STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345104	A. BUILDING _____ B. WING _____	C 02/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ZEBULON REHABILITATION CENTER	509 WEST GANNON AVENUE ZEBULON, NC 27597

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E 000	Initial Comments An unannounced Recertification survey was conducted on 2/7/2022 through 2/11/2022. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M0TJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 2/7/2022 through 2/11/2022. Event ID# M0TJ11. 1 of the 1 complaint allegation was not substantiated.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.	F 583		3/4/22

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

Electronically Signed | 02/23/2022

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F 583	Continued From page 1 §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide privacy during a visitation for 1 of 1 resident (Resident #19) reviewed for privacy. Findings included: Resident #19 was admitted to the facility on 11/10/2016 and readmitted on 10/11/2019 with diagnoses that included glaucoma and type 2 diabetes mellitus. A Minimum Data Set (MDS) dated 1/1/2022 revealed Resident #19 was cognitively intact. The current plan of care revised on 1/6/2022 have a plan that addressed Resident #19's preference. The interventions included encourage the family to continue to visit. A review of a grievance dated 3/3/2021 made by the Resident #19 revealed she voiced concerns that her sister came to visit with her and told her that her younger brother had passed away. Resident #19 stated she was upset, and the Activity Director (AD) had walked her sister to her	F 583	Resident #19's preferences will be honored to include personal privacy/confidentiality of records. SW spoke with resident #19 on 2-23-22 to ensure resident preferences related to family visits are honored and resident agreed with the plan of care. All residents have the potential to be affected by the alleged deficient practice. Concerns for the past 30 days were reviewed by the administrator on 2-23-22 to review for any other concerns related to breech in privacy or confidentiality. Results of this review determined that no other residents were noted to be affected by the alleged deficient practice. All staff were educated on 2-17-22 by DON regarding resident personal privacy and confidentiality of medical records. Alert & Oriented residents will be interviewed by the management team weekly regarding personal privacy. These	

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F 583	Continued From page 2 room and stayed outside the door the whole time her sister visited. Resident #19 stated the Activity Director (AD) told her she was supposed to walk her sister to her room and stay outside the room. Resident #19 stated this violated her privacy and was disrespectful to her and her sister. The documentation of investigation completed by the Director of Nursing (DON) on 3/3/2021 revealed the Administrator discussed the concerns with the resident and explained that compassionate care visitors were supposed to be walked to the room and then escorted back to the exit when leaving. The Administrator did not intend to make her feel disrespected and that her privacy had been violated. The investigation revealed the AD was only doing what was asked of her. During an interview with the Administrator on 2/8/2022 at 4:52 pm she stated during that period of time there were guidelines by the Center for Disease Control (CDC) that compassionate care visitors needed to be escorted to the resident's room and back to the exit when leaving. She stated they did not know at the time that the family member had brought bad news for the resident. She then stated the person did stand outside of the door for the duration of the visit. She stated she spoke with the resident and explained why the AD did what she did which were to follow CDC guidelines. During an interview with Resident #19 on 2/10/2022 at 10:38 am she stated when her sister came to visit her on 12/28/2020 to bring her news of her brother's death, the AD stood outside the room the whole time. She then stated the door was open and she and her sister was crying. She	F 583	interviews will be conducted x 4 weeks and then 3 interviews monthly x 3 months. The results of the interviews will be reviewed during QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	

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F 583	Continued From page 3 stated she felt like her privacy was invaded and she felt bad because the AD was at the door and heard her crying. During a telephone interview with the AD on 2/10/2022 at 2:00 pm she stated she remembered escorting Resident #19's sister to the room and standing beside the door where the number was on the wall for the duration of the visit. She then stated it had been a long time ago and she could not remember if she heard their conversations or not. She further stated she was told to by the Administrator to wait and escort the sister back to the exit after the visit.	F 583		
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be	F 623		3/4/22

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F 623	Continued From page 4	F 623		

made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related

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F 623	Continued From page 5 disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide a written notification for the reason for transfer to the hospital for 1 of 3 residents (Resident #17) reviewed for hospitalization. This practice affected other	F 623	Resident #17 returned to the facility on 12/23/21. All residents have the potential to be affected by the alleged deficient practice.	

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F 623	Continued From page 6 residents discharged to the hospital. Findings included: A nursing note written by Nurse #6 dated 12/20/2021 revealed Resident #17 was transferred to the hospital for vomiting. The representative was called about the decision to send the resident to the hospital. A review of the discharge summary dated 12/23/2021 revealed he was discharged from the hospital on 12/23/2021 back to the facility. During an interview with the Social Worker on 2/10/2022 at 2:00 pm she stated she did not send a written transfer notification to Resident #17 or the representative. She further stated she did not know a notification was required to be sent. She then stated she did not know who was responsible for sending out the notifications. On 2/10/2022 at 2:10 pm during an interview with the Admission Coordinator, she stated she did not send out a transfer notification to Resident #17 or his representative. She further stated she had no knowledge of a written transfer notification. On 2/10/2022 at 10:00 am during an interview with the Director of Nursing she stated she did not send out a written transfer notification. She then stated she was not aware that a written transfer notification needed to be sent to the resident or representative after he was transferred to the hospital. She stated they called the representative about the transfer but did not send out a written transfer notification. She further stated the facility did not send out written transfer notifications because they were not	F 623	The Administrator/SW or designee conducted an audit of discharges from 2-11-22 through 2-17-22 to evaluate if a written discharge notice was given to resident/representative. Results of this review determined that there were no discharge notices given to resident/representative. Moving forward to correct this alleged deficient practice, the resident/representative will receive a transfer or discharge notice in writing within 24 hours and a copy will be placed in the affected resident's medical record. Licensed staff responsible for discharge notices were educated by DON/designee through 2-28-22. Education included that a resident/representative must receive discharge or transfer notice in writing and the reasons for the move in a language that they understand and must send the letter to the state Long Term Care Ombudsman and place a copy in the resident's medical record. The SW/DON or designee will review discharges daily, during morning meeting, for the next 30 days and then 5 random audits monthly for 3 months to ensure that written notice was given to the resident/designee within 24 hours of facility-initiated discharges and a copy of the discharge notice is in the resident's medical record. The discharge audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	

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F 623	Continued From page 7 aware that it was needed.	F 623		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for 3 of 13 resident records reviewed for MDS accuracy (Residents #33, #56, and #32). Findings included: 1. Resident #33 was admitted to the facility on 1/09/17 with diagnoses which included chronic obstructive pulmonary disease and congestive heart failure. Review of Resident #33's quarterly Minimum Data Set (MDS) dated 1/11/22 indicated she was cognitively intact. Further review of the MDS revealed schizophrenia was coded as an active diagnosis. Review of Resident #33's medical records which included physician notes, physician history and physical, care plan, and medication administration record reveal no diagnoses, plan, or medication related to schizophrenia. An interview on 2/09/22 at 2:03 PM with the Regional MDS Director revealed she was unable to find a diagnosis of schizophrenia for Resident #33 in the medical record. She stated she did not	F 641	Resident #33, #56 and #32's MDS assessments were modified by the MDS nurse on 2-23-22 to reflect the resident's status. All residents have the potential to be affected by the alleged practice. An audit was conducted by the Regional Clinical Director on 2-17-22 on MDS assessments that were "In Progress" to ensure that medications that were administered to the residents for section N were coded as appropriate. Results for this review found that no other residents were noted to be affected by the alleged deficient practice. An audit was conducted by the Regional Clinical Director on 2-17-22 for residents discharged in the last 30 days to ensure the MDS appropriately coded the discharge location. The MDS assessments were modified and corrected by the MDS nurse on 2-23-22 for residents noted to be affected by the alleged deficient practice. The MDS nurse was re-educated by the Regional Clinical Director on 2-22-22 on the importance of appropriately capturing	3/4/22

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F 641	Continued From page 8	F 641		

know why this diagnosis was coded on her quarterly MDS.

An interview on 2/09/22 at 3:55 PM with the Director of Nursing (DON) revealed Resident #33 did not have documentation for a schizophrenia diagnosis and the MDS was inaccurate. She stated she expected the diagnoses on the MDS to be coded accurately.

2. Resident #56 was admitted to the facility on 11/16/21 with diagnoses which included anxiety and dementia.

Review of Resident #56's discharge Minimum Data Set (MDS) dated 12/04/21 indicated she was discharge to acute hospital with return not anticipated.

Review of Resident #56's nurses progress note dated 12/04/21 at 3:54 PM revealed she was discharged home with her family.

An interview on 2/09/22 at 4:37 PM with the Director of Nursing (DON) revealed Resident #56 was discharged home with her family and not sent to the hospital. She stated the MDS was not coded accurately and should have been coded as a planned discharge home to the community.

3. Resident #32 was admitted to the facility on 06/25/2019 with a diagnosis of chronic pain syndrome.

A review of her annual Minimum Data Set (MDS) assessment dated 10/22/2021 revealed she was cognitively intact. The Medication Received section indicated she had received an antipsychotic medication on 7 of the 7 look back

and coding the MDS to reflect the resident status.

The Nursing management team will randomly audit two “In progress” MDS’s per week, prior to submission to the state, for accuracy of coding. These audits will occur weekly x 4 weeks. The results of the audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.

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F 641	Continued From page 9 days. The Antipsychotic Medication Review section of the assessment indicated Resident #32 did not receive any antipsychotic medications since her last MDS assessment. A review of the Medication Administration Record (MAR) for October 2021 revealed Resident #32 received Olanzapine (an antipsychotic medication) 15 milligrams (mg) daily from 10/01/2021 through 10/31/2021. On 02/09/2022 at 2:09 PM a telephone interview with the facility's Regional MDS Director indicated the antipsychotic medication review section of Resident #32's 10/22/2021 MDS assessment was completed inaccurately. She stated Resident #32 received Olanzapine 15 mg daily and this was an antipsychotic medication. She further indicated Resident #32's 10/22/2021 MDS assessment should have been completed accurately to reflect her receiving this antipsychotic medication on a routine basis.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident	F 655		3/4/22

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F 655	Continued From page 10 including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a base line care plan which included the use of a high risk anticoagulant medication for 1 of 2 residents (Resident #52) whose baseline care plans were reviewed. Findings included:	F 655	Resident #52's Care plan was modified by DON on 2-10-22 to include the use of anticoagulant medication. All new admissions have the potential to be affected by the alleged deficient practice. The DON completed a review on 2-22-22 of active resident's care plans	

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F 655	Continued From page 11 Resident #52 was admitted to the facility on 01/27/2022 with diagnoses including left total knee replacement and atrial fibrillation (an irregular heart rhythm). A review of his admission Minimum Data Set (MDS) assessment dated 01/30/2022 revealed Resident #52 was cognitively intact. He received an anticoagulant (blood thinning) medication on 3 of 3 days since his admission. A review of a physician's order dated 01/27/2022 revealed Warfarin (an anticoagulant medication) 10 milligrams (mg) daily. A review of Resident #52's medical record revealed he received Warfarin 10 mg daily from 01/27/2022 through 01/30/2022. A review of Resident #52's base line care plan initiated on 01/27/2022 revealed it did not include Resident #52's anticoagulant medication use or the associated risk of bleeding. On 02/09/2022 at 8:49 AM an interview with the Director of Nursing (DON) indicated Resident #52's baseline care plan did not address his anticoagulant use. She stated Warfarin was a high risk medication that could cause bleeding side effects. She went on to say this should have been included in Resident #52's baseline care plan. The DON stated either she or the Unit Coordinator (UC) would have been responsible for including this information in Resident #52's baseline care plan when he was admitted. She stated it was missed. On 02/09/2022 at 3:20 PM an interview with the	F 655	to ensure that anticoagulant medications were in place as appropriate. No other residents were noted to be affected by the alleged deficient practice. The DON/Unit Coordinator were educated by the Regional Clinical Director on 2-22-22 related to the components of a Baseline Care plan to include, within 48 hours of admission the minimum healthcare information necessary to care for a resident: Initial goals based on admission orders (to include blood thinners), MD orders, Dietary orders, Therapy services, social services and PASARR recommendations. The DON/Designee will audit new admissions during facility morning meeting to ensure that the baseline care plan was completed and accurate to reflect the resident needs. These audits will be completed daily, M-F, for four weeks. The results of the audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	

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F 655	Continued From page 12 UC indicated Resident #52's baseline care plan did not include his anticoagulant use or the risk of bleeding. He stated nursing would have been responsible for including this information on Resident #52's baseline care plan. He stated it was missed.	F 655		
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 observations, record review, staff and Nurse Practitioner interviews, the facility failed to obtain orders for the use of supplemental oxygen for 1 of 3 residents reviewed with oxygen (Resident #33). Findings included: Resident #33 was admitted to the facility on 1/09/17 with diagnoses which included chronic obstructive pulmonary disease and congestive heart failure. Review of Resident #33's quarterly Minimum Data Set dated 1/11/22 indicated she was cognitively intact and was coded for the use of oxygen.	F 695	A physician□s order was obtained by the DON on 2-9-22 for resident #33 oxygen use. All residents that receive oxygen have the potential to be affected by the alleged deficient practice. An audit was conducted by the DON/Unit Manager through 2-18-22 to ensure that residents with oxygen in use had an order in place. DON made corrections and entered orders for oxygen therapy with correct liters per minute for residents that were noted to be affected. Licensed nurses were re-educated by DON through 2-17-22 regarding obtaining orders prior to starting any resident on	3/4/22

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F 695	Continued From page 13 Review of Resident #33's care plan last updated 10/28/21 revealed a focus that resident is on oxygen at two liters per minute continuous via nasal cannula. The care plan interventions included to monitor for respiratory distress and report any shortness of breath. Review of the physician orders revealed no order for supplemental oxygen use. An observation made on 2/07/22 at 4:00 PM revealed Resident #33 had oxygen via nasal cannula at 2 liters per minute. An interview on 2/09/22 at 8:34 AM with the Unit Coordinator confirmed Resident #33 wears supplemental oxygen at times. He confirmed there was no physician's order for oxygen for Resident #33. An interview on 2/09/22 at 9:09 AM with the Nurse Practitioner (NP) revealed Resident #33 should have an order for supplemental oxygen. An interview on 2/09/22 at 2:22 PM with the Director of Nursing (DON) revealed it was her expectation for all residents receiving supplemental oxygen to have a physician order for the administration of oxygen.	F 695	oxygen and that any order obtained will include route of administration, amount of oxygen use and indication for use. The DON/Designee will audit new orders M-F during morning meeting to ensure that any new order for oxygen is written appropriately. The audits will occur M-F for 4 weeks. The results of the audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	
F 745 SS=E	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by:	F 745		3/4/22

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F 745	Continued From page 14 Based on Physician and staff interviews, and record review the facility failed to obtain a referral for cataract surgery as ordered by the physician for 1 of 1 resident (Resident #19) reviewed for appointments. Findings included: Resident #19 was admitted to the facility on 11/10/2016 and readmitted on 10/11/2019 with diagnoses that included glaucoma and type 2 diabetes mellitus. A review of a physician order dated 5/11/2021 revealed refer for cataract surgery to the ophthalmologist of her choice. A Minimum Data Set (MDS) dated 1/1/2022 revealed Resident #19 was cognitively intact and had adequate vision. A plan of care revised on 1/6/2022 addressed Resident #19's potential for impaired vision. The interventions included monitor for signs and symptoms of acute eye problems, sudden visual loss, blurred or hazy vision. During an interview with Resident #19 on 2/7/2022 at 11:42 am she stated she could barely see out of her left eye. She then stated she knew that she had a left eye cataract when she was admitted to the facility. She stated she had informed the Unit Coordinator and a few nurses (she could not name the nurses) of her vision changes. She further stated nothing was done about her left eye cataract. She was unable to give a time frame of when she reported the vision changes to the unit manager.	F 745	Unit Manager attempted to make resident #19 an appointment for Ophthalmologist on 2-8-22 and resident declined. Resident denies any negative outcome. All residents with referrals to outside appointments have the potential to be affected by the alleged deficient practice. Unit Manager reviewed residents from 1-15-22 through 2-15-22 to ensure they made it to any scheduled appointments as ordered. Results for this review found that no other residents were noted to be affected by the alleged deficient practice. Licensed nurses were educated by DON on 2-17-22 on follow through of physician orders for resident referrals to include obtaining order, making the appointment, and setting up transportation to the appointment. The DON/designee will review MD orders M-F during morning meeting for new referrals, that the referral was scheduled and that it was placed in appointment log. The appointment log will be reviewed weekly x 4 weeks to ensure the resident attends the appointment as scheduled. The results of the audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	

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F 745	Continued From page 15 During an interview with the Unit Coordinator on 2/8/2022 at 11:00 am he stated he did not see in the computer where an appointment was made for Resident #19 to visit an ophthalmologist. He then stated the physician order was before he started working for the facility and he knew nothing about the order. He stated he did not remember Resident #19 telling him about vision changes. On 2/9/2022 at 4:46 pm during a telephone interview with Nurse #1, she stated she put the order for the ophthalmologist referral in the computer and could not remember if she made an appointment or not. She then stated if she made it, it would be in the computer. During an interview with the Director of Nursing on 2/10/2022 at 10:00 am she stated Nurse #1 should have made the appointment according to the order. She then stated normally a nurse was assigned to the desk and would take off orders and make appointments. She further stated she expected the nurses to follow the physician orders as written. The physician stated during a telephone interview on 2/10/2022 at 10:36 am he wrote the order for Resident #19 to see an ophthalmologist for her cataract. He then stated he was not aware that the order had not been followed. He further stated that it was important that Resident #19 see the ophthalmologist. He stated he did not believe any harm occurred to her eye because she did not see the ophthalmologist at that time.	F 745		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	F 757		3/4/22

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F 757	Continued From page 16 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and resident, staff, nurse practitioner, physician assistant and physician interview the facility failed to follow a provider's order to discontinue a medication. This was for 1 of 5 residents (Resident #52) reviewed for unnecessary medication. Findings included: Resident #52 was admitted to the facility on 01/27/2022 with diagnoses including left total knee replacement and atrial fibrillation (an irregular heart rhythm).	F 757	Resident #52 no longer resides in the facility. All residents that have medication discontinuation parameters have the potential to be affected by the alleged deficient practice. The facility pharmacy consultant reviewed current residents through 2-23-22 that have medication parameters in place. The DON/Unit Manager will review affected residents and obtain clarification orders or need to discontinue medications per MD order by 2-28-22.	

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F 757	Continued From page 17 A review of his admission Minimum Data Set (MDS) assessment dated 01/30/2022 revealed Resident #52 was cognitively intact. He received an anticoagulant (blood thinning) medication on 3 of 3 days since his admission. A provider order from the facility Nurse Practitioner (NP) dated 02/02/2022 revealed Resident #52 was to receive Enoxaparin Sodium (an anticoagulant medication) 105 mg injection subcutaneously (under the skin) twice daily for atrial fibrillation and to prevent a deep vein thrombosis (blood clot). The order further revealed to discontinue the medication once Resident #52's international normalized ratio (INR-a laboratory test evaluating the pathways of anticoagulation) was greater than 2. This order was included on Resident #52's February 2022 Medication Administration Record (MAR). The orders to check the INR on 1/31/2022, 2/4/2022 and 2/7/2022 were in facility orders. A review of Resident #52's INR laboratory test results revealed the following: 01/31/2022 INR 1.44 02/04/2022 INR 2.35 02/07/2022 INR 2.04 A review of the February 2022 Medication Administration Record (MAR) for Resident #52 revealed he received Enoxaparin Sodium 105 mg injection on 02/04/2022 at 9:00 AM and 9:00 PM, 02/05/2022 at 9:00 AM and 9:00 PM, 02/06/2022 at 9:00 AM, and 02/07/2022 at 9:00 AM. It further revealed the 9:00 PM dose on 02/06/2022 was documented as held (not given). The medication was discontinued on 02/07/2022 at 3:32 PM.	F 757	Licensed staff were re-educated by the DON on 2-17-22 on following physician orders and medication parameters for discontinuation of orders. The DON/Designee will review new physician's orders during morning meeting M-F for any noted parameters and that any discontinued medication is removed from the eMAR as appropriate. These audits will continue weekly x 4 weeks. The results of the audits will be brought through the QA&A Committee meetings monthly for three months, and as deemed necessary thereafter.	

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On 02/08/2022 at 8:50 AM an observation of Resident #52 revealed he did not have any bruising or bleeding. An interview with Resident #52 at that time indicated he was receiving blood thinning medication. He stated he had not had any bruising or bleeding.

On 02/09/2022 at 4:44 PM a telephone interview with Nurse #1 indicated she administered Resident #52's Enoxaparin Sodium injection on 02/04/2022 at 9:00 PM. She stated she notified the on-call physician of Resident #52's INR result of 2.35 and received an order to continue Resident #52's current Warfarin dosage. She went on to say she did not communicate with the on-call physician about Resident #52's Enoxaparin. She stated she had not realized there was an order to discontinue the Enoxaparin when Resident #52's INR was greater than 2.

On 02/09/2022 at 8:12 AM an interview with Nurse #4 indicated she administered Resident #52's Enoxaparin injection on 02/05/2022, 02/06/2022 at 02/07/2022 at 9:00 AM. She stated although she had access to Resident #52's INR results she did not check this before she administered the medication. She stated she had not realized Resident #52 had an order to discontinue the medication when his INR was greater than 2.

On 02/09/2022 at 8:19 AM an interview with the Unit Coordinator (UC) indicated he administered Resident #52's Enoxaparin injection on 02/05/2022 at 9:00 PM. The UC further indicated it was the nurse's responsibility to check the INR level before administering the medication. He stated he did not recall if he checked Resident

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#52's INR result. He went on to say the medication should have been discontinued on 02/04/2022 when Resident #52's INR was greater than 2.

On 02/09/2022 at 8:25 AM an interview with the Director of Nursing (DON) indicated Resident #52 had an order to discontinue his Enoxaparin when his INR was greater than 2. She stated the nurses should have been checking the INR before administering the medication. She went on to say the medication should have been discontinued when Resident #52's INR was greater than 2 as ordered.

On 02/09/2022 at 9:10 AM a telephone interview with Resident #52's NP indicated he ordered Resident #52's Enoxaparin injection on 02/02/2022. He stated the medication provided Resident #52 with blood thinning protection until his Warfarin resulted in an INR greater than 2. He went on to say the nurses administering Resident #52's Enoxaparin should have been checking his INR before administration. The NP further indicated Resident #52's Enoxaparin should have been discontinued when his INR was greater than 2 as per the order. He stated there was always the risk of bruising and bleeding side effects with any anticoagulant medication. He went on to say Resident #52 had not experienced any side effects.

On 02/09/2022 at 9:39 AM a telephone interview with Physician #2 indicated it was appropriate for Resident #52 to continue to receive Enoxaparin although there was an order to discontinue it when Resident #52's INR was greater then 2. He stated that wasn't the best order. He went on to say he preferred to wait until the INR was greater

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than 2 consistently before discontinuing the Enoxaparin. He stated Resident #52 had not experienced any bleeding or bruising side effects. He further indicated Resident #52's Enoxaparin was discontinued on 02/07/2022.

On 02/09/2022 at 2:35 PM a telephone interview with Nurse #3 indicated she held Resident #52's Enoxaparin medication on 02/06/2022 at 9:00 PM. She stated she saw the order to discontinue Resident #52's Enoxaparin injection when his INR was greater than 2. She stated she checked his INR before administering it. Nurse #3 further indicated because Resident #52's most recent INR was 2.35 on 02/04/2022, she contacted the on-call physician's assistant (PA) for clarification. She stated the PA told her to hold the medication until Resident #52's NP had a chance to review the INR. She further indicated she passed this information on in report to nurse #5 at the end of her shift that evening.

On 02/09/2022 at 3:48 PM a telephone interview with the on-call PA indicated on 02/06/2022 she spoke with Nurse #3 regarding Resident #52's Enoxaparin injection. She stated she gave Nurse #3 an order to hold Resident #52's Enoxaparin until it could be reviewed by his regular provider. The PA went on to say because Resident #52 was on long term Warfarin therapy and his INR was greater than 2, there was no need for him to continue to receive the Enoxaparin injection.

On 02/10/2022 at 8:33 AM a telephone interview with Nurse #5 indicated he did not recall Nurse #3 reporting to him Resident #52's Enoxaparin injection was on hold on 02/06/2022.