STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345159	A. BUILDING _____ B. WING _____	C 11/10/2022

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LINCOLNTON REHABILITATION CENTER	1410 EAST GASTON STREET LINCOLNTON, NC 28092

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted 11/07/22 through 11/10/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# XEGJ11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/07/22 through 11/10/22. Event ID# XEGJ11. The following intakes were investigated NC00181969, NC00184660, NC00187373, NC00188416, NC00189115, NC00189438, NC00189892, NC00190904, NC00192426, NC00192806, NC00193253 and NC00193606. Two of the twenty-one complaint allegations were substantiated resulting in a deficiency.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, and staff interview, the facility failed to assess (Resident #251) to determine if self-administration of medication was clinically appropriate when medication was observed to be handed to the resident (Resident #251) and medications left at the resident's bed side table (Resident #31) for 2 of 2 residents reviewed for self-administration. The findings included:	F 554	Preparation and/ or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. 1) Residents affected by this deficient	12/9/22

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

Electronically Signed | 12/09/2022

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F 554	Continued From page 1 1. Resident #251 was admitted to the facility on 10/26/22. Resident #251's admission Minimum Data Set (MDS) dated 11/02/22 revealed she was alert and oriented requiring extensive assistance of one staff member for most activities of daily living (ADL). Resident #251's physician orders were reviewed and did not reveal an order to self-administer medication. Resident #251's care plan review revealed she was not care planned for self-administering medication. On 11/09/22 at 9:22 AM an observation was conducted of Resident #251 coming to the medication cart to ask Nurse #6 for her eye drops. Resident #251 stated she needed to go ahead and take them because she had a physician's appointment. Nurse #6 proceeded to remove the residents artifical tears (over the counter eye drops used to lubricate the eye) eye drops from the medication cart and hand them to Resident #251 saying "here". Resident #251 was observed self-administering the eye drops with the liquid running down her face, off her chin and onto her clothing. Resident #251 was observed using the sleeve of her jacket to wipe her face. An interview was conducted on 11/10/22 at 9:12 AM with Nurse #6. During the interview she stated Resident #251 could not self-administer her own medication and did not have orders to do so.	F 554	practice: On 11/9/2022, Nurse #6 was provided immediate education by the Director of Nursing (DON) on the requirements of resident self-administration. Additionally, education was provided concerning medication administration with the requirement of observing residents taking their medications and not leaving medications at the bedside. On 12/6/2022, Resident #31 and Resident #251 were asked if they wanted to self-administer any of their medications and the residents declined. 2) Residents with potential to be affected by the deficient practice: On 12/6/2022, residents who are cognitively intact with a Brief Interview Mental Status (BIMS) of 13-15 were interviewed by the Director of Nursing /or designee regarding their desire to self-administer medication. Any resident who desired self-administration of medication were evaluated by the Unit Manager. Based upon these interviews and/or evaluations, no residents in the facility currently met the criteria to self-administer medications or/ did not desire to self-administer medications. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: All Licensed Nurses were provided education by the Director of Nursing and/or Staff Development Coordinator (SDC) related to the policy and procedure	

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F 554	Continued From page 2 An interview conducted on 11/10/22 at 2:17 PM with the Director of Nursing (DON) revealed no resident in the facility had orders to self-administer their medication. She stated when a resident approached a nurse on the medication cart, she expected the nurse on duty to administer the medication to the resident. The DON stated if a resident were to request to self-administer their medication, they would need to sign a form prior to doing so. The interview revealed Resident #251 was unable to self-administer her medication. 2. Resident #31 was admitted to the facility on 10/24/22. Resident #31's admission Minimum Data Set (MDS) dated 10/24/22 revealed she was alert and oriented requiring extensive assistance of one staff member for most activities of daily living (ADL). Resident #31's physician orders were reviewed and did not reveal an order to self-administer medication. Resident #31's care plan review revealed she was not care planned for self-administering medication. On 11/09/22 at 9:40 AM an observation was conducted of Nurse #6 removing Resident #31's medication from the medication cart and placing the pills into a cup. Nurse #6 then entered the resident's room and handed the cup of pills to Resident #31. Resident #31 was then observed turning the cup of medication upside down and pouring them out onto her bedside table. Nurse #6 was observed walking out of the resident's	F 554	for medication storage (not leaving medication unattended at the bedside) and self-administration of medication. This education was completed by 12/09/2022. All new employees will receive education by the SDC on the facility policy and procedure for medication storage and self-administration of medication as part of the orientation process. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur: The Staff Development Coordinator or/designee will perform medication administration observations for three (3) Licensed Nurses weekly for twelve (12) weeks. The results of these audits will be submitted to the QAPI Committee by the DON monthly for 3 months. The Quality Assurance Committee will reevaluate the need for further monitoring beyond the (3) months. 5) This was completed by 12/9/2022.	

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F 554	Continued From page 3 room and stepping back out to the medication cart in the hallway. Resident #31 was observed by the surveyor taking all of the medication that were given to her by Nurse #6. Resident #31's physician orders were reviewed and did not reveal an order to self-administer medication. An interview was conducted on 11/10/22 at 9:12 AM with Nurse #6. During the interview she stated Resident #31 did not have orders to self-administer her medication. Nurse #6 stated she did not feel like it was an issue to leave Resident #31 with her medication and step back out into the hallway to the medication cart. She stated she felt like she could see the resident from the hallway if anything were to go wrong. An interview conducted on 11/10/22 at 2:17 PM with the Director of Nursing (DON) revealed no residents in the facility had orders to self-administer their medication. She stated she expected the nurses on the medication carts to administer the resident's medication and remain in the room with the resident until they take all the medication that was ordered. The DON stated if a resident were to request to self-administer their medication, they would need to sign a form prior to doing so.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		12/13/22

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F 561	Continued From page 4 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to honor preferences to get out of bed and into their chair for 2 of 3 residents (Resident #5 and Resident #74) reviewed for choices. The findings included: 1. Resident #5 was admitted to the facility on 08/09/2021 and readmitted on 12/03/21 with diagnoses which included congestive heart failure, hypertension, arthritis, and muscle weakness among others.	F 561	Preparation and/ or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. 1) Residents affected by this deficient practice: On 12/07/2022, Resident #5 had a care plan meeting with the Director of Nursing	

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F 561	Continued From page 5 Review of Resident #5's annual Minimum Data Set (MDS) assessment dated 10/10/22 revealed she was cognitively intact with no behaviors. The assessment also revealed she required extensive assistance of 2 staff with mechanical lift for transfers. Review of Resident #5's care plan dated 10/10/22 revealed a focus area for activities of daily living (ADL) self-care deficit related to generalized weakness, and arthritis. The interventions included transfers with 2 persons assist and mechanical lift. An observation and interview on 11/07/22 at 11:51 AM revealed Resident #5 lying in bed with clothes on and head of bed elevated. Resident #5 stated she had not gotten up on Friday or over the weekend as requested because the Nurse Aides (NAs) assigned to her didn't want to get her up. Resident #5's roommate agreed with her that she had asked to get up but had not been gotten up as requested. Attempted a phone interview on 11/08/22 at 1:30 PM with NA #3 who had been assigned to Resident #5 on Friday, 11/04/22, and left voicemail with request for return call. An interview with NA #3 on 11/10/22 at 10:48 AM revealed she had been assigned to care for Resident #5 on Friday, 10/04/22. She stated Resident #5 had requested to get up but said she was unable to get her up until after lunch. NA #3 went in to get her up later in the afternoon and the resident no longer wanted to get up and told NA #3 she would just wait until Monday to get up out of bed.	F 561	and Social Worker. This meeting included establishing plan of care preferences related to when resident wants to be out of bed and most appropriate schedule for them. All preferences were care planned by the Minimum Data Set (MDS) Nurse. On 12/07/2022, Resident #47 had a care plan meeting with the Director of Nursing and Social Worker. This meeting included establishing plan of care preferences related to when resident wants to be out of bed and most appropriate schedule for them. All preferences were care planned by the Minimum Data Set (MDS) Nurse. 2) Residents with potential to be affected by the deficient practice: On 12/07/2022, interviews were conducted by the Director of Nursing and Social Services Director with interviewable residents. These interviews were to identify any other residents that may be affected by preferences as it relates to out of bed routine. After interviews were completed, it was determined that resident preferences for getting up are being followed. As applicable, resident care plan were updated by the MDS Nurse to reflect preference for out of bed routine. On 12/13/2022 the facility Social Worker, Director of Nursing, Administrator and/or designee completed interviews with responsible parties related to preferences and timing of out of bed routines for all residents who are non-interviewable. As applicable, resident care plan Minimum	

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F 561	Continued From page 6 A phone interview on 11/08/22 at 1:32 PM with NA #1 revealed he had worked over the weekend on the hall Resident #5 resided but stated he had not been assigned to the resident but said she was on NA #2's assignment. NA #1 could not recall NA #2 asking him for assistance in getting Resident #5 out of bed over the weekend. Received return call on 11/08/22 at 2:41 PM from NA #2 who stated she had been assigned to care for Resident #5 over the weekend of 11/05/22 and 11/06/22. NA #2 stated she was not able to get Resident #5 up in the chair because it took 3 people to get her up and the other NA (NA #1) working on the hall was not able to assist until later in the afternoon. NA #2 stated by the time NA #1 was available to assist in getting the resident out of bed she was no longer interested in getting up. NA #2 stated she had not asked the nurse assigned to the resident (who was an agency nurse) to assist with getting the resident up. Attempted a phone interview on 11/08/22 at 3:00 PM with the agency nurse assigned to Resident #5 over the weekend on 11/05/22 and 11/06/22 but was unable to leave voicemail for return call. An interview with Nurse #1 on 11/10/22 t 10:05 AM revealed she was assigned to Resident #5 on a routine basis 3 days a week. She stated if Resident #5 requested to get out of bed into her chair when she was working, she made sure the NAs assigned to her got her up. Nurse #1 further stated it didn't take 3 people to get her up but sometimes it was safer with 3 people. She indicated if 3 people were needed the nurse could always step in and assist with getting the resident out of bed into her chair.	F 561	Data Set (MDS) nurse to reflect preference for out of bed routine. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: The Social Services Director provided education all Nursing Staff on ensuring resident preferences are honored. An emphasis was placed upon ensuring follow through of resident#s request to get out of bed. This was completed by 12/09/2022. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur: Beginning 12/09/2022 , interviews will be conducted with cognitively intact residents with a BIMS of 13-15 to assess whether preferences are honored including requests to get out of bed. The Social Services Director or/designee will be conducting these interviews with (5) residents weekly for 12 weeks. The results of these audits will be submitted to the QAPI Committee by the Administrator monthly for 3 months. The Quality Assurance Committee will reevaluate the need for further monitoring beyond the (3) months. 5) This was completed by 12/13/2022.	

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F 561	Continued From page 7	F 561		

An interview with NA #4 on 11/10/22 at 10:30 AM revealed she was assigned to care for Resident #5 sometimes and stated she was able to get the resident up with 2 people and the mechanical lift. NA #4 stated she had not complained about not being able to get up when she had taken care of the resident because if she requested to get up, she got her up in the chair.

An interview with the Director of Nursing (DON) on 11/10/22 at 2:09 PM revealed if Resident #5 requested to get out of bed she would have expected the NAs and nurse to have assisted the resident in getting up into her chair. The DON stated if it took 3 people to get the resident up the nurse could have assisted the NAs in getting her up to her chair.

2. Resident #74 was admitted to the facility on 04/11/22 with diagnoses which included joint replacement surgery, hypertension, recurrent dislocation of left shoulder, cellulitis left lower extremity and muscle weakness.

Review of Resident #74's quarterly Minimum Data Set (MDS) assessment dated 09/01/22 revealed she was cognitively intact with no behaviors. The assessment also revealed Resident #74 required extensive assistance of 2 people with mechanical lift for transfers.

Review of Resident #74's care plan dated 09/01/22 revealed a focus area for activities of daily living (ADL) self-care deficit related to limited mobility due to shoulder fracture and wound vac. The interventions included transfers with 2 persons assist and mechanical lift.

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An observation and interview on 11/07/22 at 11:41 AM revealed Resident #74 lying in bed with clothes on and head of bed elevated with left leg elevated up on a pillow. Resident #74 stated she had not gotten up on Friday or over the weekend as requested because the Nurse Aides (NAs) assigned to her didn't want to get her up. Resident #74's roommate agreed with her that she had asked to get up but had not been gotten up as requested.

Attempted a phone interview on 11/08/22 at 1:30 PM with NA #3 who had been assigned to Resident #74 on Friday, 11/04/22, and left voicemail with request for return call.

An interview with NA #3 on 11/10/22 at 10:48 AM revealed she had been assigned to care for Resident #74 on Friday, 10/04/22. She stated Resident #74 had requested to get up but said she was unable to get her up until after lunch. NA #3 went in to get her up later in the afternoon and the resident no longer wanted to get up and told NA #3 it was too late now, and she would just wait until tomorrow to get up out of bed.

A phone interview on 11/08/22 at 1:32 PM with NA #1 revealed he had worked over the weekend on the hall Resident #74 resided but stated he had not been assigned to the resident but said she was on NA #2's assignment. NA #1 could not recall NA #2 asking him for assistance in getting Resident #74 out of bed over the weekend.

Attempted a phone interview with NA #2 who had been assigned to Resident #74 over the weekend on 11/05/22 and 11/06/22 and left voicemail with request for return call.

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F 561	Continued From page 9 Received return call on 11/08/22 at 2:41 PM from NA #2 who stated she had been assigned to care for Resident #74 over the weekend of 11/05/22 and 11/06/22. NA #2 stated she had not gotten Resident #74 up in the chair because she was not aware the resident wanted to get out of bed. Attempted a phone interview on 11/08/22 at 3:00 PM with the agency nurse assigned to Resident #74 over the weekend on 11/05/22 and 11/06/22 but was unable to leave voicemail for return call. An interview with Nurse #1 on 11/10/22 t 10:05 AM revealed she was assigned to Resident #74 on a routine basis 3 days a week. She stated if Resident #74 requested to get out of bed into her chair when she was working, she made sure the NAs assigned to her got her up. An interview with NA #4 on 11/10/22 at 10:30 AM revealed she was assigned to care for Resident #74 sometimes and stated she was able to get the resident up with 2 people and the mechanical lift. NA #4 stated she had not complained about not being able to get up when she had taken care of the resident because if she requested to get up, she got her up in the chair. An interview with the Director of Nursing (DON) on 11/10/22 at 2:09 PM revealed if Resident #74 requested to get out of bed she would have expected the NAs and nurse to have assisted the resident in getting up into her chair.	F 561		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that:	F 607		12/9/22

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F 607	Continued From page 10 §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interviews, the facility failed to report an allegation of abuse to local law enforcement for 1 of 3 residents reviewed for staff to resident abuse (Resident # 29). Findings included: A review of the facility policy and procedure titled "Abuse and Neglect Prohibition", with a revised	F 607	Preparation and/ or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws.	

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F 607	Continued From page 11 date of August 30, 2022, read in part "each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion, exploitation, and misappropriation of property." The "Investigation" section specified in part: 2. The center will make referrals to the appropriate state agencies as necessary, to ensure the protection of the resident or resident's property. Review of the facility initial allegation report dated 12/30/21 at 4:00 PM the facility became aware that Resident #29 alleged Nurse Aide (NA) # 4 had beaten Resident #29's arm against the iron bars on the bed. The report further revealed the facility did not report allegations of abuse to law enforcement. An interview conducted with the Director of Nursing (DON) on 11/10/22 at 1:55 PM revealed she was not aware the facility had not reported allegations of possible abuse to law enforcement. The DON further revealed per facility policy law enforcement should have been contacted. An interview conducted with the Administrator on 11/10/22 at 2:45 PM revealed he had handled this investigation and had failed to report to law enforcement because he felt that APS was handling the investigation. The Administrator further revealed he expected for allegations of abuse to be reported to the appropriate agencies.	F 607	1) Residents affected by this deficient practice: An investigation was initiated on 12/30/21 by the Administrator into the accusations of Resident #29. Investigation concluded that allegation was unsubstantiated. Resident #29 did not have any negative impact from the facility not contacting the police. 2) Residents with potential to be affected by the deficient practice: On 11/30/22, a review of the last 30 days of reportable events (abuse allegations) requiring police notification was conducted by the Corporate # Clinical Director. One reportable related to an allegation of abuse was identified during this look-back period. The police were notified of this abuse allegation. No issues were identified during this review. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: On 12/02/2022 education on abuse investigation and reporting was conducted by the Vice President of Operations with the facility Administrator and the DON who acts as back up. An emphasis was placed upon notification of appropriate state agencies with any allegation of abuse. This includes notifying the the police. Beginning 12/12/2022, the Vice President of Operations or/designee will review all	

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F 607	Continued From page 12	F 607	allegations of abuse (reportable) for the next three (3) months to ensure notification of police. Review findings will be shared with the facility Administrator for proper follow-up (as applicable). 4) How the corrective actions will be monitored to ensure the deficient practice will not recur: Monthly for a minimum of three (3) months, the Administrator will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months. 5) This was completed by 12/9/2022.	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review, family interview, staff interview and Nurse Practitioner interview the facility failed to prevent a medication error for 2 of 3 Residents reviewed for medication errors (Resident # 195 and Resident #40). Resident#195 a non-diabetic was administered 35 units of insulin glargine (a long-acting insulin)	F 760	Preparation and/ or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions	12/9/22

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F 760	Continued From page 13 in error by Nurse #7. Resident #40 a diabetic, was administered the incorrect dosage of 55 units of Levemir (a long-acting insulin) in addition to her prescribed evening insulin in error by Nurse #5. The findings included: 1. Resident #195 was admitted into the facility on 03/04/22 with diagnosis which included hypertension and end stage renal disease. Resident #195 did not have a diagnosis of diabetes mellitus. Resident #195's admission Minimum Data Set (MDS) dated 03/10/22 revealed she was moderately cognitively impaired requiring extensive assistance of one staff member for most activities of daily living (ADL). Resident #195 was coded as not receiving insulin. Resident #195's physician orders dated March 2022 revealed no active orders for insulin. Review of Resident #195's March 2022 Medication Administration Record (MAR) revealed no active orders for insulin glargine. A nursing progress note dated 03/08/22 at 5:06 AM written by Nurse #7 revealed she had made a medication error by administering Resident #195 35 units of insulin glargine, a long-acting insulin. The note revealed Nurse #7 notified the on-call provider who advised her to observe the resident and monitor her blood glucose levels. Nurse #7 encouraged Resident #195 to drink a supplement. Resident #195 was noted to be sitting in the bed watching television with no signs of hypoglycemia (low blood sugar).	F 760	are prepared and /or executed in compliance with State and Federal laws. 1) Residents affected by this deficient practice: Resident #195 did not have a negative impact related to Nurse #7 administering 35 units of insulin to her in error. Resident #195 blood sugars were monitored as per physician order and blood sugars remained stable. Resident #40 did not have a negative impact related to Nurse #5 administering 55 units of insulin in error. Resident #40 blood sugars were monitored as per physician order and blood sugars remained stable. 2) Residents with potential to be affected by the deficient practice: All residents in the facility are at risk of receiving medications in error when Licensed Nurses do not follow the facility medication administration policy which includes the #5# rights of medication administration which includes confirming right resident, right drug, right dose, right route, and right time. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: Education was provided to all Licensed Nurses by the Staff Development Coordinator (SDC) concerning the medication administration policy with emphasis on the five #5# rights of	

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F 760	Continued From page 14 A nursing progress note dated 03/09/22 at 5:21 AM revealed Resident #195's blood glucose level was 99 (normal range 90-100). A second nursing progress note revealed at 7:00 AM Resident #195's blood glucose level was 147. An interview was conducted on 11/08/22 at 3:38 PM with Nurse #7. Nurse #7 stated when she had obtained the insulin two Nurse Aides were at the cart talking to her and she became distracted. She stated she administered 35 units of long-acting insulin to Resident #195 by mistake because the resident had no orders for insulin and was not a diabetic. She stated she immediately knew she had administered the medication to the wrong resident and notified the on-call provider who instructed her to monitor Resident #195. The interview revealed she was a agency nurse and was not familiar with the residents. She stated she notified the family and Director of Nursing. An interview conducted on 11/10/22 at 11:26 AM with the Nurse Practitioner revealed she was not working in the facility at the time of the incident but stated the administration of insulin to a non diabetic resident was a significant medication error. She stated there was no harm or negative outcome from the review of her chart because her blood glucose levels remained within normal range of 80-100. The NP stated the lowest documented blood glucose level was 99. She stated Nurse #7 had informed the on-call provider on the date of the incident and was advised to monitor the resident for any signs of hypoglycemia. An interview conducted with the Director of	F 760	medication administration which includes confirming the right resident, right drug, right dose, right route, right time prior to medication administration. This was completed on 12/9/2022 This education will be included in new hire orientation for Licensed Nurses. The facility□s consultant pharmacist will perform medication administration observations with (3) Licensed Nurses monthly for (3) months. Any medication variances will be addressed and re-education provided by the SDC or Director of Nursing (DON). 4) How the corrective actions will be monitored to ensure the deficient practice will not recur: The facility SDC will perform medication administration observations with three (3) Licensed Nurses weekly for twelve (12) weeks. Any medication variances will be addressed, and re-education provided by the SDC or Director of Nursing (DON). Monthly for a minimum of three (3) months, the Director of Nursing will report completed audit results to the Quality Assurance and Performance Improvement Committee. The Quality Assurance and Performance Improvement Committee will review the audits to make recommendations to ensure compliance is sustained ongoing; and determine the need for further auditing beyond the three months.	

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F 760	Continued From page 15 Nursing on 11/10/22 at 2:17 PM revealed she expected for each resident to receive the correct medication ordered by the physician. The interview revealed she did not recall the incident with Resident #195, but the facility had completed an incident report and had a in-service after the incident. 2. Resident #40 was admitted to the facility on 12/20/21. Diagnoses included type 2 diabetes, heart failure, and dementia. Review of the annual Minimum Data Set (MDS) dated 10/08/22 revealed Resident #40 was severely cognitively impaired, diagnosed with diabetes, and receiving insulin medication. Review of Resident #40's revised care plan dated 09/17/22 revealed Resident #40 was at risk for altered endocrine system status related to diabetes. Care plan goal stated Resident #40 will have no complications related to altered endocrine system through next review. Interventions included medications and treatments as ordered, monitor for hyperglycemia, and monitor for hypoglycemia. Review of physician order dated 03/30/22 revealed Resident #40 was prescribed Lantus SoloStar Solution Pen-injector 100 UNIT/ML (Insulin Glargine) inject 20 units subcutaneously at bedtime for diabetes. Review of nursing note written by Nurse #5 dated 10/15/22 revealed Nurse #5 realized she had administered 55 units of Levemir insulin by injection at 9:00 PM to Resident #40 and then realized the day shift nurse had administered	F 760	5) Completed on 12/9/2022	

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Resident #40 her scheduled evening dose of 20 units of Lantus insulin by injection prior at 6:20 PM. Nurse #5 contacted on-call physician services and spoke with on-call nurse practitioner who ordered blood sugar checks for Resident #40 every 4 hours for 24 hours and if Resident #40 sugar drops below 70 administer oral glucose with food and if non-responsive administer glucagon (prevents blood sugar from dropping too low). Nurse #5 administered 240 cc of house supplement at med pass and Resident #40 had eaten 100% of sandwich provided. Nurse #5 would continue to monitor.

Review of Resident #40 incident report written by Nurse #5 dated 10/15/22 revealed description of incident, blood sugar monitored and observed for hypo or hyperglycemia, no injuries observed at time of incident, and physician notified.

Unable to obtain interview with Nurse #5 due to being on leave of absence and incorrect contact information.

Review of recorded blood sugars dated 10/15/22, 10/16/22, and 10/17/22 revealed stable blood sugars for Resident #40 with no issues.

An interview was conducted with on-call Nurse Practitioner (NP) on 11/09/22 at 3:08 PM revealed she recalled receiving a telephone call after hours about Resident #40 receiving too much long-acting insulin. She stated she instructed the nurse who called to monitor Resident #40 blood sugars every 4 hours for 24 hours and if blood sugar drops lower than 70 give oral glucose with food and if non-responsive to that treatment administer glucagon and call on-call services if any further issues.

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An interview conducted with the Unit Manager on 11/09/22 at 3:26 PM revealed she was familiar with Resident #40 and of the incident where she was administered too much insulin. She stated on the day of the incident, the first shift nurse had administered Resident #40 her ordered insulin of 20 units of Lantus and signed off in the electronic chart. The Unit Manager revealed the second shift nurse on the day of the incident, administered Resident #40 55 units of insulin prescribed for another resident. She stated the second shift nurse had only been working at the facility for two days and had gotten the room numbers confused and immediately realized her mistake and contacted the on-call physician and received treatment instructions. The Unit Manger stated she had been made aware on Monday following the incident and immediately contacted the managed care provider for Resident #40 and spoke with Resident #40's responsible person. She revealed Nurse #5 should have contacted Resident #40's responsible person and managed care provider when the incident occurred and was immediately educated on notification protocol, medication pass policy and procedure, and the 5 resident rights. The Unit Manager stated since the incident all nursing staff had been educated on notification protocol and who should be notified and time frames, medication pass policies and procedures, and 5 resident rights.

An interview was conducted with facility Nurse Practitioner (NP) on 11/10/22 at 11:26 AM revealed she had been informed of Resident #40 receiving too much long-acting insulin. She stated she considered insulin a significant medication and when too much insulin had been administered the resident could have been at risk

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F 760	Continued From page 18 for hypoglycemia (blood sugar level lower than standard level). An interview was conducted with Director of Nursing (DON) on 11/10/22 at 2:19 PM revealed she was familiar with Resident #40 and the incident where she had been administered too much insulin. She stated all residents should have received correct medications as ordered and nursing staff should be administering the correct medications to residents. The DON revealed all nursing staff has since been educated on medication pass policy and procedures and 5 resident rights.	F 760		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at	F 867		12/9/22

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§483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

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F 867	Continued From page 20 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its	F 867		

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F 867	Continued From page 21 activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation survey of 3/11/21. This was for one deficiency that was originally cited in March 2021 in the area of infection prevention and control and was subsequently recited on the current recertification survey of 11/10/22. The continued failure of the facility during two federal surveys of record shows a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referred to: F 880: Based on observations, record review, and staff interviews, the facility failed to perform hand hygiene after removing a dirty dressing with drainage on it and before cleansing the wound with normal saline soaked gauze for 1 of 3 residents (Resident #22) reviewed for wound care.	F 867	Preparation and/ or execution of this plan of correction in general, or this corrective action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. The facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the re-certification and complaint investigation survey of 3/11/21. On 3/11/21, the facility was cited F880 infection control related to proper use of personal protective equipment. The facility subsequently was cited F880 infection control related to hand washing/hygiene on the re-certification survey on 11/10/22. On 11/8/22, the facility failed to implement the Hand Washing/Hygiene policy when the Treatment Nurse failed to perform hand hygiene after removing a dirty	

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F 867	Continued From page 22 During the recertification and complaint investigation survey completed on 3/11/21, the facility failed to implement their infection control policies and the Centers for Disease Control and Prevention (CDC) guidelines for the use of Personal Protective Equipment (PPE) when 2 of 6 staff members on the quarantine hall did not wear a mask while providing care to 1 of 10 residents reviewed for infection control and did not wear a gown and gloves when entering 1 of 10 resident rooms on the quarantine hall. These failures occurred during a COVID-19 pandemic. A interview was conducted on 11/10/22 at 2:36 PM with the Administrator. He stated the quality assurance meeting was held quarterly in the facility and they discussed infection control and prevention at each meeting. The interview revealed staff members consistantly received in-service training on infection control yearly and on a routine basis. The interview revealed staff would need re-education on infection control practices.	F 867	dressing with drainage on it and before cleansing the wound with normal saline for 1 of 3 residents (Resident #22) reviewed for wound care. 1) Residents affected by this deficient practice: Resident #22 was not negatively impacted by this deficient practice. The facility Director of Nursing (DON) provided immediate education to the Treatment Nurse on 11/8/22 on the facility policy related to hand-washing/hygiene. 2) Residents with potential to be affected by the deficient practice: All residents are at risk for a communicable disease when staff fail to follow the facility infection control policies. 3) What measures will be put into place and what systemic change will be made to prevent re-occurrence: On 12/09/2022, the Corporate- Clinical Director conducted education with the Quality Assurance Performance Improvement (QAPI) Committee on F867 with emphasis on ensuring sustained compliance when deficient practice has been identified and corrected. The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. Education was initiated utilizing Centers	

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F 867	Continued From page 23	F 867	for Disease Control (CDC) # interactive education titled #Hand Hygiene & Other Standard Precautions to Prevent Healthcare-Associated Infections#. This education was provided to all staff by the Infection Prevention Control Officer. This education was completed on 12/09/2022 Education related to hand-washing/hygiene will be included in new hire orientation for all newly Licensed Nurses and Nurse Aides. 4) How the corrective actions will be monitored to ensure the deficient practice will not recur: Beginning 12/09/2022, random facility tours for staff adherence to infection control guidelines will be completed by the Infection Prevention Control Officer, Director of Nursing, or designee to ensure compliance. These facility tours will occur across all shifts including weekends. An infection control rounding tool will be utilized to perform the tours. Facility tours will be conducted daily x five (5) days for two (2) weeks, three (3) times weekly for two (2) weeks, then weekly for eight (8) weeks, then monthly for three (3) months. Audits to be completed by 04/28/2023. The results of all facility tours will be submitted to the QAPI Committee by the DON monthly for six (6) months. These finding will be reviewed for trends to determine if further monitoring and/or education is needed beyond the six (6) months. A review of audit findings will be conducted by the Corporate- Clinical	

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	345159	A. BUILDING _____ B. WING _____	C 11/10/2022

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F 867	Continued From page 24	F 867	Director or Vice President of Operations monthly or (3) months during QAPI meeting. Recommendations will be mad (as applicable) to ensure the facility sustains substantial compliance. 5) This was completed by 12/9/2022	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or	F 880		12/9/22

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F 880	Continued From page 25 infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to perform hand	F 880	Preparation and/ or execution of this plan of correction in general, or this corrective	

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F 880	Continued From page 26 hygiene after removing a dirty dressing with drainage on it and before cleansing the wound with normal saline soaked gauze for 1 of 3 residents (Resident #22) reviewed for wound care. The findings included: The facility's policy entitled; Hand Washing/Hygiene last revised on 06/05/19, under Policy read in part, "This facility considers hand hygiene the primary means to prevent the spread of infections and provides guidance to perform hand hygiene. This policy is in accordance with national standards from the Centers of Disease Prevent and Control and the World Health Organization." Under the section of Procedure, it read in part, "Alcohol-based hand rub may be used for all other hand hygiene opportunities (e.g., when soap and water is not indicated). According to the World Health Organization, hand hygiene is to be performed: c. When moving from a contaminated body site to a clean body site such as when changing a brief or wound dressing." An observation of wound care by the Treatment Nurse was made on 11/08/22 at 2:03 PM. The Treatment Nurse was observed washing her hands with soap and water and donning clean gloves. The resident was lying on his left side with his wound visible on his back side. The Treatment Nurse removed the old dressing which had a moderate amount of serous drainage on the dressing. She then reached for her normal saline soaked gauze and proceeded to clean the wound without washing her hands and changing her gloves. After cleansing the wound the Treatment Nurse doffed her gloves, washed her	F 880	action, does not constitute an admission of agreement by this facility of the facts alleged or conclusion set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and /or executed in compliance with State and Federal laws. Based on record reviews, observations and staff interviews, the facility failed to implement the Hand Washing/Hygiene policy when the Treatment Nurse failed to perform hand hygiene after removing a dirty dressing with drainage on it and before cleansing the wound with normal saline for 1 of 3 residents (Resident #22) reviewed for wound care. Resident #22 was not negatively impacted by this deficient practice. The facility Director of Nursing (DON) provided immediate education to the Treatment Nurse on 11/8/22 on the facility policy related to hand-washing/hygiene. On 12/2/2022, a root cause analysis was conducted by the Quality Assurance and Performance Improvement (QAPI) Committee utilizing the #5# whys concept to establish the root cause of the deficient practice. The QAPI Committee members involved in conducting the root cause analysis was the facility Administrator, Director of Nursing (DON), Infection Control Prevention Officer (IPCO), Medical Director, Staff Development Coordinator (SDC), Unit Manager(s) and the Corporate # Clinical Director. Residents with potential to be affected by	

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F 880	Continued From page 27 hands and donned new gloves to apply the calcium alginate with silver (highly absorbent dressing that forms gel like covering over the wound to help maintain a moist environment to promote wound healing) to the wound and applied a foam border gauze over the alginate. An interview on 11/08/22 at 3:23 PM with the Treatment Nurse revealed she had not washed or cleansed her hands and changed her gloves after removing the old dressing and before cleansing the wound with normal saline soaked gauze. She stated she should have washed or cleansed her hands after removing the old dressing and before cleansing the resident's wound. The Treatment Nurse further stated it was an oversight. An interview on 11/10/22 at 12:37 PM with the Infection Preventionist (IP) revealed the Treatment Nurse should have doffed her gloves after removing the old dressing and washed her hands and donned new gloves prior to cleansing the wound. The IP stated any time a nurse went from a dirty to a clean procedure they needed to wash their hands and don new gloves prior to starting the clean procedure. An interview on 11/10/22 at 2:12 PM with the Director of Nursing (DON) revealed she expected the nurse to clean her hands and don new gloves when moving from a dirty to a clean procedure. The DON stated the Treatment Nurse had been re-educated on infection control principles.	F 880	the deficient practice: All residents are at risk for a communicable disease when Nursing Staff fail to follow the facility hand hygiene policy. What measures will be put into place and what systemic change will be made to prevent re-occurrence: To ensure residents and staff are protected from communicable disease the following corrections will be made: Education was performed utilizing Centers for Disease Control (CDC) # interactive education titled #Hand Hygiene & Other Standard Precautions to Prevent Healthcare-Associated Infections#. This education was provided to all Licensed Nurses and Nurse Aides by the Infection Prevention Control Officer. This education was completed on 12/09/2022. To validate completion of required hand hygiene education, an attestation statement was completed by the Infection Control Prevention Officer on 12/09/2022. Education related to hand-washing/hygiene will be included in new hire orientation for all newly Licensed Nurses and Nurse Aides. How the corrective actions will be monitored to ensure the deficient practice will not recur: Beginning 12/05/2022 facility tours for adherence to hand hygiene guidelines will be completed by the Infection Prevention Control Officer or Director of Nursing to ensure compliance. Facility tours will be conducted daily x five (5) days for two (2)	

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F 880	Continued From page 28	F 880	weeks, three (3) times weekly for two (2) weeks, then weekly for eight (8) weeks, then monthly for three (3) months. Audits to be completed by 05/26/2023. Beginning 11/10/2022 wound care observations will be conducted by the facility Infection Prevention Control Officer or Staff Development Coordinator to validate hand hygiene compliance. These wound care observations will be conducted with two (2) Licensed Nurses weekly for twelve (12) weeks then monthly for 3 months. Audits to be completed by 04/28/2023. The results of all hand hygiene compliance audits will be submitted to the QAPI Committee by the DON monthly for six (6) months. These finding will be reviewed for trends to determine if further monitoring and/or education is needed beyond the six (6) months. 5) This was completed by 12/9/2022	