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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 09/26/22 through 09/29/22. The facility was found to be in compliance with CFR 483.73 Emergency Preparedness. Event ID #CNHS11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 09/26/22 through 09/29/22. Event ID# CNHS11. The following intakes were investigated: NC00185039, NC00185134, NC00187145, NC00191443, and NC00192094. 1 of the 20 complaint allegations was substantiated resulting in a deficiency.	F 000		
F 688 SS=D	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.	F 688		10/20/22

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

Electronically Signed | 10/23/2022

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F 688	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to apply bilateral hand splints for 1 of 1 resident reviewed for positioning (Resident # 9). Findings included: Resident #9 was admitted to the facility on 1/27/17 with diagnoses which included in part advanced dementia, Parkinson's disease, and abnormal posture. Review of Resident#9's 7/21/21 Occupational Therapy evaluation revealed resident with impaired range of motion (ROM) of bilateral upper extremities. Review of Resident #9's 8/16/21 Occupational Therapy Discharge Summary revealed resident was to have splint to left hand on at or prior to breakfast, remove after 3-4 hours, splint to right hand donned following removal of left hand, remove after 3-4 hours or per patient's tolerance. Review of Resident #9's physician orders revealed an order dated 12/1/21 for left hand splint on at (or prior to) breakfast, remove after 3-4 hours or per patient tolerance and splint to right hand to be applied following removal of the left-hand splint. Remove right hand splint after 3-4 hours or per patient tolerance. Review of Resident #9's care plan revealed a 12/28/21 focus which indicated resident had an activity of daily living (ADL) self-care performance deficit related to dementia, mobility impairments, and limited range of motion (ROM) with	F 688	Resident #9 has orders for splint to left hand on at or prior to breakfast, remove after 3-4 hours, splint to right hand donned following removal of left hand, remove after 3-4 hours or per patient□s tolerance. Resident #9 has not had splints applied as ordered. Resident #9 was evaluated by Occupational Therapy on 10/18/22 to ensure that current splints remain appropriate for resident. All residents with splint orders have the potential to be affected by this practice. An audit of current residents with orders for splints will be conducted by the Assistant Director or Nursing to assess compliance by 10/21/22. Nursing staff will be re-educated on complying with splint orders by the Staff Development Nurse, Director of Nursing, Assistant Director of Nursing, or Administrator. The education will be complete by 10/23/22. New staff members will be educated by the Staff Development Nurse. Beginning the week of 10/23/22, an audit will be conducted weekly for 12 weeks on a minimum of three random residents per week with splint orders to ensure compliance by the Assistant Director of Nursing. The Assistant Director of Nursing will report findings to the Quality Assurance Performance Improvement	

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F 688	Continued From page 2 contractures in the bilateral upper and lower extremities. Interventions included to apply splint to left hand on, at or prior to) breakfast, remove after 3-4 hours or per patient's tolerance and right-hand splint to be applied following removal of left-hand splint. Remove after 3-4 hours or per patient's tolerance. Review of Resident #9's 6/23/22 quarterly minimum data set (MDS) assessment revealed resident had severe cognitive impairment, required total assistance with bed mobility, transfers, toileting and eating. Resident #9 had impaired range of motion (ROM) on both sides of her upper and lower extremities. An observation of Resident #9 on 9/26/22 at 11:30 AM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm and under her fingers. Splints were observed on nightstand in room. An observation of Resident #9 on 9/27/22 at 2:10 PM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm tucked under the other fingers. Splints were observed on the nightstand in Resident #9's room. An observation of Resident #9 on 9/28/22 at 08:30 AM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm tucked under the other fingers. Splints were observed on the nightstand in Resident #9's room.	F 688	Committee monthly for 3 months and based on the findings determine if additional follow up is required. The Director of Nursing is responsible for this Plan of Correction with alleged compliance effective 10/24/22.	

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An observation of Resident #9 on 09/28/22 at 01:03 PM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm under the other fingers. Splints were observed on the nightstand in Resident #9's room.

An observation of Resident #9 on 09/29/22 at 09:12 AM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm under the other her fingers. Splints were observed on the nightstand in Resident #9's room.

An observation of Resident #9 on 09/29/22 at 12:26 PM revealed no splints were applied. Resident #9 was observed with both hands contracted with left hand tightly closed with thumb across palm and under her fingers. Splints were observed on nightstand in Resident #9's room.

An interview was conducted on 09/27/22 at 2:10 PM with Nursing Assistant (NA) #4. NA #4 stated that she worked with Resident #9 regularly. NA #4 stated Resident #9 had not been wearing the splints for a while. NA #4 stated Resident #9's left hand contracture is worse than her right. NA #2 stated that Resident #9's left thumb stays in over her palm and it was not possible to stretch any of her fingers to extend them.

An interview was conducted on 9/28/22 at 8:54 AM with the Rehab Manager. The Rehab Manager stated that when a resident was placed on a splinting program, therapy provided copies of the information regarding the splint to the Minimum Data Set (MDS) Nurse, the Director of

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F 688	Continued From page 4 Nursing (DON) and the Unit Manager. The Rehab Manager stated she was not informed of any changes or problems with the current splint or schedule for Resident #9. An interview was conducted on 09/28/22 at 4:33 PM with Unit Manager #1. Unit Manager #1 stated that no one had reported that Resident #9 had not been wearing the splints. Unit Manager #1 stated the NA assigned to Resident #9 was responsible for applying the splints daily. An interview was conducted on 09/29/22 at 02:19 PM with the Administrator. The Administrator revealed that her expectation is that splints be applied as ordered to all residents.	F 688		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interview, and physician interview, the facility failed to safely transfer a resident from the bed to a wheelchair by not using a mechanical lift for 1 of 1 resident (Resident #78) reviewed for accidents. A staff member transferred Resident #78 from the bed to a wheelchair using stand and pivot with one person assistance resulting in Resident #78 being lowered to the floor. Resident	F 689	Resident #78 was being transferred via a pivot transfer with one person assist instead of using a Hoyer lift with 2 attendants on 8/28/22. During the attempt to pivot transfer, the resident was lowered to the floor as the resident was not able to assist with sliding herself from the edge of the chair. The nursing assistant indicated she did not check the Kardex prior to the	10/20/22

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F 689	Continued From page 5 #78 later experienced pain and swelling to the left leg and was transferred to the emergency department where x-rays confirmed a proximal tibia and fibula fracture of the left lower extremity. Findings included. Resident #78 was admitted to the facility on 07/19/17 with diagnoses to include osteoporosis, cerebral vascular accident, and hemiplegia. The Minimum Data Set (MDS) quarterly assessment dated 07/27/22 revealed Resident #78 was cognitively intact and required extensive two-person assistance with bed mobility, and transfers, and extensive one person assistance with activities of daily living. Resident #78 had impaired range of motion on one side and used a wheelchair for mobility. She had no falls prior to the assessment. A care plan dated 07/29/22 revealed Resident #78 was at risk for falls related to deconditioning, gait and balance problems, incontinence, osteopenia, impaired vision, and history of falls. The goal of care was to be free of falls. Interventions included to anticipate needs, keep call light within reach, ensure appropriate footwear when out of bed, keep bed in low position, and physical therapy to evaluate and treat as ordered. A revision to the care plan revealed on 08/27/22 Resident #78 experienced a fall. Further review of the care plan details regarding the risk of falls revealed Resident #78 was to use the mechanical lift for transferring as indicated effective 03/06/22. A nursing progress note documented by Nurse #9 revealed on 08/27/22 at 2:00 PM she was notified	F 689	transfer. Resident did not present with any obvious injury and denied any pain at the time of the incident, but due to swelling and discomfort of the left leg resident was sent to the hospital and admitted on 8/29/22 with a mildly displaced fracture of the proximal tibial with mildly displaced fracture of the proximal fibula. The resident readmitted to the facility on 8/31/22 with non- weight bearing to the left leg with an immobilizer and ortho follow up. The Nursing assistant involved in the transfer was provided 1:1 education on how to use the Kardex to identify residents that need mechanical lift for transfers and that two people were always required with use of lifts. This education was provided by Director or Nursing on 8/29/22. All residents that require a mechanical lift are at risk to be affected by this practice The Director of nursing, Rehab program manager, and the lead MDS nurse reviewed all current residents to identify those that require Mechanical lifts for transfers. The care plan and Kardex of these residents were reviewed to validate the use of the mechanical lift was specified. This will be completed by 10/21/22. Current nursing assistants, medication aides, licensed nurses, therapists, and department managers received education on how to access the Kardex to review when a resident is to have a lift for transfers and to always use two people	

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by the nurse aide (#5) that during transfer from the bed to chair the resident (#78) was lifted from the bed and placed on the edge of the wheelchair seat. The resident was unable to slide herself back in the wheelchair so the nurse aide told the resident she would have to sit her on the floor because she was unable to pull her back in the chair. The nurse aide explained what happened to this nurse, so this nurse went to the residents room and the resident reported to this nurse that she did not fall to the floor and did not complain of any pain. Resident was put back in the bed by nurse and nurse aide. No apparent distress noted to resident. Will continue to monitor.

A change of condition note documented by Nurse #9 dated 08/28/22 at 5:00 PM revealed this nurse noted swelling bruising and scratches to residents (#78's) left lower leg. Resident reported to this nurse her "leg was hurt on the side of bed". Resident given PRN (as needed) Tylenol for pain. The Director of Nursing (DON) was made aware, will continue to monitor.

An x-ray report dated 08/28/22 for Resident #78 revealed a left hip x-ray was obtained and indicated no acute displaced fracture or dislocation. Left knee x-ray revealed no evidence of acute fracture or dislocation.

A nursing progress note documented by Nurse #10 dated 08/29/22 at 7:42 PM revealed resident (78's) left knee had increased redness and hot to touch with swelling. Called physician on call, sent resident out to the Emergency Department (ED) for possible broken leg. Family notified.

Review of the hospital summary revealed Resident #78 was admitted on 08/29/22 and

with use of lift. This education will be completed by 10/23/22 by the Staff Development Nurse, Director of Nursing, Assistant Director of Nursing, and Administration. Education on how to access the Kardex to review when a resident is to have a lift for transfers will be part of new employee orientation by the Staff Development Nurse.

Beginning 10/23/22 a monitoring tool will be used to document random audits on a minimum of five residents weekly for 12 weeks. The audit will include the staff□s ability to access the Kardex and to identify residents that require lift for transfers are on the Kardex. This audit will be conducted by the Director of Nursing, Assistant Director of Nursing or the Staff Development Nurse. Education will be provided if indicated from the random audits.

The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for 3 months and based on the findings determine if additional follow up is required.

The Director of nursing will ensure compliance effective 10/24/22.

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discharged 08/31/22 with diagnoses of displaced fracture of left tibia and fibula. The hospital course of stay revealed Resident #78 presented to the ED on 08/28/22 with left leg deformity after a fall while transferring from her wheelchair to her bed. In the ED, vital signs were stable. CT (computed tomography) of the left lower extremity showed a mildly displaced fracture of the proximal tibial with mildly displaced fracture of the proximal fibula. Recommendation of conservative management in the form of a knee immobilizer and bed to chair transfers. Will facilitate return to the long-term care facility. At this time, non-weightbearing on the left lower extremity until further healing allows for weightbearing in 8 to 12 weeks.

A resident encounter note documented by the Medical Director dated 08/31/22 revealed resident (#78) was transferred to the emergency room with a left lower extremity deformity, hematoma, and pain. CT of her left lower extremity showed a mildly displaced fracture of the proximal tibial and fibula. She was evaluated by orthopedics who recommended conservative management with a knee immobilizer and bed to chair transfers. She was discharged no weightbearing on the left lower extremity for at least 8-12 weeks. Once the patient was stable, she returned to us to continue long-term care. She will continue the knee immobilizer and no weightbearing for the next 12 weeks.

The Kardex (resident care guide) for Resident #78 dated September 2022 revealed mechanical lift for transfers.

An interview was conducted on 09/27/22 at 02:00 PM with Resident #78. She was alert and

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oriented to person and place. She stated she could not recall exactly what happened the day she fell but stated she remembered falling on her leg. She stated there was only one nurse aide assisting her when she fell on the floor. She stated it was an accident and the nurse aid did not intentionally make her fall. She stated she didn't recall how often staff used the mechanical lift before her injury but stated now they used the mechanical lift to move her from the bed to wheelchair. She stated she still wore a knee immobilizer and had ongoing pain in her left leg, but the pain was relieved with pain medication.

A phone interview was conducted on 09/27/22 at 04:32 PM with Nurse Aide #5. She stated she was new to the facility and was Resident 78's assigned nurse aide the day of the incident. She stated she went to get the resident up and into her chair and she was told by other staff that Resident #78 could stand and pivot to the chair. She stated she had the resident on the side of the bed and put the wheelchair by the bed to pivot her, she stated she then grabbed the residents pants and got her in the chair, but the resident was on the edge of the wheelchair seat, and she could not slide herself back and the nurse aide could not slide her back in the wheelchair. She stated she told the resident she was going to lower her to the floor. She stated once she lowered the resident to the floor, she leaned the resident against the bed while she went to get the nurse. She stated the resident had no complaints of pain or discomfort at that time. She stated the nurse (Nurse #9) came in and they both manually assisted the resident back to bed. She stated the resident ended up telling someone later that she fell. She stated she was told by the Staff Development Coordinator that she should have

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checked the residents Kardex (resident care guide) because she required the mechanical lift for transfers. She stated she just started working in the facility in August 2022 and was not trained on the Kardex and she was not aware the residents care guide was on there. She stated she was educated on using the Kardex and using the mechanical lift after the incident. She stated she went back in the residents room after the incident and the resident was sitting up watching tv and she asked if she had pain, and the resident stated no.

An interview was conducted on 09/28/22 at 09:45 AM with Nurse Aide #6. She stated she was consistently assigned to Resident #78 and was familiar with her care. She stated she was not working the weekend of the incident and could not provide details but stated Resident #78 required two-person assistance with the mechanical lift for transfers prior to her fall. She stated the residents care guide (Kardex) which was located in the electronic medical record included how the resident should be transferred and stated Resident #78 used the mechanical lift for transfers. She stated at one time therapy worked with the resident on using the sliding board for transfers, but Resident #78 did not progress with that and continued to need the mechanical lift for transfers. She stated Resident #78 could not bear weight well prior to the fracture and had right sided deficits from a history of strokes.

An interview was conducted on 09/28/22 at 10:00 AM with Nurse Aide #7. She stated she was the assigned nurse aide for Resident #78 today and stated she required the mechanical lift for transfers with two-person assistance.

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An interview was conducted on 09/28/22 at 10:15 AM with Nurse #11. She stated she was the assigned nurse for Resident #78 today. She stated Resident #78 had a history of strokes and required the mechanical lift for transfers. She stated she was not working the weekend of the fall but stated the resident had required use of the mechanical lift for months. She stated therapy worked with her months ago and worked on using the sliding board but stated the resident did not do well with it and it was safer to use the mechanical lift for transfers.

An interview was conducted on 09/28/22 at 10:45 AM with the Physical Therapy Assistant. She stated Resident #78 required maximum assistance with transfers meaning she needed full assistance by staff to transfer. She stated Resident #78 was able to hold herself up on the side of the bed and was able to squat and pivot last year around December 2021 - January 2022. She stated therapy worked with her using the slide board at one time, but she did not progress due to weakness and continued needing the mechanical lift. She stated in August 2022 Resident #78 required the mechanical lift for transfers.

A phone interview was conducted on 09/28/22 at 11:02 AM with Nurse #9. She stated she was the assigned nurse for Resident #78 on the day of the fall. She stated she just started working in the facility in August 2022 and that was her first weekend working. She stated the incident occurred over the weekend on a Saturday day shift. She reported the nurse aide (#5) reported to her that she lowered resident (#78) to the floor after trying to transfer her to the wheelchair. She

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F 689	Continued From page 11	F 689		

stated she was pivoting her from the bed to chair and got her to the chair and she couldn't slide back so she lowered the resident to the floor. The nurse assessed her and stated she thought the resident was able to stand up enough to pivot and slide herself back into the chair. She stated she thought the resident wasn't using the mechanical lift prior to the incident. She stated that she and the nurse aide (#5) manually lifted the resident from the floor and assisted her back to bed and the resident had no complaints of pain. She stated she worked a 12 hour shift that day and when she got back to work the next morning on Sunday the night nurse reported the resident had pain. She stated she also observed on Sunday that the resident had scratches on her legs, so she called the DON and explained to her that now she had scratches on the side of her leg. She stated she was not the nurse that placed the order for x-rays but stated when she left her shift Sunday evening at 7:00 PM the resident had no complaint of pain at that time.

An interview was conducted on 09/28/22 at 3:00 PM with the Rehab Director. She stated Resident #78's baseline on 03/30/22 was maximum assistance with two-person assistance for sit to stand or squat pivot transfers from bed to wheelchair. She stated during therapy she progressed however at the time of discharge from therapy she did not meet her goals and was not progressing and required moderate to maximum assistance at discharge. She stated moderate to maximum assistance meant the resident needed assistance by staff and stated the resident could have declined since the last therapy session on 03/30/22 so she could not say what her level of function was at the time of the fall.

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F 689	Continued From page 12 An interview was conducted on 09/28/22 at 4:00 PM with the DON. She stated prior to the injury she thought staff was saying Resident #78 could transfer by stand and pivot without the mechanical lift. She stated the nurse aides were trained in orientation to review the residents Kardex to determine how to transfer residents and were trained on using the mechanical lift. She stated the nurse aide should have reviewed the residents Kardex before transferring her to determine how she should have been transferred. A phone interview was conducted with the physician on 09/28/22 at 4:16 PM. She stated when she last saw Resident #78 prior to the fall she could move her arms and legs. She stated she could not answer what the residents transfer status was at the time of the fall.	F 689		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records 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	F 755		10/20/22

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F 755	Continued From page 13 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, observation and interviews with staff and the physician, the facility failed to acquire and administer omeprazole, a medication used to treat gastroesophageal reflux disorder, for Resident #91 during medication pass observation on 9/28/22 at 8:30 AM. The facility also failed to administer the medication omeprazole for Resident #91 for a period of 6 days for 1 of 3 residents whose medications were reviewed. Findings included: Resident #91 was admitted to the facility on 8/21/20 with medical diagnoses which included in part dementia, hypertension, gastroesophageal reflux disorder, and long-term use of an anticoagulant. Review of Resident #91's medical record revealed a7/12/21 physician order for omeprazole delayed release capsule 20 milligrams give one capsule by mouth one time per day for	F 755	Resident #91 omeprazole was omitted for a period of six days. The physician was made aware of the omitted medications on 9/27/22 by the Director of Nursing on resident #91, no new orders were received. A medication variance report was completed by the Director of Nursing on 9/27/22. The resident did not have any ill effects related to the omission of medications. The licensed nurse that did not give the omeprazole was provided 1:1 in servicing on 9/27/22 that omeprazole was available as it was a stock medication. All residents on omeprazole have the potential to be affected. An audit was conducted on current residents on omeprazole and the medication was available on the medication cart for all residents. This audit was conducted on 9/28/22 by the Director of Nursing.	

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F 755	Continued From page 14 gastroesophageal reflux disorder. Review of Resident #91's September 2022 Medication Administration Record (MAR) revealed that omeprazole was not administered and was charted by Nurse #8 as "see Nurses Notes" code 4 on the following dates: 9/19, 9/20,9/21, 9/22, 9/23, 9/24, 9/25, 9/27, 9/28. Review of Resident #91's nurses notes revealed notations regarding pharmacy was to be called regarding medication omeprazole. Review of Resident #91's September 2022 MAR revealed that on 9/28/22 omeprazole was charted by Nurse #8 as not administered and will follow up with pharmacy. An observation of Resident #91's medication administration on 700 Hall was conducted on 9/28/22 at 8:30 AM with Nurse # 8. The ordered omeprazole for Resident #91 was not observed in the medication cup with the other scheduled morning medications. The ordered omeprazole for Resident #91 was not observed on the medication cart and was not administered. An interview with Nurse #8 was conducted on 9/28/22 at 8:45 AM. Nurse #8 stated the omeprazole tablet for Resident #91 was not on the medication cart and she would follow up with the pharmacy. Nurse #8 stated she did not know why the medication omeprazole was not available. An interview was conducted on 09/28/22 at 04:18 PM with Unit Manager #1. Unit Manager #1 stated that the pharmacy was to be called for a medication if not available or check the Omnicell, the machine in the facility that contained	F 755	Licensed nurses and medication aides were educated by the Director of Nursing that omeprazole is a stock medication. Education was also provided to the licensed nurses and medication aides of the protocol to follow for any medication that is not available. This education included a review of the current stock medications and the medications that are available in the Omnicell. Any medication that is deemed not available requires MD notification with a mediation variance report and notification to the Director of Nursing. This education was completed on 9/27/22. Beginning the week of 10/23/22, an audit will be conducted weekly for 12 weeks to review the medication administration record for omissions on residents that receive omeprazole. An audit will be conducted weekly for 12 weeks to validate Omeprazole is available on the medication cart and in the medication supply room. The director of nursing will report findings to the quality assurance performance improvement committee monthly for 3 months and based on the findings determine if additional follow up is required. The Director of nursing is responsible for this Plan of correction with alleged compliance of 10/24/22.	

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F 755	Continued From page 15	F 755		

emergency medication doses. Deliveries of medications from the pharmacy were received daily. The pharmacy required a prior authorization form to be completed for Resident #91's insurance for the medication omeprazole. Unit Manager #1 further stated that each month she had to call the pharmacy to obtain the medication omeprazole for Resident #91 after it was reordered. Unit Manager #1 stated she would follow up with the pharmacy regarding the prior authorization form for Resident #91.

An interview was conducted on 9/28/22 at 4:50 PM with the physician for Resident #91. The physician revealed that she was not informed of omeprazole not being available for Resident #91. The physician stated Resident #91 should not experience any adverse effects from not receiving omeprazole as ordered for a few days.

An interview was conducted on 9/28/22 at 5:15 PM with the Director of Nursing (DON). The DON revealed that the nurse was to call the pharmacy and the physician if a medication was not available on the med cart. DON further stated that a medication was not to be omitted due to not available.

A follow up interview was conducted on 09/29/22 at 11:05 AM with the DON. The DON stated she was aware a prior authorization form was required by the pharmacy for the medication for Resident #91, but she did not know the status of the form for his current reorder. The DON stated she would follow up regarding the prior authorization form for Resident #91. The DON stated she had completed education with Nurse #8, a new nurse, regarding obtaining medications.

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F 755	Continued From page 16 An interview was conducted on 09/29/22 at 02:18 PM with the Administrator. The Administrator revealed that her expectation is that all residents receive medications as prescribed and there will be no omissions of medications due to not available.	F 755		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview the facility failed to perform accuchecks to obtain blood sugar readings and administer the scheduled Lispro insulin 5 units along with Lispro sliding scale insulin on 3 occasions (9/21/22, 9/22/22, and 9/23/22) and failed to administer scheduled Lispro insulin 5 units and Lispro sliding scale insulin on 1 occasion (09/27/22) for a blood sugar reading of 305 mg/dl (milligrams per deciliter) for 1 of 2 residents reviewed for insulin administration (Resident #247). Findings included. Resident #247 was admitted to the facility on 09/08/22 with a diagnoses of diabetes, and long-term use of insulin. A physician's order dated 09/08/22 revealed Insulin Lispro Solution 100 units/ml (milliliter). Inject 5 units subcutaneously three times a day for diabetes. Take before meals.	F 760	The facility did not perform accuchecks to obtain blood sugar readings and administer the scheduled lispro insulin along with lispro sliding scale on 3 occasions (9/21/22, 9/22/22 and 9/23/22). The facility did not administer lispro insulin 5 units and Lispro sliding scale on one occasion on 9/27/22. The Medical Doctor was informed of the insulin and FSBS omissions 9/27/22 by the Director of Nursing. No new orders were received. A medication variance report was completed on 9/27/22 by the Director of nursing. The resident had no adverse effects due to the insulin and FSBS omissions. The Medication aide and the licensed nurse responsible for these omissions were provided 1: 1 education related to following the Medical Doctor orders for blood sugar readings and the insulin administration by the Director of Nursing on 9/27/22: monitor resident and continue with next scheduled blood glucose check.	10/20/22

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F 760	Continued From page 17 A physician's order dated 09/08/22 revealed Insulin Lispro Solution 100 units/ml per Sliding Scale. Inject subcutaneously before meals for diabetes and long-term use of insulin. A care plan dated 09/09/22 revealed Resident #247 had diabetes. The goal of care was the resident would have no complications related to diabetes. Interventions included to administer diabetes medications as ordered, and to perform fasting serum blood sugars as ordered. A review of the Medication Administration Record (MAR) dated September 2022 for Resident #247 revealed to Administer 5 units of Lispro insulin three times a day. The scheduled administration times were 8:00 AM, 12:00 PM, and 4:00 PM. Further review of the MAR revealed on 09/21/22, 09/22/22, and 09/23/22 at 12:00 PM each day Nurse #11 documented NA (not applicable) for the 12:00 PM scheduled dose of 5 units of Lispro insulin. Review of the MAR dated September 2022 for Resident #247 revealed Lispro Insulin inject per sliding scale: for blood sugars of 150 - 200 give 2 units, 201 - 250 give 4 units, 251 - 300 give 6 units, 301 - 350 give 8 units, 351 - 400 give 10 units. Call physician for blood sugars greater than 400. The scheduled administration times were 7:30 AM, 11:30 AM, and 4:00 PM. Further review of the MAR revealed on 09/21/22, 09/22/22, and 09/23/22 no blood sugar was recorded for the 11:30 AM reading each day and no documentation that Lispro sliding scale insulin was administered to Resident #247 at 11:30 AM.	F 760	All residents that have orders for blood sugars and insulin have the potential to be affected by this practice. The Medication administration records were audited on 9/27/22 of the residents that had insulin and blood sugar orders by the Director of Nursing. Any omissions were discussed with the Medical Doctor and no new orders were required. All licensed nurses and medication aides received education that following the medical doctor orders for Accuchecks, sliding scale insulin and scheduled insulin is required. Licensed nurses and medication aides were provided education that medication aides will not be assigned to do the accuchecks effective 10/19/22, but the licensed nurse assigned to the medication aide will be responsible for the accuchecks and insulin administration. This education was completed by the Director of Nursing on 10/19/22. This will be part of orientation for all new hires. Beginning the week of 10/23/22, an audit will be conducted weekly for 12 weeks to review the Medication administration record for omissions on residents with accucheck and insulin orders. The Director of Nursing will report findings to the quality assurance performance improvement committee monthly for 3 months and based on the findings determine if additional follow up is required.	

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F 760	Continued From page 18 During the survey on 09/27/22 at 2:30 PM further review of the MAR revealed no documentation of the 11:30 AM blood sugar reading for today 09/27/22 and no documentation of administration of Lispro 5 units at 12:00 PM and no sliding scale insulin was documented as administered. An interview was conducted on 09/27/22 at 2:33 PM with Nurse #11. She stated CMA #1 (certified medication aide) was the person that checked Resident #247's blood sugar at 11:30 AM today with a result of 305 mg/dl. She stated she did not recall CMA #1 reporting to her to administer sliding scale insulin to Resident #247. She stated Resident #247 never received her lunchtime (11:30 AM) dose of Lispro insulin 5 units or any sliding scale insulin today. She stated she was orienting a new nurse and was the nurse in charge of CMA #1 and stated she was busy and had not had the chance to go administer the resident's lunchtime dose of Lispro insulin. She stated it was an oversight. Nurse #11 also stated she was the assigned nurse to Resident #247 on 09/21/22, 09/22/22, and 09/23/22. She stated she documented NA on the residents MAR because she never gave the Lispro 5 units of insulin to Resident #247 for the lunchtime (11:30AM) dose on those dates. She stated her lunchtime (11:30 AM) blood sugar was not checked until after 4:00 PM on those dates so the 12:00 PM dose of Lispro 5 units was never given and stated no sliding scale insulin was administered at 11:30 AM on those dates because the blood sugars were not checked at the scheduled time. She stated it was an error on her part. An interview was conducted on 09/27/22 at 2:43 PM with CMA #1. She stated she checked	F 760	The Director of Nursing is responsible for this Plan of correction with alleged compliance of 10/24/22.	

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Resident #247's blood sugar at 11:30 AM today which resulted in 305. She stated she usually checked all blood sugars on her assignment then when done with her medication pass, she would tell the nurse unless the blood sugar was high then she would report to the nurse right away. She stated she thought she had reported Resident 247's blood sugar reading of 305 to the nurse earlier today.

A follow up interview was conducted on 09/27/22 at 3:00 PM with Nurse #11. She stated she just informed the physician of the missed insulin dose today and was instructed not to cover Resident #247 at this time since it was so late and to be sure to administer the dinner time insulin.

An interview was conducted on 09/27/22 at 3:05 PM with Resident #247. She was lying in bed with her eyes closed. She was easily aroused and was alert and oriented. She stated she could not remember if she received any lunchtime insulin and stated she felt okay today.

An interview was conducted on 09/27/22 at 3:14 PM with the Director of Nursing (DON). She stated there needed to be better communication between the nurse and the CMA. She stated if Nurse #11 was getting behind with her assignment she would be expected to reach out and let someone know that she needed help. She stated typically the CMA collected the blood sugars and notified the nurse at that time to administer the insulin. She stated Resident #247's blood sugars should have been checked on the dates it was omitted, and insulin should be administered as ordered.

An interview was conducted on 09/27/22 at 4:24

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F 760	Continued From page 20 PM with the Administrator. She stated she was made aware of the missed doses of insulin. She stated blood sugars should be checked and insulin administered as ordered. A phone interview was conducted on 09/28/22 at 4:30 PM with the physician. She stated Resident #247 not getting the lunchtime blood sugars checked and Lispro insulin not administered on 3 occasions and not getting sliding scale coverage for a blood sugar reading of 305 was a medication error. She indicated not getting the ordered insulin could potentially cause Resident #247 harm due to the resident's blood sugar fluctuations.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		10/20/22

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F 761	Continued From page 21 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with staff, the facility failed to 1) record an opened date for 5 bottles of eye drops, remove an expired insulin pen and date a bottle of Humalog insulin when opened for 2 of 3 medication carts (East Wing and 700 hall). 2) failed to keep unattended medications stored in a locked medication cart for 1 of 4 medication carts observed (400 hall medication cart). Findings included: 1) Observation of East Wing Medication Cart on 9/27/22 at 1:22 PM with Nurse #1 in attendance revealed the following bottles of ophthalmic drops with no opened dates: Resident #299's Travoprost , Resident #299's Alphagan, Resident #80's Brimonidine, and Resident #80's Latanoprost 0.005%. A bottle of Refresh tears was observed in the drawer of the medication cart with Room 501 B and Resident #20's name written on it and no opened date. An opened and accessed multi use vial of Humalog insulin for Resident #302 was observed in the medication cart with no opened date or discard date recorded. Interview conducted on9/27/22 at 1:30 PM with Nurse #1 revealed that insulin and eye drops should be labeled with an opened date. Observation of the 700 Hall Medication Cart on	F 761	The facility failed to record an opened date for 5 bottles of eye drops, remove an expired insulin pen and date a bottle of Humalog insulin. The facility failed to keep unattended medications stored in a locked medication cart on 1 of 4 carts. The medications identified were removed from the cart at the time they were identified on 9/27/22. The licensed nurse responsible for the unlocked medication cart was provided 1:1 education on 9/27/22 by the Director of Nursing regarding ensuring the medication cart was always locked if not attended. All residents have the potential to be affected by this practice. No residents suffered any ill effects related to this practice. An audit of all medication carts was completed on 9/27/22 by the Director of Nursing and the Staff development nurse to be sure there were no expired or undated eye drops and insulin. Any identified concerns were immediately corrected. An in service was initiated on 9/27/22 by the Staff Development Nurse regarding securing the medication carts when unattended and to ensure eye drops and	

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F 761	Continued From page 22 9/27/22 at 3:37 PM with Nurse #2 in attendance revealed the following: Resident #47's opened bottle of Fluorometholene eye drops with no opened and no discard date, and Resident #18's Novolog insulin pen with a "beyond use date" sticker with the date recorded as 9/12/12 and no opened date recorded. Interview conducted on 09/27/22 at 03:35 PM with Nurse #2 revealed that bottles of eye drops, and Insulin should always be dated when opened. She further revealed that it was important to label the bottles with the date, so you know when they were to be discarded. Nurse #2 stated that the date recorded as the beyond use date of 9/12/2012 on Resident #18's Novolog insulin pen was invalid and therefore it should have been discarded. Nurse #2 stated she thought audits of the medication carts were completed but she did not know when or by whom. Interview conducted on 09/27/22 at 03:40 PM with Nurse #3 revealed that the date when opened should have been recorded on the bottles of eye drops and insulin. Nurse #3 stated that Resident #18's Novolog insulin pen should have been discarded due to the invalid beyond use date recorded. Interview conducted on 9/28/22 at 4:22 PM with Unit Manager #1 revealed that she had been in the position a few months. Unit Manager #1 further revealed that she and Unit Manager #2 completed monthly medication cart audits to check for labels and expired medications. Interview conducted on 9/28/22 5:15 PM with the Director of Nursing (DON) revealed that nursing staff were expected to date insulin and bottles of	F 761	insulins are dated appropriately and discarded if expired. Current licensed nursing staff and medication aides will receive this education by the Staff Development Nurse by 10/23/22. New hires will receive education related to labeling and storage of eye drops, insulin and ensuring medication carts are locked when not attended. Beginning the week of 10/23/22, all medication carts will be monitored 5x weekly by licensed nurses for 12 weeks. This audit will ensure all medication carts have no expired or undated insulins or eye drops and that the medication cart was secured if not in attendance. Any identified areas of concern will be addressed with retraining immediately. The Director of Nursing will present findings of the audits to the QAPI committee for three months to determine if additional audits/training are required. The Director of nursing will be responsible for ensuring compliance as of 10/24/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345234	A. BUILDING _____ B. WING _____	C 09/29/2022

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F 761	Continued From page 23 eye drops when opened. The DON acknowledged that the insulin pen and insulin vial were not dated properly and should have been discarded. The DON further stated that audits of the carts were to be completed but there was no ongoing monitoring regarding medication labeling and storage. 2) An observation of an unattended medication cart (400 Hall medication cart) was made on 09/27/22 at 4:05 PM. The medication cart was located in a common area near the nurse's station. The cart was noted to be unlocked without a staff member present at the cart or at the nurse's station. During the observation period staff members were observed coming out of the locked unit and walking by the unlocked medication cart. An interview was conducted with Nurse #4 on 09/27/22 at 4:10 PM. She stated she was the assigned nurse for the 400 hall and was responsible for the 400-hall medication cart. She acknowledged the medication cart was unlocked when she returned to the cart. She stated she left the medication cart to go check a resident's blood sugar and forgot to lock it. She stated it was an oversight on her part and stated she usually locked the cart before leaving it unattended. An interview was conducted with the Director of Nursing on 09/27/22 at 5:00 PM. She stated the nurse was responsible for keeping the medication cart locked and secured when unattended. She indicated Nurse #4 should have made sure the medication cart was locked before leaving it unattended.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities	F 867		10/20/22

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F 867	Continued From page 24 CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions put into place following the 7/19/21 recertification and complaint investigation survey and the 9/8/21 revisit survey. This was for a recited deficiency in the area of Label/Store Drugs and Biologicals (F761). The continued failure of the facility during three federal surveys of record demonstrated a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F761: Based on observation and interviews with staff, the facility failed to record an opened date for 5 bottles of eye drops, remove an expired insulin pen and date a bottle of Humalog insulin when opened for 2 of 3 medication carts (East Wing and 700 hall). The facility also failed to secure/lock an unattended medication cart for 1 of 4 medication carts. During the 7/19/21 recertification and complaint investigation survey the facility was cited for failing to: a) dispose of a bottle of aspirin with an	F 867	The facility has had repeat deficiencies in label and storage of biologicals. All residents have the potential to be affected by this practice. The facility held an Adhoc Quality assurance process improvement (QAPI) meeting with the committee on 10/19/22 to develop the plan for improvement in this area. The committee included additional licensed nurses in the discussion for the improvement plan. The QAPI committee will meet more frequently than the required quarterly meeting, meeting will be monthly. The monthly meeting will focus on the label and storage of biologicals. The facility will conduct the audits for at least 12 weeks and not decrease the auditing frequency due to the repeated survey findings. The customer service liaison with pharmacy and the pharmacist will be involved in the monthly meeting. The results from the audits on medication storage and labeling will be discussed in detail at the monthly QAPI plan. The QAPI	

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F 867	Continued From page 25 illegible expiration date on the bottle, insulin pens, and unidentified loose pills in the medication cart; and b) secure an unattended medication cart. During the 9/8/21 revisit survey the facility was cited for failing to: a) discard expired bulk stock medication and insulin pens; and b) put an opened date on an opened insulin pen. An interview with the Administrator on 9/29/22 at 2:16 PM revealed that the expectation was that medications be labeled and stored appropriately. The Administrator stated that further education of the nursing staff and monitoring was needed.	F 867	plan will be adjusted according to the results and success of the plan implemented. The Administrator is responsible for the execution of this plan with compliance date of 10/24/22.	