STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345388	A. BUILDING ______ B. WING ______	C 07/15/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTER WOODS NURSING AND REHAB	620 TOM HUNTER ROAD CHARLOTTE, NC 28213

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 7/11/22 through 7/15/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #E3H411.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 7/11/22 through 7/15/22. Three (3) of twenty-six (26) complaint allegations were substantiated. Intakes: NC00189900 and NC00190864. Event ID# E3H411	F 000		
F 641 SS=B	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 record the weight on a Minimum Data Set (MDS) assessment for 1 of 4 sampled residents reviewed for MDS accuracy (Resident #31). Findings included: Resident #31 was admitted to the facility on 8/23/21. Review of Resident #31's Quarterly Minimum Data Set (MDS) assessment dated 5/9/22 noted a weight of 297 pounds. On 5/7/22 Resident 31's weight was documented	F 641	F641: Accuracy of Assessments Root Cause: Resident's weight was not coded accurately on the Minimum Data Set (MDS) assessment. Resident #31's Minimum Data Set (MDS) assessment was modified on 07/13/22 to correct coding for K0200B. Weight. As of 8/2/22, the Minimum Data Set (MDS) nurse completed a 100% audit for Assessment Reference Date's 6/1/22 and after, for current resident's to ensure weight was coded accurately on most recent assessment. The Minimum Data Set (MDS) nurse and Minimum Data Set (MDS) traveling Nurse were educated on 8/2/22 by the Regional	8/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 08/05/2022

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 641	Continued From page 1 as 284.3 pounds in the medical record. During an interview with the MDS Coordinator on 7/13/22 at 11:33AM she explained the Registered Dietician (RD) completed the weight section of the MDS. She revealed Resident #31's weight documented on 5/7/22 was correct, and the MDS was inaccurate. An interview on 7/14/22 at 11:58 AM with the RD was conducted. She explained Resident 31's weight had been prepopulated on the assessment and should have been noted as 284 pounds, not 297 pounds. During an interview with the Administrator on 7/13/22 at 12:12 PM, he stated that the MDS assessments should be completed accurately.	F 641	Minimum Data Set (MDS) Nurse regarding accurate coding for resident’s weight. By 8/24/22, the Registered Dietician will be educated by the Regional Minimum Data Set (MDS) Nurse on accurately coding residents’ weights on the Minimum Data Set (MDS) assessment. Regional Minimum Data Set (MDS) Nurse will review 5 assessments weekly x 4 weeks then monthly for 3 months or until compliance is achieved. Monitoring results will be presented to the Quality Assurance and Performance Improvement committee monthly. Date of Compliance: 8/24/2022	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident	F 657		8/24/22

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F 657	Continued From page 2 and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide the resident with a care planning conference to participate with the interdisciplinary team in the development of a comprehensive care plan for 1 of 1 resident (Resident #42) reviewed for care plans. The findings included: Resident #42 was admitted to the facility on 7/15/19 with medical diagnoses which included: diabetes, hypertension, and neurogenic bladder. Review of Resident #42's 5/23/22 Annual Minimum Data Set (MDS) assessment revealed resident was cognitively intact and required limited assist with Activities of Daily living (ADL). Review of Resident #42's care plan revealed it had been updated on 5/23/22. Interview with Resident #42 on 7/11/22 at 12:31 PM revealed that she had not been invited to participate in a care plan meeting. Resident #42 further stated it had been a long time since she had attended a care plan meeting.	F 657	F657: Care Plan Timing and Revision Root Cause: Resident(s) and/or their representative(s) were not invited to a care plan meeting to enable them to participate in development and/or revision of the interdisciplinary comprehensive care plan. On 8/3/22, the Social Worker notified Resident #42 via letter of her upcoming care plan meeting to be held on 8/17/22. Audit: As of 8/2/22, care plan meetings are set for 100% of current residents to enable them to participate in development and revision of their plan of care. On 8/2/22 the Social Worker, Minimum Data Set (MDS) nurse and corporate traveling Minimum Data Set (MDS) nurse were educated by the Regional Minimum Data Set (MDS) Nurse regarding care plan timing and revision according to the Resident Assessment Instrument (RAI) manual. Resident and/or their representative should be invited to participate in care plan development and revision after each assessment, including both the comprehensive and quarterly review assessments.	

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F 657	Continued From page 3 There was no evidence in the medical record that Resident #42 was invited to a care plan meeting in the past 6 months. Review of the May 2022 through July 2022 care plan invitation calendars revealed there was no documentation Resident #42 had been invited to a care plan conference. Interview with the MDS Coordinator on 7/13/22 at 11:24 AM revealed that the Social Worker was responsible for inviting residents and /or resident representatives to the care plan meetings. MDS Coordinator stated that if a resident was cognitively intact, they should be invited to the care plan meeting quarterly. She further revealed Resident #42 should have been invited to a care plan conference in May 2022 and the Social Worker should have the invitation and sign-in sheets. Interview with the Social Worker on 7/13/22 at 11:47AM revealed he had been in his position for the past 6 months. He was unable to locate any care plan conferences for Resident #42. He further revealed the facility had a traveling MDS Coordinator and he was accustomed to coordinating the calendars with them. He stated the system of coordinating with the MDS Coordinator was not in place and this was how it fell through the cracks. He further stated he did not invite Resident #42 to a care plan meeting in May 2022, and she should have been invited. Interview with the Administrator on 7/13/22 at 12:12PM revealed that he expected that residents and/or their representatives would be invited to the care plan meetings. He further stated it was the Social Worker and the MDS Coordinator	F 657	The facility Minimum Data Set (MDS) Nurse will provide monthly care plan meeting list to the Social Worker. The Social Worker will invite resident and/or their representative according to the Care Plan meeting list. Attendees to the care plan meetings will be documented. Regional Minimum Data Set (MDS) Nurse will review care plan meeting invitations and care plan meetings held weekly x 4 weeks then monthly for 3 months or until compliance is achieved. Regional Minimum Data Set (MDS) Nurse will review care plan meeting list monthly x 3 months or until compliance is achieved. Monitoring results will be presented to the Quality Assurance and Performance Improvement committee monthly. Date of Compliance: 8/24/2022	

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F 657	Continued From page 4 responsibility for coordinating the care plan meetings and the invitations.	F 657		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, and staff interviews, the facility failed to apply bilateral lower leg splints for 1 of 1 resident reviewed for contractures/limited range of motion (Resident #5). Findings included: Resident #5 was admitted to the facility 7/15/2019 with diagnoses to include a progressive neurological disorder. A physical therapy discharge note dated	F 688	Resident #5 was evaluated and placed on therapy caseload on 8/2/2022 to reinitiate brace program for bilateral lower extremities. By 8/24/22, the therapy department will re-evaluate residents who have previously been on the Contracture Management Program to reinitiate the program. This process will include proper trialing and building the wearing tolerance of the brace/splint with each resident. After the resident is able to tolerate the brace/splint for desired amount of time (specific to	8/24/22

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F 688

Continued From page 5

3/30/2022 documented that physical therapy had provided services to reduce pain and joint stiffness and to increase range of motion of Resident #5's bilateral knees. The discharge note documented that Resident #5 showed improvement of the range of motion of both knees and Resident #5 was able to tolerate wearing splints for 6 hours at a time. The note documented a nursing assistant had been instructed how to apply the splints with instructions for Resident #5 to wear the splints for up to 6 hours or as tolerated.

The most recent quarterly Minimum Data Set (MDS) assessment dated 4/12/2022 assessed Resident #5 to be cognitively intact and Resident #5 did not refuse care. The MDS documented Resident #5 had limited range of motion of both lower legs.

A review of the medical records for Resident #5 revealed no order for splints. The medical record did not have a care plan in place that addressed the use of splints for Resident #5.

Resident #5 was observed on 7/12/2022 at 10:30 AM. Resident #5 was sitting in a geri-chair. It was noted Resident #5 had contractures of his lower legs and his knees were bent and pulled toward his chest. Resident #5 was interviewed at the time of the observation, and he reported he had splints, but it had been a long time since staff had applied the splints to his lower legs. Resident #5 reported the splints were on his nightstand. Two lower body splints were noted to sit on top of the nightstand on Resident #5's side of the room.

Resident #5 was observed again on 7/13/2022 at 8:35 AM. Resident #5 was in bed covered with a

F 688

patient), therapy will train/educate nursing staff on proper DONNING/DOFFING, skin checks and wearing tolerance of splint/brace specific to patient. Upon discharge from therapy□s caseload, therapist will notify Director of Nursing and Unit Manager of resident being placed on Contracture Management program and obtain a physician□s order for that resident in Point Click Care (PCC). Minimum Data Set (MDS) nurse will update the care plan and kardex with contracture management. The therapy department will also screen residents at risk for contractures upon nursing referral and/or quality of life rounds. If the resident is deemed appropriate for the Contracture Management program, the same procedures from above will be implemented.
By 8/24/22, Therapists to include: Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST) and assistants will be reeducated by the Rehabilitation Manager regarding the Contracture Management Program. The process will include obtaining and creating splint/brace physician orders in PCC upon discharge from caseload. Each resident□s name will be placed on a google document which will be shared with therapy, nursing, MDS and Administrator so that each department will be aware of residents who are on the Contracture Management program along with proper DONNING/DOFFING instructions. Shared google document will be updated by therapy department as residents are added to the program. MDS

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F 688	Continued From page 6 blanket. It was noted both his legs were bent at the knee and his knees were pulled towards his chest. Two lower leg splints were noted to be on top of the nightstand on Resident #5 ' s side of the room. Resident #5 reported the splints had not been applied to him since the last observation on 7/12/2022. Nurse #3 was interviewed 7/13/2022 at 8:15 AM. Nurse #3 reported she worked night shift (11:00 PM to 7:00 AM) and she did not think that Resident #5 had splints. Nursing assistant (NA) #1 was interviewed on 7/13/2022 at 2:40 PM. NA #1 reported she provided care to Resident #5 frequently and she did not think he had splints for his legs. An interview was conducted with NA #2 on 7/13/2022 at 2:49 PM. NA #2 reported she had provided care to Resident #5 frequently. NA #2 said Resident #5 did not have splints to his lower legs. Nurse #2 was interviewed on 7/14/2022 at 8:44 AM. Nurse #2 reported Resident #5 did not have splints to his lower legs. The Director of Rehabilitation (DOR) was interviewed on 7/15/2022 at 1:20 PM. The DOR reported that Resident #5 did not wear splints. An interview was conducted with NA #3 on 7/15/2022 at 9:40 AM. NA #3 reported she was on the shower team, and she provided showers to Resident #5. NA #3 reported she did not think Resident #5 had splints for his lower legs. The physical therapist (PT) was interviewed on 7/15/2022 at 10:10 AM. The PT reported she had	F 688	will care plan and update kardex regarding splint and/or brace reflecting proper wearing instructions from this shared google document. The Director of Nursing and/or Nurse Management will reeducate licensed nurses, medication aides, and certified nursing assistants by 8/24/2022 regarding the Contracture Management Program. The education will be provided to new employees as part of new hire orientation, contract staff and agency staff. Nurse management will utilize shared google document to audit residents on Contracture Management Program. Nurse management will randomly audit 5 residents 3x per week for one month; 1x week for two months; and 1x monthly for 3 months. Therapy department will screen residents on Contracture Management Program monthly to ensure that current regimen is appropriate. If any changes are needed, patient will be re-evaluated and placed on therapy□s caseload to initiate an appropriate program. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed. Date of compliance: 8/24/22	

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F 688	Continued From page 7 provided physical therapy to Resident #5 in March 2022. The PT explained that she worked with Resident #5 to improve the range of motion of his knees and when she discharged him from physical therapy services, Resident #5 was able to tolerate wearing lower leg splints for 6 hours at a time. The PT reported she trained a NA to apply the splints, but she had not written an order for nursing staff to apply the splints. The PT stated she was not aware an order should have been written for splints. The PT and the DOR were present during an observation of Resident #5 on 7/15/2022 at 10:15 AM. Two lower body splints were on the nightstand on Resident #5's side of the room and the PT confirmed they were the splints she had used for Resident #5. The DOR was interviewed again on 7/15/2022 at 10:18 AM. The DOR reported that all therapists were expected to write orders for ongoing use of equipment such as splints, and Resident #5 would need to have another evaluation and treatment to restart the splints. The Administrator was interviewed on 7/15/2022 at 12:32 PM. The Administrator reported it was his expectation that all therapy services wrote orders for equipment such as splints so that the resident could receive appropriate treatment.	F 688		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 693		8/24/22

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F 693	Continued From page 8 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to check residual prior to administering gastrostomy tube (G-tube) medication and failed to flush the G-tube before medication administration for 1 of 1 resident reviewed for G-tube medication administration (Resident #66). Findings included: Resident #66 was admitted to the facility 6/10/2022 with diagnoses to include dysphagia, gastrostomy, and epilepsy. The admission Minimum Data Set (MDS) assessment dated 6/17/2022 assessed Resident #66 to be rarely or never understood and severely cognitively impaired. The MDS documented Resident #66 received more than 51% of her calories per day by G-tube.	F 693	Nurse #1 reeducated by Director of Nursing on 8/1/22 regarding Medication Administration and Gastrostomy Tube (G-tube) Policy to include check for residual prior to administering medication and flushing the G-tube before medication administration. On 7/14/22 a new order was received for Resident #66 for medications to be crushed, mixed, and administered together. Medication Error Reports completed for each incident with notification to Physician. Current residents who require enteral feeding have the potential to be affected. A quality review was completed on 8/1/22 by the Director of Nursing to ensure residents with gastrostomy tube orders are correct and up to date as prescribed by physician. The orders were reviewed	

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F 693

Continued From page 9

A physician order for Resident #66 dated 7/13/2022 ordered enteral feed by bolus 4 times per day with 100 milliliters (ml) flush of sterile water before and after the bolus feeding.

An observation of medication administration was conducted on 7/14/2022 at 9:12 AM. Nurse #1 mixed approximately 50 ml of sterile water with the crushed medications in the cup. Nurse #1 proceeded to uncap Resident #66's G-tube and connect the syringe to the G-tube and poured the medication directly into the syringe to drain into the G-tube without flushing or checking for residual stomach contents. Nurse #1 did not flush the G-tube with sterile water after the administration of medications.

When asked about the medication administration procedure on 7/14/2022 at 9:12 AM, Nurse #1 reported Resident #66 did not usually have residual and she did not check for residual stomach contents. Nurse #1 explained that Resident #66 required sterile water flush of 100 ml before the G-tube feeding and 100 ml after the feeding, and she used the 100 ml to dilute the medications and to dilute the tube feeding. Nurse #1 reported she did not flush the G-tube prior to medication administrator or between the medications and the enteral feeding bolus. Nurse #1 reported there was no order to check for residual prior to administration of medication or G-tube bolus feeding for Resident #66.

Nurse #1 was interviewed again at 7/14/2022 at 2:55 PM. Nurse #1 again reported she was not aware she should have checked for residual stomach contents.

F 693

to ensure whether medications can be crushed and mixed together for administration. Any issues identified were addressed.
The Director of Nursing and/or Nurse Management will reeducate licensed nurses by 8/24/2022 on Medication Administration to include Medication Administered through an Enteral Tube. The education will include nurses to administer medications as prescribed. Nurses should administer each medication separately and flush the tubing between each medication administered, unless there□s a physician order to crush and mix medications together to give at one time. Nurse management will complete Medication Administration through an Enteral Tube skills competency for nurses with return demonstration. The education will be provided to new employees as part of new hire orientation, contract staff and agency staff.
Nurse Management will observe Medication Administered through an Enteral Tube on random shifts and carts 3x week for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 10 The Director of Nursing (DON) was interviewed on 7/14/2022 at 3:10 PM. The DON reported she thought Nurse #1 was nervous during the medication administration. The DON stated she expected G-tube medication administration to include checking for residual stomach contents and flushing before and after the medications.	F 693	needed. Date of Compliance: 8/24/2022	
F 759 SS=E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews, the facility failed to maintain a medication administration error rate of less than 5% as evidenced by a medication error rate of 22.22% (7 out of 27 opportunities) (Resident #66). Findings included: 1. Review of the facility policy "Medication administration via enteral tube" dated 11/30/2014 and revised on 3/6/2019 specified "finely crush each medication with a pill crusher, or open capsule and pour powder into a medication cup with 5-15 milliliters (ml) of water and dissolve ... there should be one medication per cup. Do not mix medications unless there is a specific physician order to do so ... pour at least 15 ml of water into the syringe and allow to drain into the tube prior to medication administration. Pour one liquefied mediation in the syringe and allow	F 759	Nurse #1 reeducated by Director of Nursing on 8/1/22 regarding Medication Administration and Gastrostomy Tube (G-tube) Policy to include check for residual prior to administering medication and flushing the G-tube before medication administration. Medication Error Reports completed for each incident with notification to Physician. Current residents have the potential to be affected. On 8/1/22 a quality review was completed of Medication Administration Records to ensure resident orders are correct and up to date as prescribed by physician. Any issues identified were addressed. The Director of Nursing and/or Nurse Management will reeducate licensed nurses and medication aides by 8/24/2022 on Medication Administration to include:	8/24/22

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	345388	A. BUILDING ______ B. WING ______	C 07/15/2022

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F 759

Continued From page 11

gravity to drain each medication, follow each medication with at least 15 ml of water to flush the tube."

A. An observation of medication administration was conducted on 7/14/2022 at 9:12 AM. Nurse #1 removed Resident #66's medications from the medication cart and placed each medication in a cup:

. Aspirin 81 milligrams (mg) 1 tablet
· Fluoxetine 20 mg 1 capsule
· Thiamine 100 mg 1 tablet
· Vitamin B12 500 micrograms (mcg) 2 tablets
· Vitamin D 10 mcg 1 tablet
· Lacosamide 100 mg 1 tablet

Nurse #1 proceeded to crush all the medications together in a plastic pouch and placed all of the crushed medications back into a cup. Nurse #1 reported Resident #66 had sterile water in her room for medication administration.

Nurse #1 mixed approximately 50 milliliters (ml) with the crushed medications in the cup. Nurse #1 proceeded to administer the mixed medications into the G-tube.

When asked about the medication administration procedure, Nurse #1 explained that Resident #66 required sterile water flush of 100 ml before the G-tube feeding and 100 ml after the feeding, and she used the 100 ml to dilute the medications and to dilute the tube feeding. Nurse #1 reported she was not aware the medications for Resident #66 should be crushed and administered individually.

Orders for Resident #66 were reviewed and for the 9:00 AM medication doses included:

F 759

Review Physician□s order and compare the medication unit/dose label against the MAR or EMAR prior to returning the medication container or card to the medication cart or disposing of the empty container. Nurse management will complete Medication Administration skills competency for nurses and medication aides. The education will be provided to new employees as part of new hire orientation, contract staff and agency staff.

Nurse Management will observe medication administration passes on random shifts and carts 3x week for 4 weeks, then 1x week for 2 months and then 1x monthly for 3 months. The Director of Nursing will report on the results of the quality monitoring (audits) to the Quality Assurance Performance Improvement committee. The findings will be reviewed monthly by the Quality Assurance Improvement Committee monthly and audits updated if changes are needed based on findings. The Quality Assurance Improvement Committee meets monthly and as needed.

Date of Compliance: 8/24/2022

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F 759	Continued From page 12	F 759		

· Aspirin 81 mg 1 tablet by G-tube daily ordered 6/11/2022
· Fluoxetine 20 mg 1 capsule by G-tube daily ordered 6/11/2022
· Thiamine 100 mg 1 tablet by G-tube daily ordered 6/11/2022
· Vitamin B12 500 mcg 2 tablets by G-tube daily ordered 6/11/2022
· Vitamin D3 25 mcg 1 tablet by G-tube daily ordered 6/11/2022
· Lacosamide 100 mg 1 tablet by G-tube twice daily ordered 6/10/2022

There were no orders to administer crushed medications together for Resident #66.

B. A medication administration for Resident #66 was conducted on 7/14/2022 at 9:12 AM. Nurse #1 was observed preparing Vitamin D 10 mcg 1 tablet for administration to Resident #66. Nurse #1 administered Vitamin D 10 mcg to Resident #66. The physician orders for Resident #66 were reviewed and an order dated 6/11/2022 ordered Vitamin D3 25 mcg to be administered daily.

Nurse #1 was interviewed on 7/14/2022 at 2:55 PM. Nurse #1 reported she was not aware of she had not administered the correct dosage of Vitamin D to Resident #66. Nurse #1 reported she would contact the physician and report the error.

The Director of Nursing (DON) was interviewed on 7/14/2022 at 3:10 PM. The DON reported Nurse #1 had been very nervous during the medication administration observation. The DON stated she expected for each medication to be administered separately for G-tube medication administration unless there was a physician

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F 759	Continued From page 13 order to administer the medications together. The DON reported she expected nurses to administer medications according to standards and to self-report any errors they made. The Nurse Practitioner (NP) was interviewed on 7/15/2022 at 12:51 PM. The NP stated she was aware G-tube medications should be administered individually, but the administration of medications for Resident #66 that were mixed would not impede the absorption or change the efficacy of the medications.	F 759		
F 919 SS=D	Resident Call System CFR(s): 483.90(g)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area. §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure a call light was functioning for 1 of 6 resident rooms (Room 512) on 1 of 4 halls. The findings included: An observation on 07/11/22 at 11:39 AM revealed call light was activated and the light inside of the room 512 was on. Observation further revealed the light outside of Room 512 was not illuminated. Further observation revealed Room #512 was not illuminated at the nurse's station call light panel	F 919	On 7/13/22 Resident (44) Room 512 was inspected by the Maintenance Director to ensure the bulb outside of the room and the bulb at the nursing station call light panel for room 512 was properly functioning. Both bulbs are properly functioning. On 7/22/22 all other resident call light bulbs outside of the rooms and at both nursing station call light panels were inspected by the Maintenance Director to ensure they are all properly functioning. All bulbs at each location are properly	8/24/22

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F 919

Continued From page 14

and was occupied by Resident #44.

Resident #44 was interviewed at the time of the observation and he indicated there were no concerns with his call light functioning properly.

In an interview on 07/11/22 at 11:42 AM Nurse #1 stated when the resident pressed the call light in the room it would light up outside of the door and at the nurses' station call light panel. She further revealed there were no call lights activated at the doors on the 500 hall at this time. She stated there were also no lights showing up on the nurse call light panel.

An interview and observation on 07/11/22 at 11:50 AM with the Maintenance Director revealed the nurses station call panel for Room #512 was not illuminated. The Maintenance Director stated when the resident pushed the call light it would alert the staff by lighting up outside of the door and at the nurses' station call light panel. He further revealed there was no lights currently activated on 500 hall.

In an interview and observation on 7/11/22 at 11:55 AM with the Maintenance Director in Room #512 revealed light activated in the room. The Maintenance Director removed the cover of the light outside of Room #512 and noted the bulb was blown out. He further revealed the call light system was wired that if something was going on with one room it might affect other rooms. He stated he was responsible for checking the call lights monthly and was unaware Room #512 bulb was out. He further revealed the bulb was also blown out at the nurses' station call panel. He stated there was a maintenance log at each nurse's station and they usually report any issues

F 919

functioning.
Education was provided to the Maintenance Director by the Executive Director to ensure the Maintenance Director knows that the call light bulbs outside of the resident rooms and at both nursing station call light panels must be properly functioning / illuminating.
The facility Maintenance Director will conduct audits using a quality monitoring tool 3 times a week for 4 weeks on 10 residents then 1 time a week for 4 weeks on 10 residents to ensure that all call light bulbs outside of the resident rooms and at both nursing station call light panels are properly functioning / illuminating. Any discrepancies will be brought to the facility Quality Assurance and Performance Improvement committee for further review.
Date of Compliance: 8/24/22

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F 919	Continued From page 15 they become aware of. He further revealed the administrative staff made room rounds everyday and this would have been identified during the rounds this morning. He further revealed the rounds were not made this morning due to surveyors arrival. He stated he was responsible for random audits monthly. An interview with Med Aide #2 on 7/13/22 at 2:32 PM revealed she assisted Resident #44 last week and his call light was functioning. An interview with the Administrator on 7/12/22 at 10:05AM revealed he was made aware the call light bulb outside of Room #512 was not functioning properly yesterday. He stated the administrative staff made daily rounds. He further revealed this should have been identified during the rounding and reported it to the Maintenance Director. He further revealed it was the Maintenance Director responsibility to do monthly audits to ensure call lights were functioning properly. He stated the call lights should be functioning properly.	F 919		