2021 at 10:48 AM after a delay when Nurse #1 went to the computer at the nursing desk searching for a wound care order for Resident #3 and could not find one per Nurse #1. Nurse #1 then went to the room of Resident #3 and secured her permission to perform wound care. Nurse #1 performed hand hygiene, went back to the treatment cart and gathered supplies together for the wound care of Resident #3. Nurse #1 brought into the room of Resident #3 the open container of saline, the open package of Petrolatum gauze, the scissor, the tape container, opened gauze bandage roll, and the open box of gloves, all of which had previously been in the room of Resident #2. From the drawers of the treatment cart Nurse #1 also brought into the room an open package containing a gauze pad with a portion of the gauze pad cut, two more closed packages of gauze pads, and an open bulk paper gauze sponge container half full. Nurse #1 performed hand hygiene again and donned gloves to take off a black medical boot and sock for Resident #3. The sock of Resident #3 was observed to be saturated with reddish brown drainage at the heel. The dressing under the sock was also saturated with reddish brown drainage. Resident #3 stated her wound dressing had not been changed for several days. Nurse #1 stated she was there to change the dressing prior to the resident going home. Nurse #1 removed the old dressing, removed her gloves, performed hand hygiene and donned a new pair of gloves. Nurse #1 took the open container of saline, poured it on a square of gauze sponge from the open bulk gauze sponge container, and proceeded to clean the heel of Resident #3 with the wet gauze. Nurse #1 then removed her gloves, performed hand

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|---|---|---|---|
| | 345420 | A. BUILDING _____ B. WING _____ | C 09/24/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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hygiene, and donned a new pair of gloves. Nurse #1 then put more saline on a square of gauze sponge, applied it to the heel wound, opened a new package with a gauze dressing pad applying overtop of the wet gauze sponge. Nurse #1 then wrapped the entire heel with gauze from the gauze bandage roll. Nurse #1 then cut off a piece of tape with the scissors, secured the bandage with tape, and dated the tape along with her initials. Nurse #1 gathered up the dirty supplies putting them in the garbage, removed her gloves, performed hand hygiene, and donned a new pair of gloves. Nurse #1 then put the soiled sock of resident #1 into a separate plastic garbage bag for the resident. Nurse #1 removed her gloves and assisted Resident #1 with a new sock and medical boot. Nurse #1 performed hand hygiene and carried the unused supplies back to the treatment cart to put away.

Nurse #1 was interviewed at the completion of the wound care observation on 9/3/2021 at 11:03 AM. Nurse #1 stated she had not been in the facility for two or three days and had had been called in today as an extra nurse to do the dressing changes in the building. She stated she does not usually do the dressing changes for the building, was not the wound care nurse, and she had to figure out on her own who needed dressing changes for the day. Nurse #1 stated she could not find a dressing order for Resident #1, so her plan was to bring supplies into the room and copy what she saw after she removed the dressing. Nurse #1 stated, "I cannot anticipate how much I am going to need" referring to the supplies.

An interview was conducted on 9/3/2021 at 5:25 PM with the Director of Nursing and the facility

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| F 880 | Continued From page 127<br>corporate Nurse Consultant. The Director of Nursing and the Nurse Consultant both confirmed the nurse should not have taken supplies used by one resident into the room of another resident due to infection control concerns. | F 880 | | |