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CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

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{F 000}	INITIAL COMMENTS An unannounced onsite revisit was conducted on 05/09/2022 through 05/13/2022. A new complaint allegation was investigated onsite from 5/31/22 through 6/1/22; therefore the exit date was changed to 06/01/22. Tags F558, F608, F689, F835, F838, and F843 were corrected as of 06/01/2022. Repeat tags were cited. New tags were also cited as a result of the recertification and complaint investigation survey completed at the same time as the revisit. The facility is still out of compliance. Event ID# QW8312.	{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)	{F 580}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 580}	Continued From page 1 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 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 staff and Medical Director interviews and record review the agency failed to notify the physician of missed injections of Capoxone (for multiple sclerosis) for 1 of 8 residents reviewed for medications (Resident #17) and failed to notify the resident representative (RP) and the physician of transfer to the hospital for 1 of 1 resident reviewed for hospitalization (Resident #84). The findings included: 1. Resident #17 was admitted to the facility on	{F 580}		

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{F 580}	Continued From page 2	{F 580}		

5/5/21 with a diagnosis of multiple sclerosis (MS). Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known.

An interview was conducted on 5/9/22 with Resident #17. She stated she missed 5 shots of the Capoxone 20 milligrams in May, which she was getting for MS.

Review of the physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS.

Review of the Medication Administration Record (MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2, 5/3, 5/4, 5/5 and 5/6/22 with the reason stated as waiting to receive from the pharmacy.

This writer was unable to interview the Med Tech who was assigned to Resident #17 on 5/2/22.

An interview with Nurse #2 on 5/12/22 at 8:52am revealed she was assigned to Resident #17 on 4/30/22, 5/1/22 and 5/3/22. She stated she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she was not sure why she didn't reorder. She stated she did not administer the Capoxone injection on 5/3/22 because there was none in the med cart. She stated she did not notify the physician that the injection was not given. She was unable to state why she failed to notify the physician.

An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She acknowledged that

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{F 580}	Continued From page 3 Resident #17 did not receive Capoxone 20mg injections at bedtime on 5/4/22 and 5/6/22. Nurse #4 was assigned to Resident #17 on 5/4/22 and 5/6/22. She stated she was off a couple days and when she returned on 5/4/22, there were no more doses in the med cart. She reordered the medication on 5/4/22. Nurse #4 stated she did not notify the physician on 5/4/22 or on 5/6/22 that Resident #17 had missed the injections of Capoxone. She was unable to state why she failed to notify the physician. An interview with Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22. She was unable to administer the Capoxone because there was none in the med cart. She stated the medication should have been reordered by 4/29/22 so that it would have been delivered to the facility by 5/2/22, when the first dose was missed. She did not notify the physician that the Capoxone was not administered. She was unable to state why she failed to notify the physician. An interview with the Medical Director was conducted on 5/12/22 at 11:19 AM. He stated he should have been notified that Resident #17 had missed injections of Capoxone 20mg. He stated he was not aware of any harm from the missed injections although the Capoxone was a significant medication for her. An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM. He stated he was not aware that Resident #17 had missed 5 injections of Capoxone. He stated the physician should have been notified by the nurse with each missed dose.	{F 580}		

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{F 580}	Continued From page 4	{F 580}		

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to notify the physician when a medication was not administered.

2. Resident #84 was admitted to the facility on 10/11/19.

A document entitled, "Health Care Power of Attorney," dated 12/12/17 and signed by Resident #84 indicated he chose his RP (responsible party) as his health care agent with no special instructions or any limitations on his agent's authority.

The quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #84 was cognitively intact.

A progress note in Resident #84's medical record dated 5/7/22 at 1:06 PM written by Nurse #1 indicated Nurse #1 was informed by dialysis that Resident #84 had a fever of 102.5, shivers, and chills. Resident #84 told staff at dialysis that he did not feel well. DON (Director of Nursing) notified, unit manager notified, and Administrator notified. Resident #84 was then sent back to facility with instructions from Administrator, DON, and unit manager to direct transportation to the hospital. Transportation did not take Resident #84 to the hospital. Instructions per DON, Administrator, and unit manager to leave resident outside until EMS (emergency medical services) arrived and to not let him in the facility. Resident #84 was left outside with nurse aides until the arrival of EMS. Resident waited outside per management of the facility for 30-45 minutes awaiting the arrival of EMS with nurse aides and

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{F 580}	Continued From page 5 nurse. An interview with Nurse #1 on 5/11/22 at 10:30 AM revealed there was too much going on that day when Resident #84 came back from dialysis and ended up being sent to the hospital. She didn't think about calling Resident #84's responsible party (RP) because he wasn't supposed to come back to the facility. Resident #84's RP came to the facility later in the afternoon on 5/7/22 when she found out Resident #84 had been outside before he got sent out to the hospital, but Nurse #1 did not talk to her. Nurse #1 also didn't know she needed to notify the physician because the call had already been made to send Resident #84 out to the hospital. Nurse #1 stated she thought the DON might have already talked to the doctor about it. An interview with Resident #84 on 5/13/22 at 10:55 AM revealed he called his responsible party on 5/7/22 from the ER to report that the facility won't let him inside. He told her that he had a fever when they checked his temperature at dialysis so he got sent back to the facility but when he arrived back, they would not let him in. The EMS transported him from the facility to the hospital. A phone interview with Resident #84's RP (responsible party) on 5/10/22 at 9:22 AM revealed Resident #84 called her from the ER (emergency room) on 5/7/22 and reported to her that the facility won't let him go inside the facility after being sent back by the dialysis clinic. Resident #84's RP stated she did not receive a phone call from the facility to notify her of Resident #84 being sent to the hospital. She went by the facility on the afternoon of 5/7/22 and	{F 580}		

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{F 580}	Continued From page 6 talked to some of the staff members but she was given conflicting stories about why Resident #84 was not allowed to come inside the facility and whether he was left alone by himself while he was outside. She came to the facility on 5/9/22 and talked to the Administrator and the Social Services Director who told her that Resident #84 was not allowed inside the facility because they did not have any COVID-19 rooms set up on 5/7/22 and they had suspected that Resident #84 might have had COVID-19. An interview with the Medical Director on 5/12/22 at 10:22 AM revealed the facility used an on-call service on the weekends and he was not sure if they had called it on 5/7/22. He stated he was not aware that Resident #84 had to be sent to the hospital on 5/7/22 but he expected to be notified of any transfer to the ER. A phone interview with the Director of Nursing (DON) on 5/13/22 at 4:06 PM revealed he had a text message interaction on 5/7/22 with Nurse #1 who notified him that Resident #84 was being sent back from dialysis because his oral temperature was over 102. The DON stated he gave directions to send Resident #84 to the hospital per protocol because he needed to be seen by a medical provider and the facility did not have a Nurse Practitioner at the facility on the weekends and they only utilized an on-call service for emergencies. The DON stated he had assumed that Nurse #1 had already called Resident #84's RP and notified the on-call provider that Resident #84 was being sent to the hospital because that was the facility protocol.	{F 580}		
{F 600} SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1)	{F 600}		

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{F 600}	Continued From page 7 §483.12 Freedom from Abuse, Neglect, and Exploitation 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record review, and interviews with resident, resident representative, staff, dialysis clinic personnel, transportation service personnel and the Medical Director, the facility neglected to assess a resident who had voiced complaints of burning up during the night, failed to obtain vital signs before sending the resident to dialysis, and failed to assess the resident and give him any medication for fever on return to the facility. Resident #84 was sent back to the facility without having dialysis due to a fever on arrival at the dialysis clinic. In addition, the facility mistreated Resident #84 when he returned to the facility when they refused to allow him to come inside while waiting on transport to the hospital without notifying the physician or giving Resident #84 an explanation why. Resident #84 complained to staff that he was shaking; he was cold because it had been chilly outside and that he was not feeling good, but they would not let him inside the facility.	{F 600}		

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{F 600}	Continued From page 8 The findings included: Resident #84 was admitted to the facility on 10/11/19 with diagnoses that included end-stage renal disease. Resident #84's care plan revised on 11/16/21 indicated he was at risk for complications related to hemodialysis on Tuesday, Thursday, and Saturday. Hemodialysis is a process of purifying the blood of a person whose kidneys are not working normally. The quarterly Minimum Data Set (MDS) assessment dated 4/22/22 indicated Resident #84 was cognitively intact, had no behaviors and required extensive physical assistance with all activities of daily living including transfer. The MDS further indicated Resident #84 received dialysis while a resident at the facility. A progress note in Resident #84's medical record dated 5/7/22 at 1:06 PM written by Nurse #1 indicated Nurse #1 was informed by dialysis that Resident #84 had a fever of 102.5, shivers, and chills. Resident #84 told staff at dialysis that he did not feel well. DON (Director of Nursing) notified, unit manager notified, and Administrator notified. Resident #84 was then sent back to facility with instructions from Administrator, DON, and unit manager to direct transportation to the hospital. Transportation did not take Resident #84 to the hospital. Instructions per DON, Administrator, and unit manager to leave resident outside until EMS (emergency medical services) arrived and to not let him in the facility. Resident #84 was left outside with nurse aides until the arrival of EMS. When EMS was called they	{F 600}		

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{F 600}	Continued From page 9 refused to come pick up resident due to their consideration of non-emergent transport. EMS was called again for emergent transportation. Resident waited outside per management of the facility for 30-45 minutes awaiting the arrival of EMS with nurse aides and nurse. An interview with Nurse #1 on 5/10/22 at 10:22 AM revealed on 5/7/22 while she was giving Resident #84's morning medications, Resident #84 stated he was burning up the night before and he felt a little cold today, but he felt fine now. Nurse #1 stated she did not check his vital signs prior to him leaving for his dialysis appointment at 12:00 PM. Nurse #1 stated even though Resident #84 complained of being cold, it didn't raise a red flag to her because Resident #84 sometimes complained of being hot and sometimes he complained of being cold. Resident #84 went on to his dialysis appointment and while Nurse #1 was attending to another resident, she received a phone call from the dialysis clinic and spoke with the dialysis nurse who reported to her that Resident #84 had a fever of 102.5 and that he was going to be sent back to the facility due to concerns that he might have COVID-19. The dialysis nurse told her that they could not test him for COVID-19 at the dialysis clinic so he was sent back to the facility so they could test him. Nurse #1 immediately tried to call the Director of Nursing (DON) and Unit Manager (UM) #1 around 11:50 AM to let them know that Resident #84 might be positive for COVID-19, but she received no response. Nurse #1 did not call the on-call Nurse Practitioner. Nurse Aide (NA) #1 was able to contact Unit Manager #2 who gave Nurse #1 directions not to let Resident #84 into the facility and that he was to go to the hospital directly. Nurse #1 told UM #2 that by the time	{F 600}		

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she spoke with her, Resident #84 had already arrived at the facility. UM #2 continued to tell Nurse #1 not to let him into the facility due to concerns that he might have COVID-19. Nurse #1 received a forwarded text message at 12:40 PM coming from the DON to send Resident #84 directly to the ER because he had a temperature of over 102. The text message further read: don't test him, just send him, he meets criteria whether he had a test or not, let the hospital test him.

The interview with Nurse #1 on 5/10/22 at 10:22 AM further revealed she had to call EMS twice because when she called non-emergent EMS transport, she was told they did not have trucks at that time, and she would need to call emergent EMS. When she called emergent EMS, they told her they did not know how long it would take them to get to the facility. Resident #84 complained of having chills and being cold while he was outside. Nurse #1 said she was wearing a jacket and she thought it had been cold outside. Nurse #1 stated the wind was blowing at around 1:06 PM. Resident #84 was wearing sweatpants, a t-shirt, and a black jacket. Nurse #1 stated Resident #84 was never alone while he was outside and NA #1, NA #2, NA #3, and Nurse #4 took turns sitting with him. At some point, while waiting for EMS to arrive, Nurse #3 did a rapid test for COVID-19 on Resident #84 and his roommate and both residents tested negative. Nurse #1 stated Resident #84 sat outside for 45 minutes waiting to get transported to the ER. Nurse #1 stated she did not assess Resident #84 and obtain his vital signs when he came back from the dialysis clinic because she really did not know what to do at that point and she was directed not to let him inside the facility and to send him to the

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{F 600}	Continued From page 11	{F 600}		

hospital. She also did not think of administering any anti-pyretic medication (substance that reduces fever) to Resident #84 for his fever. She couldn't remember if she had made the DON aware that Resident #84 tested negative for COVID-19 because she wasn't even supposed to test him per his directions. When the EMT (emergency medical technicians) arrived, they were very upset about finding Resident #84 outside and upon learning that he was not allowed to come inside the facility. Nurse #1 stated the EMT told them that refusing to let Resident #84 was highly illegal.

A phone interview with the supervisor at the dialysis clinic on 5/11/22 at 9:18 AM revealed Resident #84 was screened as soon as he arrived at the clinic on 5/7/22 and his temperature was 102.5. The dialysis nurse called the facility to let them know they couldn't treat him because he had a fever and he needed to get tested for COVID-19. The dialysis supervisor stated the facility should have known not to send any resident to dialysis with a fever and that the nursing home was responsible for testing their residents for COVID-19.

A phone interview with the transportation service personnel on 5/11/22 at 9:26 AM revealed Resident was transported back to the facility at 12:00 PM after the dialysis clinic called to send him back because he had a fever of 102.5. They did not do emergency transport and could not transfer Resident #84 to the hospital which was what they told the facility staff after returning Resident #84 to the facility.

A phone interview with Resident #84 on 5/12/22 at 3:50 PM revealed he went to dialysis on 5/7/22

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{F 600}	Continued From page 12 but when they took his temperature, they said he had a fever, so they sent him back. When he got back to the facility, he asked the staff why they wouldn't let him in, but they didn't tell him why. Resident #84 stated he couldn't understand why they wouldn't let him into the facility. He said it was a little chilly outside, he was shaking, and trembling and he told the staff that he was not feeling good. Resident #84 stated he was worried he might get pneumonia while sitting outside in the cold wind. He further stated he eventually found out that they wouldn't let him in because they thought he might have had COVID-19 but they could have placed him in an empty room at that time while he waited for EMS to pick him up. He said he waited for 45 minutes outside because the transporter refused to take him to the hospital, and they had to call EMS to come pick him up. Resident #84 stated he didn't have cough or other symptoms of COVID-19. A phone interview with Resident #84's RP (responsible party) on 5/10/22 at 9:22 AM revealed Resident #84 called her from the ER (emergency room) on 5/7/22 and reported to her that the facility wouldn't let him go inside the facility after being sent back by the dialysis clinic. Resident #84's RP stated she did not receive a phone call from the facility to notify her of Resident #84 being sent to the hospital. Resident #84 sat outside the facility for 45 minutes while waiting for EMS to pick him up to take him to the ER. Resident #84 told her that the wind was blowing, and it was cold outside. Resident #84's RP stated she couldn't understand why they didn't let him in when Resident #84 had been a resident at the facility since 2019. She went by the facility on the afternoon of 5/7/22 and talked to some of the staff members but she was given conflicting	{F 600}		

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stories about why Resident #84 was not allowed to come inside the facility and whether he was left alone by himself while he was outside. She came to the facility on 5/9/22 and talked to the Administrator and the Social Services Director who told her that Resident #84 was not allowed inside the facility because they did not have any COVID-19 rooms set up on 5/7/22 and they had suspected that Resident #84 might have had COVID-19.

An interview with Nurse Aide (NA) #1 on 5/10/22 at 11:48 AM revealed on 5/7/22 after Nurse #1 received a phone call from the dialysis clinic, she came over to the 200-hall side and asked her and Nurse #3 what she needed to do because dialysis was sending Resident #84 back to the facility and she couldn't get ahold of the DON and UM #1. NA #1 stated she called UM #2 who told her and Nurse #1 not to let Resident #84 enter the building and send him to the hospital right away because he had a fever of 102.5. NA #1 stated she didn't ask UM #2 why they couldn't let Resident #84 come inside the facility, but she later found out that the reason was because the facility was not prepared for a COVID-19 unit at that time. NA #1 further stated there were 2 empty rooms at the end of 200 hall at that time. When Resident #84 arrived outside the facility, Nurse #3 went out to request the transportation service to take him to the hospital instead. They refused to take him, so NA #2 stayed with Resident #84 while he was outside. NA #1 also took a turn and replaced NA #2 watching Resident #84 because this happened during lunch time. Resident #84 mentioned to NA #1 that he was cold even though he had a jacket and a blanket over his legs. NA #1 confirmed that it was windy, the sun was not shining and there

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{F 600}	Continued From page 14 was an overcast around the time she stayed with Resident #84 outside. When EMT arrived, they were upset upon learning that they did not let Resident #84 inside the facility. An interview with Nurse #3 on 5/10/22 at 12:20 PM revealed the transportation service driver told her they couldn't take Resident #84 to the ER because they only did non-emergent transportation and they needed to call EMS to take him. While Nurse #1 called EMS, Nurse #3 came out to do a rapid test on Resident #84 and it was negative even though they were told not to even test him. She couldn't remember if she had relayed to the DON that Resident #84 tested negative for COVID-19. Nurse #3 stated they shouldn't have left Resident #84 outside the facility, but they were only following orders and directions from the DON, and they couldn't do anything about it. They didn't want to spread COVID-19 in case he did have COVID-19. Nurse #3 further stated they were supposed to obtain vital signs before sending a resident for dialysis and after a resident receives his dialysis treatment. She was not sure if Resident #84 was given any medication for his fever because she was not assigned to him. An interview with Nurse #4 on 5/10/22 at 11:05 AM revealed she worked on the day shift on 5/7/22 and was not assigned to Resident #84 but she alternated with the nurse aides in checking on Resident #84 when he was outside the facility. Nurse #4 stated Resident #84 was outside for 45 minutes before he was picked up by EMS. She said it was windy and he was complaining to her that he was cold. Resident #84 had a jacket and a blanket over his legs. Nurse #4 also stated that they were supposed to get pre-dialysis vital signs	{F 600}		

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prior to sending a resident to the dialysis clinic, make sure the resident was not in distress and take care of the dialysis site by applying topical lidocaine to the access site. When the resident comes back from his treatment, they were again supposed to obtain post-dialysis vital signs. Around the time EMS got to the facility, they decided to let Resident #84 in, but it was too late. EMS had already arrived.

An interview with Unit Manager (UM) #2 on 5/10/22 at 2:59 PM revealed she received a phone call from Nurse #1 on 5/7/22 after NA #1 called her. She was notified by Nurse #1 that the dialysis clinic was sending Resident #84 back to the facility because he had a fever of 102.5. UM #2 tried to explain to Nurse #1 that Resident #84 just had urine collected on 5/6/22 for urinalysis because he had been complaining of pain while voiding. UM #2 texted the DON who texted her back with directions not to let Resident #84 into the building and just send him to the ER. UM #2 shared the text message she received from the DON which read: test him outside, go ahead and send to ER, we don't have a COVID-19 unit set up. UM #2 stated she did not know whether Resident #84 was tested for COVID-19 and no one from the facility contacted her anymore after she talked to Nurse #1.

A review of the weather conditions per Weather Underground website revealed the following data for Asheville, North Carolina on 5/7/22 at 11:54 AM: 62 degrees Fahrenheit (F) with no precipitation, wind gust of 20 miles per hour (mph) and North wind speed at 13 mph. The conditions at 12:54 PM were 64 degrees F with no precipitation, wind gust of 22 mph and North wind speed of 15 mph.

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A review of the local EMS patient care record for Resident #84 dated 5/7/22 indicated a call was received by EMS at 12:36 PM for a request to transport Resident #84 from the nursing home facility to the hospital and they arrived on scene at 1:04 PM. The record further indicated the following information: dispatched routine traffic in reference to subject (Resident #84) having fever and chills. On arrival, Resident #84 was sitting in a reclining type of chair outside the facility. Resident #84 was alert and oriented x 4. The staff advised the EMT (emergency medical technician) that the Administrator told them not to allow the resident back into the facility due to him having a fever. Resident #84 complained of being cold. The staff on scene were standing outside with the resident on EMS arrival. Resident #84 complained of having chills, and that he needed dialysis. Resident #84's vital signs taken by EMT at 1:20 PM indicated the following: temperature of 99, blood pressure of 146/80, pulse of 102, respiratory rate of 20 and oxygen saturation of 100%. Resident #84 was transported routine to the ER (emergency room) for treatment.

The Emergency Room hospital record for Resident #84 dated 5/7/22 indicated Resident #84 had a temperature when he arrived at the dialysis clinic. He could not be dialyzed because of the fever and was sent back to the nursing home who would not let him in the building because of fever, hence he was sent to the hospital. On arrival to the hospital, he had a temperature of 99.9 and a white count of 14,500. Chest x-ray unremarkable. He reported the skilled nursing facility did a rapid COVID-19 test and it was negative. His only symptoms were

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{F 600}	Continued From page 17 urinary. He described feeling like fire when he urinated. No other voiding issues. He voided at least once a day and periodically needed catheterization. He reported no sore throat, earache, cough, shortness of breath, nausea, vomiting, diarrhea, or abdominal pain. He has had no COVID-19 contacts and PCR (polymerase chain reaction) is pending. The ER physician further noted that Resident #84's only symptoms were urinary, and he suspected he had a urinary tract infection. They will try to obtain urine for urinalysis and culture and will also start him on empiric antibiotics. Resident #84 will have a COVID-19 study but he had no symptoms to suggest COVID-19. An interview with the Medical Director on 5/12/22 at 10:22 AM revealed he would not have advised for Resident #84 to miss a dialysis treatment just because he had a fever because it would make it worse for him if he did not receive dialysis. He stated he had been providing education to facility staff about the importance of taking vital signs and he was not sure if it could have prevented the whole situation of Resident #84 being sent back to the facility due to fever, but the facility should have assessed him prior to sending him to dialysis and after he came back to the facility. The Medical Director stated he wasn't aware of Resident #84 being left outside and not allowed to come in on 5/7/22 and he didn't know the reason behind it so he couldn't comment on what the facility had done. A phone interview with the Director of Nursing (DON) on 5/13/22 at 4:06 PM revealed he had a text message interaction on 5/7/22 with Nurse #1 who notified him that Resident #84 was being sent back from dialysis because his oral	{F 600}		

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temperature was over 102. The DON stated he gave directions to send Resident #84 to the hospital per protocol because he needed to be seen by a medical provider and the facility did not have a Nurse Practitioner at the facility on the weekends and they only utilized an on-call service for emergencies. The DON stated he jumped to conclusion and thought Resident #84 might be positive for COVID-19 and an exceedingly high temperature met the criteria for being evaluated at the ER. Resident #84 also needed emergency dialysis at that time. The DON also stated he did not know that the transportation service did not do emergency room transports and he thought that they could have transported Resident #84 from either the dialysis clinic or from the facility to the ER. The DON further stated Nurse #1 should have followed the facility's policy for care of dialysis residents and obtained a set of vital signs for Resident #84 prior to sending him to the dialysis clinic and after receiving him back. The DON stated he knew Resident #84 had been complaining that he had not been feeling good, but it was different from having a temperature of over 102. He gave directions to staff to keep Resident #84 outside and not let him in the building because he thought he might have been positive for COVID-19, and he didn't want to spread COVID-19 to the other residents.

An interview with the Administrator on 5/13/22 at 6:46 PM revealed she didn't see her text messages from the DON and UM #2 until later in the afternoon of 5/7/22. The Administrator stated when she called UM #2, Resident #84 had already gone to the hospital, but UM #2 told her that the facility staff let him wait outside the facility for EMS to pick him up. The Administrator stated he did not know that Resident #84 was not

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{F 600}	Continued From page 19 allowed to come inside the facility until 5/9/22 when his responsible party (RP) talked to him and the Social Services Director. He stated that he asked Resident #84's RP to let him investigate what happened to Resident #84 on 5/7/22. He also stated they could have placed Resident #84 in an empty room while waiting for EMS to pick him up instead of not allowing him to come inside the facility. The Administrator stated the decision not to let him inside the facility was made to protect the other residents in case he turned out to be positive for COVID-19. She also said Resident #84 should have been assessed by Nurse #1 when he got back to the facility, but it wasn't right not to let him inside the facility. She said the reason to send him to the hospital was because he had fever and they thought he might have COVID-19. Resident #84 needed to be seen by a physician and he needed to have dialysis.	{F 600}		
{F 725} SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following	{F 725}		

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types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.

§483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
This REQUIREMENT is not met as evidenced by:
Based on observations, resident and staff interviews and record reviews the facility failed to provide sufficient nursing staff to accommodate a resident's request to be assisted out of bed; failed to provide showers / hair washing; failed to provide nail care, oral care, and facial hygiene. This affected 6 residents (Resident #20, #2, #54, #91, #23 and #79).

The findings included:

This tag is cross-referenced to:

1. F561: Based on record review, observations, resident and staff interviews, the facility failed to accommodate a resident's request to be assisted out of bed at their preferred time of day (Resident #20) and provide residents with their preferred number of showers per week (Resident #20, #2, #54, #91, and #23) for 5 of 8 residents reviewed for choices.

2. F677: Based on observations, record review, staff interviews the facility failed to provide nail care, oral care, and facial hygiene to 2 of 7

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{F 725}	Continued From page 21 dependent residents reviewed for activities of daily living (ADL) (Resident #79 and #20). Interview with NA #19 on 5/13/2022 at 9:35 AM revealed she was agency staff who had worked at the facility for 6 years. NA #19 indicated showers, shaving, nail care, and oral care were not getting done at the facility due to staffing. The NA stated the workload was too much and there was not enough time to get everything done. Interview with Nurse #9 on 5/13/2022 at 11:05 AM revealed she had been hesitant to accept her assignment the first weekend in May 2022 because she was going to be the only nurse in the building. Nurse #9 was scheduled to work with Medication Aides (MA) and NAs. Telephone interview with the Director of Nursing (DON) on 5/13/2022 at 5:04 PM revealed he was aware of staffing challenges. He stated he expected staff to complete showers / bed baths, hair washing, nail care, facial hygiene, and oral care daily. The DON indicated the facility was actively seeking to hire permanent staff. He revealed for every permanent staff member hired, they could eliminate use of one agency staff. Interview with the facility Administrator, Administrator #13, and the Vice President of Risk on 5/13/2022 at 7:08 PM revealed they expected residents to be out of bed per their preference, showers provided / hair washed, nail care, oral care, and facial hygiene completed daily or as care planned. The Administrator stated hiring permanent staff was an active pursuit for the facility.	{F 725}		
{F 755} SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records	{F 755}		

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{F 755}	Continued From page 22 CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services 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. §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. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §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 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review and staff, Medical Director and Pharmacy Manager interviews the facility failed to acquire Capoxone pre-filled syringes (used to treat multiple sclerosis) and as	{F 755}		

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{F 755}	Continued From page 23 a result Resident #17 missed 5 doses. This affected 1 of 8 residents reviewed for medications (Resident #17). The findings included: Resident #17 was admitted to the facility on 5/5/21 with a diagnosis of multiple sclerosis (MS). Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known. Review of the physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS. An interview was conducted on 5/9/22 at 1:46 PM with Resident #17. She stated she did not get 5 Capoxone shots in May, which she was getting for multiple sclerosis. Review of the Medication Administration Record (MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2/22, 5/3/22, 5/4/22, 5/5/22 and 5/6/22 with the reason stated as waiting to receive from the pharmacy. On 5/12/22 at 5:05 PM, an interview was conducted with Nurse #1. She stated medications should be reordered 3 days before running out. She confirmed she worked at the facility and cared for Resident #17 on 4/29/22 and she should have reordered the medication then. She stated she was not sure why she didn't reorder. An interview with Nurse #2 on 5/13/22 at 8:52	{F 755}		

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AM. She confirmed she cared for Resident #17 on 4/30/22 and 5/1/22. She stated the medication should have been ordered 7 days before it ran out. She stated that she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she was not sure why she didn't reorder.

This writer was unable to interview the Med Tech who was assigned to Resident #17 on 5/2/22.

An interview with Nurse #2 on 5/12/22 at 8:52am revealed she was assigned to Resident #17 on 4/30/22, 5/1/22 and 5/3/22. She stated she should have reordered the medication when she cared for Resident #17 on 4/30/22. She stated she did not administer the Capoxone injection on 5/3/22 because there was none in the med cart. She stated she was not sure why she didn't reorder.

An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She confirmed she was assigned to Resident #17 on 5/4/22 and 5/6/22 acknowledged that Resident #17 did not receive the Capoxone 20mg injections at bedtime on 5/4 and 5/6/22. Nurse #4 stated she was off a couple days and when she returned on 5/4/22, there were no more doses of Capoxone in the med cart to give to Resident #17. She reordered the medication on 5/4/22 but did not notify the physician. She stated when a resident's medication was low she reordered using the electronic medical record. The Capoxone should have been reordered 2-3 days before it ran out.

An interview with the Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22 and was

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA PINES AT ASHEVILLE	91 VICTORIA ROAD ASHEVILLE, NC 28801

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unable to administer the Capoxone injection because there was none in the med cart. She stated the medication should have been reordered by 4/29/22 so that it would have been delivered to the facility by 5/2/22, when the first dose was missed.

On 5/10/22 at 1:55 PM, an interview was conducted with the Pharmacy Manager. She stated a 30-day supply of Capoxone 20mg injections were ordered on 3/24/22 and delivered to the facility on 3/26/22. The next order was made on 5/4/22 and delivered to the facility on 5/7/22. She stated the pharmacy had 72 hours to refill medication orders. The pharmacy has asked the facility to reorder 3-5 days before the doses ran out. She stated the facility could have run a report that told them when refills were due.

An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM revealed the nurses have control of the medication carts and the medication record and they should reorder medication at least 48 hours before the last dose is to be given.

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to follow the pharmacy protocol for ordering medications so that doses were not missed.

An interview with the Medical Director was conducted on 5/12/22 at 11:19 AM. He stated he thought it was a pharmacy problem across the board and there are plans to provide education to the staff to start using an app to reorder medications.

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{F 760} SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	{F 760}		

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:
Based on record review, observations, staff and Physician interviews, the facility failed to prevent significant medication errors whey they failed to acquire and administer Capoxone pre-filled syringes (used to treat multiple sclerosis) and as a result Resident #17 missed 5 doses and when pain medications were not administered as ordered by the physician to Resident #345 for 2 of 8 sampled residents whose medications were reviewed.

The findings included:

1. Resident #17 was admitted to the facility on 5/5/21 with a diagnosis of multiple sclerosis (MS).

Review of the quarterly minimum data set (MDS) assessment dated 2/22/22 revealed Resident #17 was cognitively intact and could make her needs known.

An interview was conducted on 5/9/22 at 1:46pm with Resident #17. She stated she did not get 5 Capoxone shots in May, which she was getting for multiple sclerosis.

Review of the Physician order dated 2/14/22 stated to inject Capoxone 20 milligrams (mg) subcutaneously at bedtime for MS.

Review of the Medication Administration Record

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(MAR) for May 2022 revealed the Capoxone injections were documented as not given on 5/2/22, 5/3/22, 5/4/22, 5/5/22 and 5/6/22 with the reason stated as waiting to receive from the pharmacy.

This writer was unable to interview the Med Tech who was assigned to Resident #17 on 5/2/22.

An interview was conducted with Nurse #2 on 5/12/22 at 8:52 AM. She stated she cared for Resident #17 on 5/3/22 and was not able to administer the Capoxone injection because there was none in the med cart. She stated when she cared for her on 4/30/22, she should have reordered the medication. She was not sure why she did not reorder the medication.

An interview was conducted with Nurse #4 on 5/10/22 at 1:42 PM. She acknowledged that Resident #17 did not receive the Capoxone 20mg injections at bedtime on 5/4/22 and 5/6/22. She stated she administered Capoxone 20mg injections to Resident #17 on 4/25/22, 4/26/22, 4/27/22, and 4/28/22. When she returned to the facility on 5/4/22, there were no more doses of Capoxone in the med cart to give to Resident #17. She stated she reordered the medication on 5/4/22.

An interview with Unit Manager #2 was conducted on 5/12/22 at 4:03 PM. She stated she was assigned to Resident #17 on 5/5/22 and there were no doses of the Capoxone in the med cart. She stated she confirmed that Nurse #4 had reordered the medication using the electronic medical record on 5/4/22. She stated the medication should have been ordered by 4/29/22 in order to have been delivered to the facility by

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5/2/22, when the first dose was missed.

An interview with the Medical Director was conducted on 5/12/22 at 11:19 PM. He stated he was not aware of any harm from the missed doses although the Capoxone injections were necessary to prevent a flare up of the MS.

An interview with the Director of Nursing (DON) on 5/13/22 at 05:10 PM. He stated he was not aware that Resident #17 had missed 5 injections of Capoxone for her MS. The Capoxone injections should have been administered as ordered by the physician.

An interview with the Administrator was conducted on 5/13/22 at 7:12 PM. He stated he expected the staff to follow physician's orders.

2. Resident #345 was admitted to the facility on 05/02/22 with a diagnosis of malignant neoplasm of rectum, secondary neoplasm of liver and intrahepatic bile duct and secondary malignant neoplasm unspecified lung.

Review of the nursing skills assessment dated 05/02/22 revealed Resident #345 was cognitively intact.

Review of initial care plan 05/04/22 revealed goal for Resident #345 to be free of signs of pain or complaints of pain and will state relief of pain daily. Interventions include administer pain medication for pain and observe for effectiveness/side effects and report ineffectiveness to physician.

Review of the Physician order dated 05/03/22

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stated to give Oxycontin Tablet ER 10 MG by mouth every 12 hours for pain. (Narcotic analgesic that releases slowly over 12 hours)

Review of Physician order dated 05/06/22 stated to give Oxycodone HCl 10 MG by mouth every 3 hours as needed for severe pain. (Narcotic analgesic that relieves pain for 4 to 6 hours)

Review of the Medication Administration Record (MAR) for May 2022 revealed Oxycontin Tablet ER 10MG every 12 hours (8AM, 8PM) was initialed as being administered to Resident #345 as scheduled on 05/05/22, 05/06/22, 05/07/22 and 05/09/22.

Review of the 200 Hall narcotics book sheet for Resident #345 revealed Oxycontin Tablet ER 10 MG every 12 hours for pain was not signed out in the narcotics book for the evening dose of 05/05/22, morning dose of 05/06/22, evening dose of 05/07/22 and morning dose of 05/09/22.

A comparison of the MAR and narcotics sheets revealed Resident #345 was administered Oxycodone instead of Oxycontin at 19:31 PM on 05/05/22, 9:00 AM on 05/06/22, 8:20 PM on 05/07/22 and 9:58 AM on 05/09/22.

Observation of Resident #345 on 05/09/22 at 11:05 AM revealed resident lying in bed resting and did not respond to knock on door.

Observation of Resident #345 on 05/09/22 at 12:56 PM revealed resident lying in bed resting with eyes closed and did not respond to name or knocking on door.

Record review revealed Resident #345 was sent

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{F 760}	Continued From page 30 out to the hospital on 5/10/22 at 3:27 AM due to a change of condition. An interview was conducted with Med Aide #1 on 05/11/22 at 3:06 PM. She acknowledged that on the morning of 05/09/22, she gave Resident #345 her as needed Oxycodone instead of her ordered Oxycontin. She revealed she filled out the narcotic book sheet for the Oxycodone correctly and that is why the medication count was correct but filled out the MAR incorrectly. She acknowledged she made a mistake and should have double checked the medication with the orders and given Resident #345 the correct medication at the correct time. A telephone interview was conducted with Med Aide #4 on 05/13/22 at 7:23 AM. She acknowledged she worked from 7 PM to 7 AM on 05/07/22 and remembers giving medication to Resident #345. She stated she does not recall an as needed order and gave Resident #345 the medication order for Oxycodone. She was not aware that she had given the wrong medication or of the Oxycontin order. She revealed the process when giving medications is to check the medications with the order and then once given sign off in the book and the computer. A telephone interview was conducted with Nurse #9 on 05/13/22 at 10:57 AM. She acknowledged she worked on the evening of 05/05/22 and remembered giving medication to Resident #345. She stated she was aware Resident #345 had a standing order for pain medication and an as needed order for pain medication. She was not aware that she had given the wrong medication order of the Oxycontin order. She stated it was an error that does not typically happen, and she tries	{F 760}		

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{F 760}	Continued From page 31 to double check order with the MAR and the narcotic notebook sheet. Nurse #11 who was assigned to Resident #345 on 05/06/22 was not available for interview. An interview with the Medical Director was conducted on 05/12/22 at 11:16 AM. He stated he was not made aware of the medication error regarding Resident #345 being administered Oxycodone instead of Oxycontin and requested to review the narcotic book sheet. He revealed not receiving pain medications as prescribed could affect pain level for a resident with her diagnoses. He stated medications should be given as ordered. A telephone interview was conducted with the Director of Nursing (DON) on 05/13/22 at 6:19 PM due to the DON being out on medical leave that week. He stated it was not brought to his attention that Resident #345 was not administered her correct medication as ordered by the physician. His expectation would be that med aides and nursing staff would give the correct medication as ordered so resident would be free from pain, and he would consider Resident #345 not receiving the pain medication as ordered a significant medication error. An interview with the Administrator was conducted on 05/13/22 at 7:20 PM. He stated he expected the staff to follow physician's orders.	{F 760}		