STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 02/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation was conducted from 2/02/22 through 2/03/22. Event ID# XPOC11 3 of the 10 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (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- (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	F 580		2/18/22

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

Electronically Signed | 02/17/2022

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F 580	Continued From page 1 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 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). This REQUIREMENT is not met as evidenced by: Based on record review, staff and Physician interview, the facility failed to notify the Physician of an enteral feeding that was not provided for 1 of 1 resident (Resident #1) reviewed for enteral feeding. Findings included: Resident #1 was re-admitted to the facility on 1-27-22 with multiple diagnoses that included tracheostomy Physician order dated 9-13-21 revealed an order for Resident #1 to receive enteral feeding at 60cc (cubic centimeter) per hour from 6:00pm to 10:00am daily. Review of Resident #1's Medication Administration Record (MAR) for January 2022	F 580	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 580 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to notify the physician of an enteral tube feeding that was not	

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F 580	Continued From page 2 revealed no documentation that Resident #1 received his enteral feeding on 1-27-22 through 1-28-22. During a telephone interview with Resident #1 on 2-2-22 at 11:28am, Resident #1 discussed his return to the facility from the hospital on 1-27-22 in the afternoon. The resident stated he was not provided his tube feeding at 6:00pm on 1-27-22 through 10:00am on 1-28-22. Nurse #3 was interviewed on 2-2-22 at 3:45pm. Nurse #3 acknowledged he was assigned to care for Resident #1 on 1-27-22 during the 3:00pm to 11:00pm shift. The nurse stated he did not provide Resident #1 with his enteral feeding at 6:00pm. The nurse stated he did not contact the Physician to inform him that Resident #1's enteral feeding had not been provided. Nurse #4 was interviewed by telephone on 2-3-22 at 7:08am. The nurse acknowledged she was assigned to care for Resident #1 on the night shift (11:00pm to 7:00am) on 1-27-22. She explained she did not investigate why Resident #1 did not have his enteral feeding and she stated she had not informed the Physician that Resident #1 had not received his enteral feeding. The facility Physician was interviewed by telephone on 2-2-22 at 5:30pm. The Physician discussed not being aware Resident #1 had not received his enteral feeding upon his return to the facility from the hospital on 1-27-22. He stated he would have expected staff to contact him and inform him that Resident #1 had not received his enteral feeding. The Administrator was interviewed on 2-3-22 at	F 580	administered to resident #1. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 1 was sent to the emergency room on 1/28/ 2022 and admitted to the hospital. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered enteral tube feeding have the potential to be affected by the alleged deficient practice. On 02/04/2022, the Director of Nurses, Support Nurse (LPN) initiated an audit of 100% of all residents with ordered enteral tube feedings for the last 14 days for notification of the physician of any enteral feeding that had not been administered . There were no other concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/03/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: Medication errors and notification of the physician/RP. Documentation process for notification of the physician/RP. On 2/07/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: Facility policy on resident change in condition. Continual nursing care to include any	

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F 580	Continued From page 3 1:20pm. The Administrator discussed Resident #1's enteral feeding was available and was unaware he had not received his feeding on 1-27-22. She stated she would have expected staff to notify the Physician when Resident #1's enteral feeding was not provided.	F 580	service from any department. The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/18/2022 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F580 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include monitoring during Daily QOL(Monday-Friday) for compliance with the notification process by auditing 4 residents who have been admitted/readmitted or who have had a medication/tx error occur for compliance with the facility notification process. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary	

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F 580	Continued From page 4	F 580	Manager.	
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care 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. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff, and Physician interview the facility failed to perform an admission assessment on a resident being re-admitted from the hospital with multiple concerns including a tracheostomy, dependence on oxygen therapy, enteral feedings, indwelling catheter and positive for COVID-19. This occurred for 1 of 1 resident (Resident #1) reviewed for assessments. Findings included: Resident #1 was re-admitted to the facility on 1-27-22 with multiple diagnoses that included quadriplegia, tracheostomy, dependence on supplemental oxygen, COVID-19. The quarterly Minimum Data Set (MDS) dated 11-12-21 revealed Resident #1 was cognitively intact and was coded for an indwelling catheter, feeding tube, oxygen, and trach. During a telephone interview with Resident #1 on	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 684 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to clarify physician orders for oxygen and failed to perform an admission assessment for resident # 1 who was being readmitted to the facility. 1. Corrective action for resident(s) affected by the alleged deficient practice:	2/18/22

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F 684	Continued From page 5 2-2-22 at 11:28am, the resident discussed returning to the facility from the hospital on 1-27-22 during the afternoon. He stated he was placed in a resident room and no staff had checked his vital signs, trach, catheter, or his peg tube for his enteral feedings. Resident #1 said he had questioned staff (Nurse #3) about checking his vital signs, trach, catheter and peg tube and he stated Nurse #3 told him the previous nurse (Nurse #1) had already assessed him. An interview with Nurse #1 occurred on 2-2-22 at 12:20pm. Nurse #1 confirmed she was the admitting nurse for Resident #1 on the 7:00am to 3:00pm shift on 1-27-22. She stated she did complete an admission assessment on Resident #1 and had not assessed his tracheostomy, catheter, oxygen status, peg tube, or retrieved a set of vital signs. Nurse #1 said she believed the Wound Care nurse was going to complete the admission assessment. The Wound Care nurse (Nurse #2) was interviewed on 2-2-22 at 12:27pm. Nurse #2 discussed assessing Resident #1's wounds with the wound care Physician on 1-27-22 at 4:00pm. She stated she had informed Nurse #1 she would complete the skin assessment section of the admission assessment but had not said she would complete the whole admission assessment. Nurse #2 confirmed she did not retrieve a set of vital signs, assess the resident's trach, oxygen status, catheter, or peg tube while she was assessing his wounds. Nursing Assistant (NA) #3 was interviewed on 2-2-22 at 3:40pm. NA #3 confirmed she was the NA assigned to Resident #1 on 1-27-22 for the 3:00pm to 11:00pm shift. She discussed	F 684	Resident # 1 was sent to the emergency room on 1/28/ 2022 and admitted to the hospital. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents being admitted or readmitted have the potential to be affected by the alleged deficient practice. On 02/03/2022, the Director of Nurses, Support Nurse (LPN) completed an audit of 100% of admission/readmissions for the last 14 days for completion of admission/readmission assessments and admission orders utilizing the facility Admission and Readmission Checklist. There were no other concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 02/02/2022 the Director of Nurses and Support Nurse (LPN) were retrained on the admission/readmission daily clinical process by the QA Nurse Consultant. On 2/03/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and on the following topics: The admission/readmission process Admission/Readmission orders and reconciliation Review of all discharge documentation for order accuracy. Review of any additional documents received to reconcile any new or changed orders. Completion admit/readmit UDA and nursing documentation.	

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F 684	Continued From page 6 observing Resident #1 2 times during her shift but stated she did not obtain a set of vital signs or observe his catheter or oxygen status. During an interview with Nurse #3 on 2-2-22 at 3:45pm, Nurse #3 confirmed he was assigned to Resident #1 on 1-27-22 during the 3:00pm to 11:00pm shift. He also confirmed he had not completed an admission assessment on Resident #1. The nurse stated he believed the nurse from the 7:00am to 3:00pm shift (Nurse #1) had completed the assessment. Nurse #3 acknowledged he did not obtain a set of vital signs or assess Resident #1's trach, catheter, peg tube, or oxygen status during his shift. Nurse #4 was interviewed by telephone on 2-3-22 at 7:08am. Nurse #4 confirmed she was assigned to Resident #1 on the 11:00pm to 7:00am shift for 1-27-22. Nurse #4 also confirmed she did complete an admission assessment on Resident #1, and she stated, "I thought the previous nurses had since he was admitted during day shift (7:00am to 3:00pm)." A telephone interview was conducted on 2-2-22 at 5:30pm with the facility's Physician. The Physician discussed Resident #1 being a high-risk resident. He stated he would have expected staff to perform a complete assessment of Resident #1's needs. The Administrator was interviewed on 2-3-22 at 1:20pm. The Administrator stated her staff were trained in completing admission assessments on new or re-admitted residents and did not know why an admission assessment was not completed for Resident #1.	F 684	The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/18/2022 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction iseffective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F684 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include monitoring of admit/readmit assessments and admitting orders utilizing the facility Admission/Readmission Checklist Audit Tool for compliance. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and Dietary Manager. The Director of Nurses or LPN Support	

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F 684	Continued From page 7	F 684	Nurse will monitor compliance by completing 4 random trach care observation audits weekly x 4 then monthly x 3 months or until resolved. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills	F 693		2/18/22

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F 693	Continued From page 8 and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and physician interview, the facility failed to administer enteral feeding as prescribed for 1 of 1 resident (Resident #1) reviewed for tube feeding. Findings included Resident #1 was re-admitted to the facility on 1-27-22 with multiple diagnoses that included tracheostomy Physician order dated 9-13-21 revealed an order for Resident #1 to receive enteral feeding enteral feeding at 60cc (cubic centimeter) per hour from 6:00pm to 10:00am daily. Physician order dated 9-13-21 also revealed an order for Resident #1 to receive a regular diet as tolerated. Resident #1's care plan dated 9-22-21 revealed a goal that he would remain free of signs and symptoms of fluid overload. The interventions for the goal were in part administer tube feeding as ordered, administer water flushes as ordered. The quarterly Minimum Data Set (MDS) dated 11-12-21 revealed Resident #1 was cognitively intact and was coded for tube feeding and receiving 51% or more calories from his tube feeding. Review of Resident #1's Medication	F 693	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 693 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to administer ordered enteral tube feeding for resident # 1. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 1 was sent to the emergency room on 1/28/ 2022 and admitted to the hospital. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered enteral tube feeding have the potential to be affected by the alleged deficient practice. On 02/03/2022, the Director of Nurses, Support Nurse (LPN) initiated an audit for the last 14 days of 100% of residents with	

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F 693	Continued From page 9 Administration Record (MAR) for January 2022 revealed no documentation that Resident #1 received his enteral feeding on 1-27-22 through 1-28-22. During a telephone interview with Resident #1 on 2-2-22 at 11:28am, Resident #1 discussed his return to the facility from the hospital on 1-27-22 in the afternoon. The resident stated he was not provided his tube feeding he was supposed to receive at 6:00pm on 1-27-22 through 10:00am on 1-28-22. The resident discussed eating some soup on the evening of 1-27-22 but stated he did not receive any food on 1-28-22. He explained he had questioned Nurse #3 why he was not receiving his tube feeding and stated the nurse told him he was checking for an order, and he said he questioned Nurse #4 who told him she did not know. Resident #1 discussed feeling upset on 1-28-22 that he did not ask any more questions. Nurse #3 was interviewed on 2-2-22 at 3:45pm. Nurse #3 acknowledged he was assigned to care for Resident #1 on 1-27-22 during the 3:00pm to 11:00pm shift. The nurse stated he did not provide Resident #1 with his enteral feeding at 6:00pm. He explained he could not find Resident #1's enteral feeding until the end of his shift. He explained the resident's medication was in several different places and it took him all shift to locate the medications and enteral feeding. The nurse stated he did not think of starting Resident #1's enteral feeding. Nurse #3 acknowledged he did not contact the Physician to inform him that Resident #1's enteral feeding had not been provided. Nurse #4 was interviewed by telephone on 2-3-22	F 693	enteral tube feeding orders for administration of tube feeding as ordered. No other concerns identified. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/03/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses on the following topics: Med error prevention to include medication/treatment administration/documentation and notification/documentation of MD/RP of refusals or meds/tx□s/oxygen or enteral feedings not administered. The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/18/2022 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F693 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include monitoring of enteral tube feeding administration to assure it is being provided as ordered. Reports will be presented to the Quality Assurance Committee by the Administrator or	

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F 693	Continued From page 10 at 7:08am. The nurse acknowledged she was assigned to care for Resident #1 on the night shift (11:00pm to 7:00am) on 1-27-22. Nurse #4 stated she was aware Resident #1 was to receive enteral feedings during the night and said she had observed there was no enteral feeding hanging. She explained she did not investigate why Resident #1 did not have his enteral feeding and she stated, "I thought if he (the resident) was to have it (enteral feeding) the previous nurse would have hung it." Nurse #4 acknowledged she had not received a report on Resident #1 from the previous nurse (Nurse #3). During an interview with Nurse #1 on 2-2-22 at 12:20pm, Nurse #1 acknowledged she was assigned to care for Resident #1 on 1-28-22 during the 7:00am to 3:00pm shift. The nurse stated she had not noticed Resident #1 did not have his enteral feeding hanging when she provided him with his medications at 9:00am on 1-28-22. The facility Physician was interviewed by telephone on 2-2-22 at 5:30pm. The Physician discussed Resident #1 being able to eat some foods by mouth but most of the resident's nutrition was provided by his enteral feedings. He stated he would have expected staff to provide Resident #1 with his enteral feeding no matter what time during the evening the feeding was located. The Administrator was interviewed on 2-3-22 at 1:20pm. The Administrator discussed Resident #1's enteral feeding was available and was unaware he had not received his feeding on 1-27-22 as ordered. She stated she expected her staff to follow physician orders.	F 693	Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager.	

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	345358	A. BUILDING _____ B. WING _____	C 02/03/2022

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F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on record review, resident, staff and Physician interview, the facility failed to clarify Physician orders for oxygen therapy and failed to provide tracheostomy care as ordered by the Physician for 1 of 1 resident (Resident #1) reviewed for tracheostomy care. Findings included: Resident #1 was re-admitted to the facility on 1-27-22 with multiple diagnoses that included tracheostomy and dependence on supplemental oxygen. Resident #1's care plan dated 9-15-21 currently in place revealed a goal that the resident's airway would remain patent and he would receive optimal oxygenation. The interventions for the goal were in part give humidified oxygen as ordered, trach care as ordered and as needed. The quarterly Minimum Data Set (MDS) dated 11-12-21 revealed Resident #1 was cognitively intact and was coded for oxygen, suctioning and trach.	F 695	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 695 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to clarify physician orders for oxygen and failed to provide ordered tracheostomy care for resident # 1. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 1 was sent to the emergency room on 1/28/ 2022 and admitted to the hospital.	2/25/22

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F 695	Continued From page 12 Review of discharge hospital record dated 1-27-22 revealed Physician orders to continue oxygen therapy. Resident #1's physician order for January 2022 was reviewed and revealed documentation that Resident #1 had been on 4 liters of oxygen prior to his hospitalization on 1-19-22. During an interview with Nurse #1 on 2-2-22 at 12:20pm, the nurse acknowledged she was the admitting nurse for Resident #1 on 1-27-22. She discussed not completing Resident #1's admission assessment or processing the resident's orders from the hospital so she had not called and clarified the number of liters of oxygen Resident #1 was to receive. Nurse #3 was interviewed on 2-2-22 at 3:45pm. Nurse #3 acknowledged he was assigned to care for Resident #1 on the 3:00pm to 11:00pm shift on 1-27-22. The nurse stated he had not assessed Resident #1's oxygen liters or called the hospital to clarify the Physician order on the number of liters of oxygen Resident #1 was to receive but stated he thought the resident was to receive 3 liters of oxygen. The facility's Physician was interviewed by telephone on 2-2-22 at 5:30pm. The Physician discussed Resident #1 being high risk and he would have expected staff to call the hospital and clarify the oxygen orders. He also stated he would have expected the staff to place Resident #1 back on the liters of oxygen he received prior to his hospitalization which was 4 liters. Review of the facility's Physician order dated 1-11-22 revealed an order for Resident #1 to	F 695	2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents with ordered oxygen or residents with a tracheostomy have the potential to be affected by the alleged deficient practice. On 02/04/2022, the Director of Nurses, Support Nurse (LPN) initiated an audit of 100% of admission/readmissions and of those residents receiving oxygen to assure physician orders are in place and that residents are receiving oxygen as ordered with no other identified concerns noted On 2/04/2022 the Director of Nurses, Support Nurse audited all current residents with a tracheostomy to assure tracheostomy care was being provided as ordered. There were no other concerns identified for oxygen or tracheostomy care. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 2/03/2022 the Director of Nurses began education of all full time, part time, as needed nurses and agency nurses and med aides on the following topics: The admission/readmission process Admission/Readmission orders and reconciliation Review of all discharge documentation for order accuracy. Review of any additional documents received to reconcile any new or changed orders. Completion admit/readmit UDA and nursing documentation.	

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F 695	Continued From page 13 receive trach care (suctioning, cleaning, replacing trach ties and inner cannula) every shift and as needed. Resident #1's Medication Administration Record (MAR) for 1-27-22 and 1-28-22 revealed Resident #1 had not received trach care as ordered. Nurse #3 was interviewed on 2-2-22 at 3:45pm. Nurse #3 acknowledged he was assigned to care for Resident #1 on the 3:00pm to 11:00pm shift on 1-27-22. The nurse stated he had not provided Resident #1 with trach care on 1-27-22 and he said, "I was not made aware the resident needed trach care completed." Nurse #3 also acknowledged there was an order for trach care to be completed each shift and as needed but stated he did not perform trach care for Resident #1. During an interview with Nurse #1 on 2-2-22 at 12:20pm, the nurse acknowledged she was the nurse for Resident #1 on 1-28-22 on the 7:00am to 3:00pm shift. The nurse stated she had not performed trach care on Resident #1 during her shift. She explained she was busy during the morning hours and could not perform the care and stated Resident #1 left the facility around 2:00pm on 1-28-22. Nurse #1 stated she could not remember if Resident #1 needed trach care provided before he left the facility on 1-28-22. The facility's Physician was interviewed by telephone on 2-2-22 at 5:30pm. The Physician discussed Resident #1 being high risk and that he would have expected staff to follow Physician orders and provide trach care each shift. The Administrator was interviewed on 2-3-22 at	F 695	Med error prevention to include medication/treatment administration/documentation and notification/documentation of MD/RP of refusals or meds/tx's/oxygen or enteral feedings not administered. The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/18/2022 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. The Director of Nurses will complete education of all full time, part time, as needed nurses and agency nurses on trach care. The DON will ensure that any of the above identified staff who does not complete the in-service training by 2/25/2022 will not be allowed to work until the training is completed. This in-service will be incorporated into the new employee facility orientation. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F695 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include monitoring of admit/readmit orders for oxygen therapy delivery and that tracheostomy care is being provided as ordered for residents with a tracheostomy. Reports will be	

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F 695	Continued From page 14 1:20pm. The Administrator stated she believed trach care was provided and documented incorrectly. She also said she did not know why nursing would document trach care was not provided.	F 695	presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager. The Director of Nurses or LPN Support Nurse will monitor compliance by completing 4 random trach care observation audits weekly x 4 then monthly x 3 months or until resolved. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:	F 760		2/18/22

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F 760	Continued From page 15 Based on record review, staff, and resident interview the facility failed to administer medications prescribed to treat residents' pain, hypotension, and shortness of breath per physician's orders. This occurred for 1 of 1 Residents (Resident #1) reviewed for medication errors. Findings included: Resident #1 was re-admitted to the facility on 1-27-22 with multiple diagnoses that included dependence on supplemental oxygen, COVID-19, depression with anxiety, atypical psychosis. The quarterly Minimum Data Set (MDS) dated 11-12-21 revealed Resident #1 was cognitively intact. Hospital discharge record dated 1-27-22 was reviewed and revealed Resident #1 was discharged back to the facility at 1:30pm on 1-27-22. The physician orders dated 1-27-22 revealed the following medication orders; Midodrine (anti-hypotensive) 2.5mg three times a day, DuoNeb (nebulizer solution) 0.5/2.5mg/3ml (milliliters) every 6 hours, Gabapentin (pain medication) 300mg nightly. Review of Resident #1's Medication Administration Record (MAR) for 1-27-22 on the 3:00pm to 11:00pm shift revealed Resident #1 did not receive the following medications: Gabapentin 300mg at bedtime, Midodrine 2.5mg three times a day, DuoNeb 0.5/2.5mg/3ml every 6 hours. Resident #1's MAR for the morning of 1-28-22	F 760	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F760 The plan of correcting the specific deficiency. The plan should address the processes that lead to the deficiency cited: The facility failed to administer ordered medications for pain, hypotension and shortness of breath for resident # 1. 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident # 1 was sent to the emergency room on 1/28/ 2022 and admitted to the hospital. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 02/15/2022, the Director of Nurses, Support Nurse (LPN) initiated an audit of 100% of the Medication Administration for the last 14 days for all current residents. The audit consisted of a review of the Electronic Medical Administration Records (EMAR) notes to identify any medications that were omitted or not administered due	

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revealed he was not provided the following medications: Midodrine 2.5mg three times a day, DuoNeb 0.5/2.5mg/3ml every 6 hours.

Resident #1 was interviewed by telephone on 2-2-22 at 11:28am. He discussed being re-admitted to the facility on 1-27-22 in the afternoon. Resident #1 stated he was not provided any of his medications the evening of 1-27-22 and only some of his medication in the morning of 1-28-22.

Nurse #3 was interviewed on 2-2-22 at 3:45pm. He acknowledged he was assigned to Resident #1 on the 3:00pm to 11:00pm shift on 1-27-22. The nurse stated he had not provided Resident #1 with any of his evening medications, and he stated, "I could not find his medications to administer." He added he had found Resident #1's medications at the end of his shift around 11:00pm but still did not provide any of the medications to Resident #1.

Nurse #1 was interviewed on 2-2-22 at 12:20pm. The nurse acknowledged she was assigned to care for Resident #1 on 1-28-22 from 7:00am to 3:00pm. Nurse #1 stated she had provided Resident #1 with the medications that were available. She stated some medications were on order from the pharmacy.

The Administrator was interviewed on 2-3-22 at 1:20pm. She discussed Resident #1's medication being present upon his return from the hospital on 1-27-22 and did not know why the medications were not provided. The Administrator also stated she did not know where the system breakdown occurred.

to not being available for any reason. The audit identified 0 residents who had medications that were not administered. All medications were found to be available on the carts.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

Beginning on 02/03/2022, the facility staff were also educated to contact the Director of Nurses or the on-call nurse to communicate any obstacles that would prevent the staff from being able to administer medications as ordered. The Director of Nurses or designee will add review of the EMAR progress notes to their daily checklist to identify any residents who did not have medications available for administration.

On 02/03/2022, the Director of Nurses initiated education on Medication Availability for all Licensed Nurses (RN□s and LPN□s), Medication Aides, Full Time, Part Time, PRN, and Agency Nurses on the following education:

"The learner will understand the importance of ensuring that medications are always available to be given to the resident as ordered by the Physician.
"The learner will understand the steps necessary to obtain medications from the McNeill□s Long-Term Care Pharmacy during business hours and after business hours for all situations.
"The learner will understand the

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importance of administering ordered medications to prevent delay in tx, uncontrolled pain or a change in condition. "Reordering needed medications for the med dispense if needed.

All education for current staff will be completed by 02/18/2022. As of 02/18/2022, any employee who has not received this training will not be allowed to work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency staff, and PRN staff. This in-service will be incorporated into the new employee facility orientation.

4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Director of Nurses or LPN Support Nurse will monitor compliance utilizing the F760 Quality Assurance Tool by completing an audit weekly x 4 then monthly x 3 months or until resolved. The audit will include review of the EMAR progress notes to identify any residents who have medications that have not been administered related to any obstacle that would prevent the staff from being able to administer medications as ordered. Reports will be presented to the Quality Assurance Committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored

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F 760	Continued From page 18	F 760	and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Support Nurse and the Dietary Manager.	