STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345270	A. BUILDING _____ B. WING _____	C 01/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE GREENS AT SPRUCE PINES	218 LAUREL CREEK COURT SPRUCE PINE, NC 28777

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation and COVID-19 Focused Infection Control survey were conducted on 01/18/2023 through 01/25/2023. A total of 15 allegations were investigated and 5 were substantiated: NC00197417, NC00197294, NC00196138, NC00195450. Intake #NC00196138 resulted in immediate jeporady. Event ID #0IJK11. Immediate Jeopardy was identified at: CFR 483.24 at tag F580 at a scope and severity K. CFR 483.24 at tag F755 at a scope and severity K. CFR 483.24 at tag F760 at a scope and severity K. The tag F760 constituted Substandard Quality of Care. Immediate Jeopardy began on 12/11/2022 and was removed 1/20/2023. A partial extended survey was conducted.	F 000		
F 580 SS=K	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		1/25/23

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

Electronically Signed | 02/08/2023

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F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Physician Assistant (PA), and Medical Director (MD) interviews, the facility failed to notify the physician when two medications, an intravenous (IV) antibiotic and an antiarrhythmic medication (a medicine used to treat irregular heartbeat) were unable to be delivered to the facility and failed to notify the physician when the medications were unable to be administered. Resident #1 missed three doses of the IV antibiotic and four doses of the antiarrhythmic medications after admission to the facility. Additionally, the facility failed to notify the physician when Resident #1 missed three additional doses of the IV antibiotic due to the antibiotic being unavailable. This was for 1 of 3 sampled residents reviewed for notification (Resident #1). By not receiving these medications there was the high likelihood for bacterial regrowth, sepsis, resistance to antibiotic, heart arrhythmias and/or return to hospital. Immediate jeopardy began on 12/11/22 when the facility failed to notify the physician when two medications (an intravenous antibiotic and antiarrhythmic medication) were unable to be administered to Resident #1. Immediate jeopardy was removed on 01/20/23 when the facility implemented an acceptable credible allegations of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put into place are effective. Findings included:	F 580	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and executed because it is required by the provisions of federal and state law. F 580 Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed, Bacteremia and atrial fibrillation. From December 11 through December 21, 2022, facility failed to ensure an ordered IV antibiotic to treat sepsis for Resident #1 was available for 6 of the 42 ordered administrations and failed to ensure an antiarrhythmic medication was available for 4 missed doses for Resident #1 *Resident #1 was at risk of suffering from the deficient practice placing him at increased risk for rehospitalization, however showed no adverse outcome as a result of non-compliance. Resident had planned discharge to home on 12/22/2022 and continued his Cefazolin IV antibiotic with a stop date of 12/28/22.	

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F 580	Continued From page 3 Review of hospital discharge summary physician order dated 12/10/22 revealed an order for Cefazolin Sodium-Dextrose Solution 2-4 Grams (GM)/100Milliliters (ML)-% (antibiotic used to treat bacterial infection). Use 100 ML intravenously every 8 hours for bacteremia for 18 days. Review of hospital discharge summary physician order dated 12/10/22 revealed an order for Flecainide Acetate Tablet 100 milligrams (MG) (medication used to prevent irregular heartbeat). Give 1 tablet by mouth two times a day for atrial fibrillation (A-fib). Resident #1 was admitted to the facility on Sunday, 12/11/22 with diagnoses to include bacteremia due to methicillin susceptible staphylococcus, chronic atrial fibrillation, and diabetes. Interview conducted with Nurse #1 on 01/19/22 at 12:20 PM revealed she confirmed Resident #1's medication orders and sent the orders electronically to the pharmacy on 12/11/22. Nurse #1 stated she was aware Resident #1 did not have his IV antibiotic and antiarrhythmic medication available upon admission and would not receive them until the following day, Monday (12/12/22). Nurse #1 stated she did not notify the physician about Resident #1's medications not being available upon admission or any missed doses on 12/11/22. Review of Medication Administration Record (MAR) for December 2022 revealed Resident #1 was to receive the following: " Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100ML intravenously every 8 hours (6AM, 2PM, 10PM) for bacteremia for 18	F 580	*All other residents prescribed medications are also at risk from suffering from the deficient practice. On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and orders for the audit of 1/19/23. " Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete 0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining all medications from pharmacy, the utilization of the stat safe (an electronic emergency/stat dose medication cabinet), the process of obtaining back up services from pharmacy, and the requirement to notify the DON and Physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy. On 01/18/2023, the DON educated all	

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F 580	Continued From page 4 days starting 12/10/22. Resident #1 was not administered doses on 12/11/22 at 10 PM, 12/12/22 at 6AM, 12/12/22 at 2PM, 12/19/22 at 2PM, 12/19/22 at 10PM, and on 12/20/22 at 6AM due to being on order from pharmacy and not available at facility. " Flecainide Acetate Tablet 100 milligrams (MG). Give one tablet by mouth two times daily (8AM, 8PM) for atrial fibrillation (A-fib) starting 12/10/22. Resident #1 was not administered doses on 12/11/22 at 8PM, 12/12/22 at 8AM, 12/12/22 at 8PM, and 12/13/22 at 8AM due to being on order from pharmacy and not available at facility. Review of Resident #1's electronic medical record and physician correspondence notebook revealed there was no documentation of the physician being notified of Resident #1's missed medication doses or medications not being available at facility. A telephone interview was conducted with Nurse #2 on 01/19/23 at 5:45 PM revealed when she arrived at work on 12/11/22 for her 6:30PM to 7AM shift she was told Resident #1 was a new admission and his medication orders had been sent to pharmacy and medications would not be arriving until the following day, 12/12/22. She stated a notebook had been available at nurse's station for nursing staff to leave correspondence or notify the physician about issues with residents to include issues with medications, but she does not recall if she informed physician or made a note in the notebook of Resident #1's missed doses of IV antibiotic or antiarrhythmic medication not being available to be administered. A telephone interview was conducted with Nurse	F 580	licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup The Director of nursing will review the MAR for missed administration, and ensure if medications are missed that MD was notified for further direction. This will be completed 5X's a week for 4 weeks, and then 2 X's a week X 4 weeks. Findings shall be presented to QAPI committee and audits shall continue at the recommendation of the committee. The Director of Nursing is responsible for the Plan of Correction. Corrective action was completed on 1-25-23	

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#3 on 01/19/23 at 6:41 PM revealed she was familiar with Resident #1 and not receiving his medications upon his admission on 12/11/22 until the evening of 12/12/22. She stated when she arrived at work on 12/12/22 for her 6:30AM to 7PM shift she was told Resident #1 was a new admission and his medications had been sent to pharmacy and were waiting for arrival to the facility and his medications to include his IV antibiotic and medication for atrial fibrillation had been administered. Nurse #3 stated she did not notify the physician of being unable to administer the medications. She revealed a notebook had been available at nurse's station for nursing staff to correspond with physician about any issues with residents but she did not leave any correspondence about Resident #1 because she assumed the nurse from previous shift had notified physician.

A second interview was conducted with Nurse #1 on 01/19/23 at 12:20 PM. She stated on 12/19/22 she was administering Resident #1 his medications and his IV antibiotic was unavailable. She revealed she does not recall informing the physician of Resident #1 missing his dosage of IV antibiotic on 12/19/22 during her 6:30AM to 7PM shift. Nurse #1 stated a notebook was located at nurse's station for physician correspondence to include issues with medications, but she does not recall writing down any correspondence about Resident #1's missed doses and medication not being available.

A telephone interview was conducted with Nurse #4 on 01/23/23 at 11:05 AM revealed she was familiar with Resident #1 and had been responsible for administering his medications. She stated she was working at the facility on the

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evening of 12/19/22 and had been assigned to Resident #1. She revealed she did not administer Resident #1 evening dose of his IV antibiotic. Nurse #4 stated she did not administer Resident #1's morning dose of his IV antibiotic on 12/20/22 due to the medication being on order and not available at the facility. She revealed she did not notify the physician Resident #1 missed doses of his IV antibiotic on 12/19/22 or 12/20/22.

An interview was conducted with Physician Assistant (PA) on 01/18/23 at 4:18 PM revealed Resident #1 was admitted to the facility on Sunday 12/11/22 and she was made aware on 12/12/22 by Resident #1 that his medications had been delayed and when asked nursing staff about Resident #1 medication was told they were enroute from pharmacy and would be available later that day. The PA revealed she was not made aware of Resident #1 missed doses of his IV antibiotic on 12/19/22 and 12/20/22 and had she been told she could have investigated another way of receiving the antibiotic and ordered a culture to see if there had been any growth.
A second interview was conducted with Physician Assistant (PA) on 01/19/23 at 12:54 PM that revealed Resident #1 was admitted with diagnosis of having atrial fibrillation (a-fib) which can cause an irregular heartbeat and was ordered an antiarrhythmic medication to be administered two times a day. The PA revealed she was not notified of Resident #1 missing four doses of his a-fib medication (from 12/11/22 through 12/12/22) and the medication not being available at the facility and had she been told she could have administered another medication until medication was available and monitored for any signs of A-fib.

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An interview was conducted with Administrator and Director of Nursing (DON) on 01/18/23 at 5:56 PM revealed they were both familiar with Resident #1 and had not been made aware until today by the State Agency of the issues with him not being administered ordered medications when admitted and during his stay due to pharmacy issues. They stated no knowledge if medical providers were notified of Resident missed doses of his IV antibiotics. The Administrator and DON revealed nursing staff should have contacted medical providers or left a note in the medical provider notebook located at nurses' station to inform of missed doses.

A telephone interview was conducted with Medical Director (MD) on 01/19/23 at 3:02 PM revealed he saw residents at the facility every Friday and was familiar with Resident #1. He stated he had not been made aware of any issues with residents not receiving their medications and pharmacy not being able to provide medications upon resident admission and or during their stay at facility. He revealed he was not made aware of Resident #1 missing doses of his IV antibiotic or antiarrhythmic medication while at the facility, and had he been made aware he could have looked at prescribing similar medications for Resident #1 to be administered until ordered medications arrived.

The facility was notified of immediate jeopardy on 01/19/23 at 10:10 AM.

The facility provided the following plan for IJ removal.

o Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as

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a result of the noncompliance

Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed and Bacteremia.

From December 11 through December 21, 2022, facility failed to ensure an ordered IV antibiotic to treat sepsis for Resident #1 was available for 6 of the 42 ordered administrations.

*Resident #1 was at risk of suffering from the deficient practice placing him at increased risk for rehospitalization, however showed no adverse outcome as a result of non-compliance. Resident had planned discharge to home on 12/22/2022 and continued his Cefazolin IV antibiotic with a stop date of 12/28/22.

*All other residents prescribed medications are also at risk from suffering from the deficient practice.

On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and orders for the audit of 1/19/23.

o Specify the action the entity will take to alter the

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process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining all medications from pharmacy, the utilization of the stat safe (an electronic emergency/stat dose medication cabinet), the process of obtaining back up services from pharmacy, and the requirement to notify the DON and Physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy.

On 01/18/2023, the DON educated all licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy.

Licensed nurses and medication aides newly hired including agency will receive education prior to working their initial shift as part of their orientation. The DON or designee is responsible to ensure education occurs by obtaining a signature attestation of education.

The education consisted of the following:
" Medications must be administered as ordered by the medical provider. When a medication is ordered the nurse/medication aide is responsible to medicate the resident as ordered.
" If the medication is not available to be

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F 580	Continued From page 10 administered the nurse must notify the medical provider and document the providers response as well as an order to support the response. " When all medications orders are confirmed electronically, between the hours of 9am - 5pm Monday through Friday, the pharmacy is electronically alerted, and medications are prepared and will arrive on the next scheduled pharmacy delivery to the facility. All medication orders confirmed electronically during the hours of 5pm - 9am, and on weekends, holidays, or any other scheduled closure, requires the individual confirming the order electronically to call pharmacy and speak with the on-call pharmacist to initiate back up services through the stat safe, or other stat back up services. If prescribed medication(s) cannot be obtained by utilizing regular or back up stat pharmacy services prior to the scheduled administration time of the medication, the physician must be notified for further guidance and orders. Alleged IJ removal date is 01/20/2023. On 1/25/23, the facility's credible allegation for immediate jeopardy removal effective 1/20/23 was validated by the following: Staff interviews revealed they had received education on how and when to notify the on-call or in-house physician if medications were not available and/or unable to be administered. The facility provided evidence in-service education. It was determined in-service education was completed for staff. The facility provided evidence of audits.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		1/28/23

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F 677	Continued From page 11 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on record reviews, family member, and staff interviews, the facility failed to provide assistance with bathing for 1 of 3 dependent residents (Resident #12) reviewed for providing activities of daily living (ADL) care to residents. The findings included: Resident #12 was admitted to the facility on 12/12/22 with diagnoses which included a history of prostate and bladder cancer with urostomy, chronic obstructive pulmonary disease, and heart failure and was discharged to the local hospital on 01/17/23. Review of Resident #12's admission Minimum Data Set (MDS) assessment dated 12/19/22 revealed he was severely cognitively impaired and required extensive assistance of 2 staff for bed mobility, transfers and toileting and required extensive assistance of 1 staff with personal hygiene and bathing. The assessment also revealed Resident #12 had no rejection of care behaviors. Review of Resident #12's care plan dated 12/19/22 revealed he had a focus area for having an activities of daily living (ADL) self-care performance deficit related to his disease process. Resident requires assistance to completed ADL tasks daily and fluctuations are expected related to his diagnoses. He is at risk for decline in physical function due to confusion,	F 677	F 677 Criteria 1 - Corrective Action: Resident #12 was discharged to hospital with return not anticipated on 1/17/23. Criteria 2 - Identification of other residents: All other residents who are dependent for bathing and residing in the facility are also at risk of not receiving at least 2 showers/baths in a 7-day period. On January 26, 2023 an audit was completed by the Assistant Director of Nursing, (ADON) and the facility MDS nurse to identify any resident residing in the facility that had not had at least 2 showers documented during the 7 day period starting on 1/19/23 and ending on 1/25/23. The shower audit revealed 10 residents who did not have documentation that they received 2 showers during the period of 1/19/23 to 1/25/23 and were not out of the facility on a leave of absence or have documented refusal of shower(s). The 10 residents identified not to have received 2 showers, were offered a shower/bath between 1/26/23 and 1/27/23. Criteria 3 - Measures for systemic Change:	

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F 677	Continued From page 12 fatigue, impaired balance, and limited mobility. The interventions included: bathing/showering the resident required extensive assistance of 1 staff with bathing/showering as necessary, bed mobility the resident required extensive assistance of 2 staff, dressing the resident required extensive assistance of 1 staff, encourage the resident to participate to the fullest extent possible with each interaction, encourage the resident to use bell to call for assistance, Hygiene/grooming the resident required extensive assistance of 1 staff, toileting extensive assistance of 2 staff and transfers extensive assistance of 2 staff. Review of the shower schedule for the 200 hall where the resident resided revealed Resident #12 was scheduled for bed baths/showers on Tuesday and Friday on first shift (7:00 AM to 3:00 PM) each week. Review of the bathing report for Resident #12 from 12/12/22 through 01/17/23 revealed the following: 12/13/22 - missed bed bath/shower - no documentation as to why it was not provided. 12/16/22 at 11:36 AM (Friday) - resident refused shower and was not provided bed bath - no documentation as to why bed bath not provided. 12/20/22 - missed bed bath/shower - no documentation as to why it was not provided. 12/23/22 - missed bed bath/shower - no documentation as to why it was not provided. 12/27/22 - missed bed bath/shower - no	F 677	All licensed nurses and Certified Nursing Assistants (CNA) were educated by the Director of Nursing (DON) or designee between 1/26/23 and 1/27/23 on the requirement for resident to have a minimum of 2 showers/baths per week and the process and implementation of shower sheets. Through the shower sheet process, nurses will pull the shower schedules for that day and provide shower sheets for each resident with a scheduled shower to the CNA□s on their hallway. The CNA will shower resident and return the completed shower sheet to their nurse before the end of their shift. Any refusal of bathing will be documented in the patient□s record by the nurse. Any new employee (including agency) will receive this education prior to working their first shift. Criteria 4 - Monitoring performance: The Director of Nursing, or designee, shall audit 5 random residents, 5 days per week x 4 weeks, and will audit 5 random residents per day, 3 days per week x 4 weeks for a total of 8 weeks to ensure all residents receive a minimum of 2 showers/bed baths per week. Findings of these audits shall be reported to QAPI committee; audits will continue at discretion of QAPI committee. Criteria 5 - Dates when corrective action will be completed: The Director of Nursing is responsible for the Plan of Correction.	

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F 677	Continued From page 13 documentation as to why it was not provided. 12/29/22 at 3:47 PM (Thursday) - bed bath or shower was provided. 12/30/22 - missed bed bath/shower - no documentation as to why it was not provided but had received one the day prior. 01/02/23 - missed bed bath/shower - no documentation as to why it was not provided. 01/06/23 at 11:42 AM (Saturday) - bed bath or shower was provided. 01/09/23 at 10:42 AM (Tuesday) - bed bath or shower was provided. 01/12/23 - missed bed bath/shower - no documentation as to why it was not provided. 01/16/22 at 3:46 PM (Tuesday) - bed bath or shower was provided. According to the facility's documentation, Resident #12 missed 6 bed baths/showers out of 11 for the time of 12/12/22 through 01/17/23. A phone interview on 01/24/23 at 10:35 AM with Resident #12's family member revealed she visited him every weekend because of the distance of the facility from her residence. The family member stated the resident was not getting his bed baths or showers like he was supposed to because of the way he looked and smelled so the quality time she preferred to spend with him had to be spent providing him care and bathing him on the weekend. She further stated when she visited him every weekend, he looked disheveled,	F 677	Corrective action was completed on 1-28-23	

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and he had body odor. She indicated she had expressed her feelings to the nurses caring for Resident #12 on the weekends she had visited and had expressed her concerns to the Hospice nurse assigned to the resident.

An interview on 01/25/23 at 11:50 AM with Nurse Aide (NA) #1 who cared for Resident #12 on 01/12/23 along with NA #4 revealed the shower schedule for each hall did not always match the showers scheduled for each day. She stated she always documented her showers in Point of Care (POC) which was the facility's documentation system for Nurse Aides. NA #1 could not recall why Resident #12's bed bath or shower was not provided and said it may have been that NA #4 was assigned to give his shower on that date or his shower was not included in the daily assignment. NA #1 reported she had not bathed or showered Resident #12 on 01/12/23.

A phone interview on 01/24/23 at 4:27 PM with the Hospice nurse revealed they were secondary payor to the Veteran's Administration for Resident #12 and provided nursing, social services and chaplan services for the resident but had not provided nurse aide assistance for the resident. The Hospice nurse further stated the facility was responsible for activities of daily living care for the resident.

A phone interview on 01/25/23 at 3:00 PM with NA #3 who cared for Resident #12 on 12/13/22 revealed she was not sure why Resident #12 had not received his shower on 12/13/22 unless she had been pulled to another hall to assist with caring for residents. She further stated the schedule did not always match the showers assigned and said it may have been missed for

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F 677	Continued From page 15 that reason. NA #3 indicated the facility had not used shower sheets and what was documented in POC should have been accurate. Several attempts were made to contact NA #4 who was assigned to care for Resident #12 on 12/20/22, 12/23/22, 12/27/22 and 01/02/23 with voicemail's left with no return call. A phone interview on 01/25/23 at 3:36 PM with the Director of Nursing (DON) revealed she was not aware that Resident #12 had missed showers during his stay at the facility. She stated she was not aware of the schedule not matching assigned showers daily and said they should match unless they were including showers not completed from the day before for whatever reason. The DON further stated she would check into the schedule to assure it was accurate and matched the assignments given to the NAs. She indicated it was her expectation that residents received their showers as scheduled unless they refused and then the refusal should be brought to the nurse's attention and documented in the record.	F 677		
F 691 SS=D	Colostomy, Urostomy, or Ileostomy Care CFR(s): 483.25(f) §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record reviews, resident, family	F 691	F 691	1/28/23

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F 691	Continued From page 16 member, staff, and Physician's Assistant (PA) interviews, the facility failed to change a urostomy bag (special bag used to collect urine on the abdomen after removal of the bladder), as ordered for 1 of 1 resident (Resident #12) reviewed for providing care for urostomy as ordered by the physician. The findings included: Resident #12 was admitted to the facility on 12/12/22 with diagnoses which included a history of prostate and bladder cancer with urostomy, chronic obstructive pulmonary disease, and heart failure. Review of a physician order written for Resident #12 on 12/14/22 revealed the following order: Change urostomy bag every 4 days on day shift every 4 days effective 12/15/22. Review of Resident #12's admission Minimum Data Set (MDS) assessment dated 12/19/22 revealed he required extensive assistance of 1 to 2 staff with most activities of daily living (ADL). The assessment also revealed he was incontinent of bowel and bladder and had a urostomy bag. Review of Resident #12's care plan dated 12/19/22 revealed he had a focus area for having a urostomy to drainage bag related to malignant neoplasm of bladder and prostate. The interventions included hand washing before and after delivery of care, observe for signs and symptoms of discomfort on urination and frequency, observe/document for pain/discomfort due to urostomy and observe/record/report to provider any signs and symptoms of urinary tract	F 691	Criteria 1 - Corrective Action The facility failed to change a urostomy bag on Resident # 12. Resident # 12 was discharged to the hospital on 1/17/23 with return not anticipated. Criteria 2 - Identification of other residents: All residents with an ostomy are at risk for this deficient Practice. On 1/26/23 Assistant Director of Nursing, (ADON) conducted a 100% audit of all residents with ostomy to ensure physician order ostomy changes were completed as ordered. Any deficient practice identified during audit was immediately corrected by the ADON. Criteria 3 - Measures for systemic Change: On 1/26/23 -1/27/23, the DON, and ADON provided education to all licensed nurses on ostomy care which include the requirement to follow all ostomy physician orders and to provide accurate ostomy documentation. Treatment administration records will be reviewed in morning clinical meetings by Director of Nursing, or designee, to ensure all ostomy physician orders are followed and documentation is accurate. Any new employee (including agency) will receive this education prior to working their first shift.	

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F 691	Continued From page 17 infection such as pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse or temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior and change in eating patterns. Review of Resident #12's Treatment Administration Record (TAR) for December 2022, revealed his urostomy bag was scheduled to be changed on 12/15/22. The block for 12/15/22 was initialed it had been changed by Nurse #5. Phone interview on 01/24/23 at 10:35 AM with the family member revealed when she visited on 12/18/22 Resident #12 still had the same bag on from 12/12/22 which was the date on the bag. She stated it had not been changed since his admission to the facility. Interview on 01/24/23 at 1:42 PM with Nurse #5 who was assigned to Resident #12 on 12/15/22 revealed she had initialed the treatment as his bag being patent and flowing into the urinary bag without difficulty but admitted she had not changed the urostomy bag because it was changed on 12/12/22 and it had not been 4 days. Nurse #5 stated she had spoken with the Unit Manager and asked if the dates could be changed and said she wasn't sure why they had not been changed. Review of Resident #12's TAR for January 2023 revealed his urostomy bag was scheduled to be changed on 01/08/23. The block for 01/08/23 was blank. The bag was due to be changed again on 01/12/23 and the block was marked by Nurse #5 as though she had changed the bag.	F 691	Criteria 4 - Monitoring performance: The Director of Nursing, or designee, shall audit all ostomies 5 x weekly x 4 weeks and then 3 x weekly x 4 weeks to ensure the requirement to follow all ostomy physician orders and to provide accurate ostomy documentation. Findings of these audits shall be reported to QAPI committee; audits will continue at discretion of the QAPI committee. Criteria 5 - Dates when corrective action will be completed: The Director of Nursing is responsible for the Plan of Correction. Corrective action was completed on 1-28-23	

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Phone interview on 01/24/23 at 10:35 AM with the family member revealed when she visited Resident #12 on the evening of 01/08/23 the urostomy bag had not been changed and was dated 01/04/23. The family member contacted the Hospice Nurse who agreed to visit the resident on 01/09/23 and told her she would change the bag on her visit. The family member stated she had visited Resident #12 again on 01/15/23 and said on that visit the urostomy bag was dated 01/09/22 and had not been changed on 01/12/23 as scheduled.

Interview on 01/24/23 at 1:42 PM with Nurse #5 who was assigned to Resident #12 on 01/12/23 revealed she had initialed the treatment as his bag being patent and flowing into the urinary bag without difficulty but admitted she had not changed the urostomy bag because it was changed on 01/09/23 by the Hospice Nurse and it had not been 4 days. She further stated it had been changed on 01/09/23 because Nurse #6 had not changed it on 01/08/23 as scheduled on the TAR. Nurse #5 indicated the Hospice Nurse changed the urostomy bag on 01/09/23.

Phone interview on 01/25/23 at 11:33 AM with Nurse #6 revealed she had taken care of Resident #12 on 01/08/23, 01/09/23, and the following weekend on 01/15/23. She stated she could not recall why she had not changed the bag on 01/08/23 as scheduled but probably just forgot to go back and change it before she left for the day. Nurse #6 further stated she did recall changing the urostomy bag on 01/15/23. Nurse #6 indicated she had changed the bag on 01/15/23 because the family member wanted it changed. Nurse #6 further indicated she had taken care of the resident on 01/16/23 and the

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bag was due to be changed but said the Unit Manager told her not to change it since she had changed it the day before and just to mark the block for 01/16/23 as though she had changed it.

Several attempts were made to contact the Unit Manager by phone and voicemails left with no return call.

Phone interview on 01/25/23 at 4:27 PM with the Hospice nurse who was assigned to care for Resident #12 revealed she tried to coordinate between the family member and facility staff to ensure the resident's bag was changed as ordered by the physician. The Hospice nurse stated there had been difficulty trying to get the urostomy bag changed and the changes recorded correctly on the Treatment Administration Record (TAR).

An interview on 01/25/23 at 1:40 PM with the Physician's Assistant (PA) working at the facility revealed she had spoken with the Hospice nurse and she had informed her the resident's urostomy bag had not been changed according to the physician's order. The PA stated she had discussed the concern the resident's bag was not being changed with the Director of Nursing and was told by the DON there was a plan in place to ensure the bag was changed.

A phone interview on 01/25/23 at 3:36 PM with the Director of Nursing (DON) revealed she had devised a plan with Resident #12's family member to ensure his urostomy bag was changed as ordered but said he was discharged out to the hospital before the plan was executed. The DON stated she knew about one time the bag was not changed when it should have been

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F 691	Continued From page 20 and it was an error on the part of Nurse #5. She further stated she was unsure why it was left blank on 01/08/23 but could only assume it had not been changed as scheduled by Nurse #6. The DON indicated she was not aware Resident #12's urostomy bag had not been changed on 12/15/22 as ordered by Nurse #5 and said she would have expected all the nurses to have changed his urostomy bag as ordered or consult with the Unit Manager, Assistant Director of Nursing, or her if there were any questions about the order or they needed further direction. Review of Resident #12's hospital record revealed he was discharged to the local hospital on 01/17/23 and admitted with diagnoses which included pneumonia and urinary tract infection. The culture from the urinalysis grew out 3 different bacteria for which the resident was placed on intravenous (IV) antibiotics. The resident was discharged to another facility on 01/20/23. Interview on 01/25/23 with the Medical Director (MD) he remembered the resident but not specifics about him without looking at his medical chart. The MD stated he didn't recall hearing anything about his urostomy bag not being changed as ordered. The MD further stated the urostomy bag should have been changed as ordered.	F 691		
F 755 SS=K	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	F 755		1/25/23

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F 755	Continued From page 21 §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record reviews, staff, Pharmacist, Physician Assistant (PA), and Medical Director (MD) interviews, the facility failed to have an effective system in place to ensure a physician ordered Intravenous (IV) antibiotic and an antiarrhythmic medication (medication used to prevent irregular heartbeat) was available to administer for 1 of 3 residents (Resident #1) reviewed for pharmacy services. Resident #1 was ordered an IV antibiotic for bacteremia and did	F 755	F 755 Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed, bacteremia, atrial fibrillation. From December 11 through December 21, 2022, facility failed to ensure an	

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F 755	Continued From page 22 not receive the first three doses of the antibiotic due to the medication being on order from pharmacy and not available at the facility. Resident #1 did not receive another three doses of the IV antibiotic beginning on 12/19/22 due to being on reorder from the pharmacy and staff not checking the facility back-up safe for the medication. Resident #1 was also ordered an antiarrhythmic medication for atrial fibrillation (A-fib) and did not receive the first four doses of this medication due to the medication being on order from pharmacy and not available at the facility. By not receiving these medications there was the high likelihood for bacterial regrowth, sepsis, resistance to antibiotic, heart arrhythmias or return to hospital. Immediate jeopardy began on 12/11/22 when facility failed to obtain Resident #1's antibiotic and antiarrhythmic medications. Immediate jeopardy was removed on 01/20/23 when the facility implemented an acceptable credible allegations of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put into place are effective. Findings included: Review of facility medication order policy revised July 2022 revealed read in part under documentation of medical order: Clarify order and call, fax, or electronically submit the medication orders to Pharmacy. The facility began using the current pharmacy on 07/01/22. Review of the hospital discharge physician order	F 755	ordered IV antibiotic to treat sepsis was available for 6 of the 42 ordered administrations, and failed to ensure an antiarrhythmic medication was available for 4 missed doses for Resident #1. *Resident #1 was at risk of suffering from the deficient practice placing him at increased risk for rehospitalization, however showed no adverse outcome as a result of non-compliance. Resident had planned discharge to home on 12/22/2022 and continued his Cefazolin IV antibiotic with a stop date of 12/28/22. *All other residents prescribed medications are also at risk from suffering from the deficient practice. On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and orders for the audit of 1/19/23. 0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining all medications from	

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F 755	Continued From page 23 dated 12/10/22 revealed an order for Cefazolin Sodium-Dextrose Solution 2-4 Grams (GM)/100Milliliters (ML)-%. Use 100 ML intravenously every 8 hours for bacteremia for 18 days. Review of the hospital discharge physician order dated 12/10/22 revealed order for Flecainide Acetate Tablet 100 milligram (MG). Give 1 tablet by mouth two times a day for atrial fibrillation (A-fib). Resident #1 was admitted to the facility on Sunday 12/11/22 and discharged home on 12/22/22 with diagnoses to include bacteremia due to methicillin susceptible staph, chronic atrial fibrillation, and diabetes. Interview conducted with Nurse #1 on 01/19/22 at 12:20 PM revealed she was familiar with Resident #1 and had been responsible for completing his admission paperwork, confirming his medication orders, and sending the orders electronically to the pharmacy on 12/11/22. Nurse #1 stated she was aware Resident #1 did not have his ordered medications including his IV antibiotic and his antiarrhythmic medication available upon admission and would not be available until the following day 12/12/22. Nurse #1 revealed residents not receiving their ordered medications upon admission and having to wait a day or two to receive their medications from the pharmacy was an ongoing issue, especially for residents admitted on the weekends due to the pharmacy not delivering medications on the weekends. She stated unless the medication for a resident was available in the facility back-up safe, residents would not receive ordered medications until they arrived from pharmacy.	F 755	pharmacy, the utilization of the stat safe (an electronic emergency/stat dose medication cabinet), the process of obtaining back up services from pharmacy, and the requirement to notify the DON and Physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy. On 01/18/2023, the DON educated all licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy. Licensed nurses and medication aides newly hired including agency will receive education prior to working their initial shift as part of their orientation. The DON or designee is responsible to ensure education occurs by obtaining a signature attestation of education. The education consisted of the following: " Medications must be administered as ordered by the medical provider. When a medication is ordered the nurse/medication aide is responsible to medicate the resident as ordered. " If the medication is not available to be administered the nurse must notify the	

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F 755	Continued From page 24 Review of the Medication Administration Record (MAR) for December 2022 revealed the following: " Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100ML intravenously every 8 hours (6AM, 2PM, 10PM) for bacteremia for 18 days starting 12/10/22. Resident #1 was not administered doses at 10 PM on 12/11/22, 6AM on 12/12/22, 2PM on 12/12/22, 2PM on 12/19/22, 10PM on 12/19/22, and 6AM on 12/20/22 due to being on order from pharmacy and not available at facility. " Flecainide Acetate Tablet 100 MG. Give 1 tablet by mouth two times a day (8AM, 8PM) for atrial fibrillation. Resident #1 was not administered scheduled doses at 8PM on 12/11/22, 8AM on 12/12/22, 8PM on 12/12/22, and 8AM on 12/13/22 due to being on order from pharmacy and not available at facility. A telephone interview conducted with Nurse #2 on 01/19/23 at 5:45 PM revealed she was familiar with Resident #1 and not having medications available upon his admission on 12/11/22 until the following day. She stated when she arrived at work on 12/11/22 at 6:30 PM she was told Resident #1 was a new admission and his medication orders had been sent to pharmacy and medications would not be arriving until the following day. She revealed there have been on-going issues with pharmacy and resident's not having their prescribed medications upon admission and having to wait a day or two to receive their medications and nursing staff has expressed these issues to the Director of Nursing (DON). She stated she did not recall if she checked the back-up safe to see if there were any medications available including Resident #1's IV antibiotic and a-fib medication that could have	F 755	medical provider and document the providers response as well as an order to support the response. " When all medications orders are confirmed electronically, between the hours of 9am □ 5pm Monday through Friday, the pharmacy is electronically alerted, and medications are prepared and will arrive on the next scheduled pharmacy delivery to the facility. All medication orders confirmed electronically during the hours of 5pm □ 9am, and on weekends, holidays, or any other scheduled closure, requires the individual confirming the order electronically to call pharmacy and speak with the on-call pharmacist to initiate back up services through the stat safe, or other stat back up services. If prescribed medication(s) cannot be obtained by utilizing regular or back up stat pharmacy services prior to the scheduled administration time of the medication, the physician must be notified for further guidance and orders. The director of nursing or assistant director of nursing will review 5 admissions for 4 weeks then 2 admissions for 4 weeks to ensure medications were available upon admission via pharmacy or stat safe to ensure meds were given timely and appropriately. Findings shall be presented to QAPI committee and audits shall continue at the recommendation of the committee. The Director of Nursing is responsible for	

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F 755	Continued From page 25 been administered. A telephone interview conducted with Nurse #3 on 01/19/23 at 6:41 PM revealed she was familiar with Resident #1 and him not having received his medications upon his admission on 12/11/22 until the evening of 12/12/22. She stated when she arrived at work on 12/12/22 at 6:30 AM she was told Resident #1 was a new admission and his medication orders had been sent to pharmacy and were waiting for arrival to the facility and none of his medications to include his IV antibiotic and medication for atrial fibrillation had been administered. She stated she contacted the pharmacy who stated Resident #1 medications were enroute. She revealed this had been an on-going issue with pharmacy and not having resident medications available upon admission or medications not being reordered and having to wait a day or two for resident medications to arrive to be administered. Nurse #3 stated residents not having their medications happens weekly and the issues with pharmacy have been brought to the Director of Nursing's (DON) attention and it continued to happen. She revealed she did not recall if she had checked the facility back-up safe to see if IV antibiotic or a-fib medication was available that could have been administered to Resident #1. An interview conducted with Nurse #1 on 01/19/23 at 12:20 PM revealed she was familiar with Resident #1 and had been responsible for administering his medications. She stated on 12/19/22 she was administering Resident #1 his medications and his IV antibiotic was unavailable. She revealed she contacted the pharmacy and was told IV antibiotic had been reordered and was enroute to facility. Nurse #1 stated this was	F 755	the Plan of Correction. Corrective action was completed on 1-25-23	

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an ongoing issue with pharmacy and not receiving medications on time and residents having to wait for their medications and she had spoken with her Director of Nursing (DON) about these issues and was told it was a pharmacy issue. She revealed she does not recall if she checked the facility back-up safe for medications that could have been administered to Resident #1.

A telephone interview conducted with Nurse #4 on 01/23/23 at 11:05 AM revealed she was familiar with Resident #1 and had been responsible for administering his medications. She stated she was working at the facility on the evening of 12/19/22 and had been assigned to Resident #1. She revealed she did not administer Resident #1 evening dose of his IV antibiotic due to being told by the daytime nurse the medication was on order from the pharmacy and not available at the facility and the MD had been aware. Nurse #4 stated she did not administer Resident #1's morning dose of his IV antibiotic on 12/20/22 due to the medication being on order and not available at the facility. She also stated she had not been given access to the back-up safe and was not able to check for any back-up medications. Nurse #4 revealed there had been on-going issues with pharmacy and medications not being available for residents upon their admission and during their stay at the facility and she had made the DON aware of these concerns and was told it was a pharmacy issue and nothing else was done.

An interview conducted with Physician Assistant (PA) on 01/18/23 at 4:18 PM revealed she was familiar with Resident #1. She stated Resident #1 was admitted to the facility on Sunday 12/11/22

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and she was made aware on 12/12/22 his IV antibiotic and antiarrhythmic medication for a-fib had been delayed but was enroute from pharmacy and would be available later that day. She revealed this had been an ongoing issue with pharmacy and medications not being available upon resident admission and she has had to call pharmacy herself about medication orders and had also spoken with the DON about the pharmacy issues and was told it was a pharmacy issue.

A telephone interview conducted with Pharmacist on 01/18/23 at 4:57 PM revealed the pharmacy received the medication orders electronically for Resident #1 on 12/11/22 at 3:25 PM. She stated the medication order was filled and sent out to the facility on 12/12/22 at 11:00 AM. She also stated if an order for medication was received on a workday prior to 2PM the order would be filled on the same day and sent out for night delivery, and if an order for medication was received after 5PM during the workday or received on the weekend the medication would be filled the morning of the next working day and sent out for delivery before lunch. The Pharmacist revealed although Resident #1 IV antibiotic order was for 18 days the pharmacy sent a 7-day supply for the IV antibiotic. She stated the IV antibiotic was on automatic reorder and the next 7-day supply was filled at 8:22 PM on 12/19/22 and sent out to the facility between 9PM and 10PM. The Pharmacist revealed the facility should have had enough doses of IV antibiotics available on 12/19/22 for Resident #1 and should not have missed any of his doses. She stated the facility also had a back-up safe in the facility with extra medications and 1-gram bags of the IV medication for Resident #1 was available in the back-up safe.

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She revealed the facility could have administered Resident #1 the 1-gram bags of IV antibiotics back-to-back to make the 2 grams and no doses would have been missed. She stated she had no knowledge if staff had been made aware of the IV antibiotic being available in facility back-up safe.

A follow up telephone interview conducted with the Pharmacist on 01/23/22 at 9:45 AM revealed the pharmacy received Resident #1's order for the Flecainide Acetate, a-fib medication on 12/11/22 at 3:25 PM and the medication was filled and sent out to the facility on 12/12/22 at 11:00 AM with his other medications. She stated Resident #1's a-fib medication was available at the facility for his evening dose on 12/12/22 and his morning dose on 12/13/22 and should not have been missed due to pharmacy issues or not being available at the facility.

An interview conducted with Administrator and Director of Nursing (DON) on 01/18/23 at 5:56 PM revealed they were both familiar with Resident #1 and had not been made aware until today of the issues with him not being administered ordered medications when admitted and during his stay due to pharmacy issues. They stated when a resident was going to be admitted to the facility, they received a list of ordered medications prior to admission but were not able to send order for medication to pharmacy until the resident was in the building. They revealed they were not aware of pharmacy delivery times on weekends but through the week medication orders and reorders had to be sent to pharmacy before 5PM for late delivery. The Administrator and DON stated the facility did not have back-up contracts with the hospital or any of the local pharmacies. They revealed the pharmacy would

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be responsible for contacting another local pharmacy about a resident's medications and for making sure resident receive their medications. They stated they were not aware of what medications had been available in the facility back-up safe and did not understand why pharmacy did not inform nursing staff when they called on 12/19/22 about back-up IV antibiotics being available for Resident #1. The Administrator and DON stated the facility had switched to the current on pharmacy on 07/01/22 and there had been on-going issues with pharmacy and medications not being available upon admission and not being reordered or sent to facility on time and they have spoken with upper management about the issues.

A telephone interview was conducted with Medical Director (MD) on 01/19/23 at 3:02 PM revealed he saw residents at the facility every Friday and was familiar with Resident #1. He stated he had not been made aware of any issues with residents not receiving their medications and pharmacy not being able to provide medications upon resident admission and or during their stay at facility. He revealed he was not made aware of Resident #1 missing doses of his IV antibiotic or of his a-fib medication while at the facility, and had he been made aware he could have looked at prescribing similar medications for Resident #1 to be administered until ordered medications arrived. The MD revealed he had spoken with the Administrator about the facility did not having a back-up contract with the hospital and other local pharmacies to be able to send in an order and receive medications when not available from main pharmacy and was told that was a pharmacy issue and the main pharmacy out of

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Raleigh was responsible for contacting other pharmacies if they had issues with medications.

A telephone interview conducted with Hospital Physician on 01/23/23 at 3:22 PM revealed he was familiar with Resident #1 and had treated him prior to his admission to the facility for multiple medical issues including bacteremia which is bacterial infection in the bloodstream and atrial fibrillation (a-fib) which is when the heartbeat is out of rhythm or an irregular heartbeat. He stated he had ordered Resident #1 and IV antibiotic to be administered uninterrupted every 8 hours for 18 days for treatment of bacteremia. He revealed best practice would have been for Resident #1 to have received all of his scheduled doses of IV antibiotic and missing doses could have caused bacterial regrowth and a possible return to hospital. He stated he had ordered antiarrhythmic medication for Resident #1 to be administered twice daily to continue his heartbeat at a normal rhythm and administering this medication as prescribed was best practice. He revealed Resident #1 missing his doses of his a-fib medication was a potential for harm due to each resident being different in how they respond to missed doses of a-fib medication. The Hospital Physician stated every resident responds to a-fib differently and some residents might be able to miss doses of medication and have no issues and other residents may miss one dose of medication and it would send them into a-fib and they would have to be sent back to hospital and there is no way of knowing how each resident would respond. He revealed the hospital informs the facility prior to any discharge of ordered medications to ensure the medications would be available for resident at facility upon admission. He stated if the facility was not able to ensure

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medications would be available upon admission, then the facility would inform the hospital prior to discharge so the resident could remain at the hospital for another day and receive their ordered medication doses the following morning and then be discharged to accommodate facility being able to receive medications from pharmacy in time for next dose and keep residents from missing multiple doses of their ordered medications.

The facility was notified of immediate jeopardy on 01/19/23 at 10:10 AM.

The facility provided the following plan for IJ removal.

Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed, bacteremia, atrial fibrillation.

From December 11 through December 21, 2022, facility failed to ensure an ordered IV antibiotic to treat sepsis was available for 6 of the 42 ordered administrations,
and failed to ensure an antiarrhythmic medication was available for 4 missed doses for Resident #1.

*Resident #1 was at risk of suffering from the deficient practice placing him at increased risk for rehospitalization, however showed no adverse outcome as a result of non-compliance. Resident had planned discharge to home on 12/22/2022 and continued his Cefazolin IV antibiotic with a stop date of 12/28/22.

*All other residents prescribed medications are also at risk from suffering from the deficient

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practice.

On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and orders for the audit of 1/19/23.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete

0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining all medications from pharmacy, the utilization of the stat safe (an electronic emergency/stat dose medication cabinet), the process of obtaining back up services from pharmacy, and the requirement to notify the DON and Physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy.

On 01/18/2023, the DON educated all licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup

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services provided by pharmacy.

Licensed nurses and medication aides newly hired including agency will receive education prior to working their initial shift as part of their orientation. The DON or designee is responsible to ensure education occurs by obtaining a signature attestation of education.

The education consisted of the following:
" Medications must be administered as ordered by the medical provider. When a medication is ordered the nurse/medication aide is responsible to medicate the resident as ordered.
" If the medication is not available to be administered the nurse must notify the medical provider and document the providers response as well as an order to support the response.
" When all medications orders are confirmed electronically, between the hours of 9am - 5pm Monday through Friday, the pharmacy is electronically alerted, and medications are prepared and will arrive on the next scheduled pharmacy delivery to the facility. All medication orders confirmed electronically during the hours of 5pm - 9am, and on weekends, holidays, or any other scheduled closure, requires the individual confirming the order electronically to call pharmacy and speak with the on-call pharmacist to initiate back up services through the stat safe, or other stat back up services. If prescribed medication(s) cannot be obtained by utilizing regular or back up stat pharmacy services prior to the scheduled administration time of the medication, the physician must be notified for further guidance and orders.

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F 755	Continued From page 34 Alleged IJ removal date is 01/20/2023. On 1/25/23, the facility's credible allegation for immediate jeopardy removal effective 1/20/23 was validated by the following: Staff interviews revealed they had received education on medication administration, obtaining medicine through pharmacy, and how to notify the on call or in-house provider if medicines are not available. Facility stat safe was observed in locked medication room behind nurse's station where nursing staff have a personalized code to enter for access to receive back-up medications for residents and staff interviews revealed if resident medication was not available on medication cart they were to utilize stat safe first and if not there then to contact pharmacy about other option for receiving medication and to notify physicians of missing medication. Audits were completed to residents who had received IV medication and missed medication for all residents in the facility.	F 755		
F 760 SS=K	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 reviews, staff, Pharmacist, Physician Assistant (PA), Medical Director (MD) and Hospital Physician interviews, the facility failed to administer antibiotics for 1 of 3 residents (Resident #1) reviewed for pharmacy services. Resident #1 was not administered the first three doses of an Intravenous (IV) antibiotic for bacteremia as ordered due to the medication	F 760	F 760 Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed, Bacteremia, and atrial fibrillation.	1/25/23

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F 760	Continued From page 35 being on order from pharmacy and not available at facility. Resident #1 did not receive another three doses of the IV antibiotic beginning on 12/19/22. The facility also failed to administer the first four doses of an antiarrhythmic medication (medication used to treat or prevent irregular heartbeats) due to being on order from the pharmacy and staff not checking the facility back-up safe for the medication. There was the high likelihood for bacterial regrowth, sepsis, resistance to antibiotic, heart arrhythmias, or return to hospital due to the missed medications. Immediate jeopardy began on 12/11/22 when facility failed to administer Resident #1's antibiotic medication and antiarrhythmic medication. Immediate jeopardy was removed on 01/20/23 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of "E" no actual harm with potential for more than minimal harm that is not immediate jeopardy to ensure monitoring systems and staff education put into place are effective. Findings included: 1a. Resident #1 was admitted to the facility on Sunday 12/11/22 with diagnoses to include bacteremia due to methicillin susceptible staphylococcus aureus (an infection the blood that can lead to sepsis and death), chronic atrial fibrillation, and diabetes. Resident discharged home on 12/22/2022. Review of hospital discharge summary dated 12/10/22 revealed Resident #1was anticipated to be discharged to facility on 12/11/22 with	F 760	On December 11, 12, 19 & 20, 2022, facility failed to administer six doses of ordered intravenous (IV)antibiotic, Cefazolin, and four doses of and antiarrhythmic medication, Flecainide Acetate, to Resident #1 with no adverse outcome. *Resident #1 was at increased risk for rehospitalization as result from the deficient practice; however, resulted in no adverse outcomes. *All other residents prescribed an intravenous (IV) antibiotic and antiarrhythmic medications are also at risk from suffering from the deficient practice. Resident #1 was discharged home from the facility on 12/22/22 with a written order for IV antibiotic, Cefazolin, with the stop date of 12/28/22. On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and orders from the audit of 1/19/23. " Specify the action the entity will take to	

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F 760	Continued From page 36 diagnoses to include methicillin susceptible staphylococcus aureus (MSSA) bacteremia due to positive blood culture for growth. Physician ordered medications included an intravenous (IV) antibiotic (Cefazolin 2 grams) every 8 hours with an end date of 12/28/22. Review of hospital discharge physician order dated 12/10/22 revealed order for Cefazolin Sodium-Dextrose Solution 2-4 Grams (GM)/100Milliliters (ML)-%. Use 100 ML intravenously every 8 hours for bacteremia for 18 days. Review of the Medication Administration Record (MAR) for December 2022 revealed the following: " Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100ML intravenously every 8 hours (6AM, 2PM, 10PM) for bacteremia for 18 days starting 12/10/22. Resident #1 was not administered doses at 10 PM on 12/11/22, 6AM on 12/12/22, 2PM on 12/12/22, 2PM on 12/19/22, 10PM on 12/19/22, and 6AM on 12/20/22 due to being on order from pharmacy and not available at facility. A telephone interview conducted with the Hospital Physician on 01/23/23 at 3:22 PM revealed he was familiar with Resident #1 and had treated him prior to his admission to the facility for multiple medical issues including bacteremia and methicillin-susceptible staph bacteremia or MSSA (bacterial infection in bloodstream). He stated he had ordered an IV antibiotic as treatment for Resident #1's MSSA to be administered uninterrupted every 8 hours for 18 days ending on 12/28/22 and administering this medication as prescribed was best practice. The Hospital Physician revealed the hospital informs the facility	F 760	alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. 0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy. On 01/18/2023, the DON educated all licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy. Licensed nurses and medication aides newly hired including agency will receive education prior to working their initial shift as part of their orientation. The DON or designee is responsible to ensure education occurs by obtaining a signature attestation of education. The education consisted of the following:	

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F 760	Continued From page 37 prior to any discharge of ordered medications to ensure the medications would be available for resident at facility upon admission. He stated if the facility was not able to ensure medications would be available upon admission, then the facility would inform the hospital prior to discharge so the resident could remain at the hospital for another day and receive their ordered medication doses the following morning and then be discharged to accommodate facility being able to receive medications from pharmacy in time for next dose and keep residents from missing multiple doses of their ordered medications. Review of admission nursing note written by Nurse #1 dated 12/11/22 at 1:53 PM read in part: Resident #1 arrived via hospital van to the facility on 3 liters of oxygen. He was alert and oriented to person, place, time, and event. Resident #1 had a peripherally inserted central catheter (PICC), used for access of large central veins near the heart, and was to receive medications through the PICC line. Review of admission Minimum Data Set (MDS) dated 12/18/22 revealed Resident #1 was cognitively intact and coded for intravenous medications and receiving antibiotics. Interview conducted with Nurse #1 on 01/19/22 at 12:20 PM revealed she was familiar with Resident #1 and had been responsible for completing his admission paperwork, confirming his medication orders and sending the orders electronically to the pharmacy on 12/11/22. Nurse #1 stated she was aware Resident #1 did not have his ordered medications including his IV antibiotic available upon admission and did not receive them until the following day. Nurse #1	F 760	" Medications must be administered as ordered by the medical provider. When a medication is ordered the nurse/medication aide is responsible to medicate the resident as ordered. " If the medication is not available to be administered the nurse must notify the medical provider and document the providers response as well as an order to support the response. " When all medications orders are confirmed electronically, between the hours of 9am □ 5pm Monday through Friday, the pharmacy is electronically alerted, and medications are prepared and will arrive on the next scheduled pharmacy delivery to the facility. All medication orders confirmed electronically during the hours of 5pm □ 9am, and on weekends, holidays, or any other scheduled closure, requires the individual confirming the order electronically to call pharmacy and speak with the on-call pharmacist to initiate back up services through the stat safe, an electronic emergency/stat dose medication cabinet, or other stat back up services. If prescribed medication(s) cannot be obtained by utilizing regular or back up stat pharmacy services prior to the scheduled administration time of the medication, the physician must be notified for further guidance and orders. Director of Nursing or assistant director of nursing will review medication administration audit report 5 X's a week for 4 weeks, 2X week for 4 weeks to ensure every resident received	

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F 760	Continued From page 38 revealed residents not receiving their ordered medications upon admission and having to wait a day or two to receive their medications from pharmacy was an ongoing issue, especially for residents admitted on the weekends due to the pharmacy not delivering medications on the weekends. She stated unless the medication for a resident was available in the facility back-up safe for them to use, residents would not receive ordered medications until they arrived from pharmacy. Review of nursing note written by Nurse #2 dated 12/11/22 revealed Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100 ML intravenously every 8 hours for bacteremia for 18 Days. On order. Review of nursing note written by Nurse #2 dated 12/12/22 revealed Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100 ml intravenously every 8 hours for bacteremia for 18 Days. On order. A telephone interview conducted with Nurse #2 on 01/19/23 at 5:45 PM revealed she was familiar with Resident #1 and not receiving medications upon his admission on 12/11/22 until the following day. She stated when she arrived at work on 12/11/22 she was told by Nurse #1 who had worked the previous shift, Resident #1 was a new admission and his medication orders had been sent to pharmacy and medications would not be arriving until the following day. She revealed there have been on-going issues with the pharmacy and resident's not having their prescribed medications upon admission and having to wait a day or two to receive their medications, she reported nursing staff had expressed these	F 760	medications as ordered and were free from significant med errors. Findings of this audit shall be presented to QAPI committee and audits shall continue at the recommendation of the committee. The Director of Nursing is responsible for the Plan of Correction. Corrective action was completed on 1-25-23	

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issues to supervisors. Nurse #2 stated the facility does have a back-up safe for medications that can be administered to residents until they receive their medications from the pharmacy, but she could not recall if she checked the back-up safe to see if there were any medications to include Resident #1's IV antibiotic.

A telephone interview conducted with Nurse #3 on 01/19/23 at 6:41 PM revealed she was familiar with Resident #1 and him not receiving his medications upon admission on 12/11/22 until the evening of 12/12/22. She stated when she arrived at work on 12/12/22 she was told by Nurse #2 who had worked the previous shift, Resident #1 was a new admission and his medications had been sent to pharmacy and were waiting for arrival to the facility and none of his medications to include his IV antibiotic and medication for atrial fibrillation had been administered. She revealed this has been an on-going issue with pharmacy not having resident medications available upon admission or not being reordered and having to wait a day or two for resident medications to arrive to be administered. Nurse #3 stated when a resident did not have their medications she looked to see if the medications had been ordered and sent to pharmacy and then she checked to see if the medication were available in the facility back-up safe. She stated she did not recall if she had checked the facility back-up safe to see if medications to include IV antibiotic were available that could have been administered to Resident #1.

Review of nursing note written by Nurse #1 dated 12/19/22 revealed Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100 ml intravenously every 8 hours for bacteremia for 18

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Days. Unavailable.

An interview conducted with Nurse #1 on 01/19/23 at 12:20 PM revealed she was familiar with Resident #1 and had been responsible for administering his medications. She stated on 12/19/22 she was administering Resident #1 his medications and his IV antibiotic was unavailable. She revealed she contacted pharmacy and was told the IV antibiotic had been reordered and was enroute to facility. Nurse #1 stated this was an ongoing issue with pharmacy and not receiving medications on time and residents having to wait for their medications and she had spoken with her supervisors about these issues. She revealed she did not recall if she checked the facility back-up safe for the medications.

Review of nursing note written by Nurse #4 dated 12/19/22 read in part Cefazolin Sodium-Dextrose Solution 2-4 GM/100ML-%. Use 100 ml intravenously every 8 hours for bacteremia for 18 Days. Awaiting pharmacy. MD aware.

A telephone interview conducted with Nurse #4 on 01/23/23 at 11:05 AM revealed she was familiar with Resident #1 and had been responsible for administering his medications. She stated she was working at the facility on the evening of 12/19/22 and had been assigned to Resident #1. She revealed she did not administer Resident #1's evening dose of his IV antibiotic due to being told by the daytime nurse the medication was on order from the pharmacy and not available at the facility and the MD had been aware. Nurse #4 stated she did not administer Resident #1's morning dose of his IV antibiotic on 12/20/22 due to the medication being on order and not available at the facility. She stated she

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was not given access to the facility back-up safe and would not have been able to check and see if there were any back-up doses of IV antibiotic for Resident #1 that could have been administered. Nurse #4 revealed there had been on-going issues with pharmacy and medications not being available for residents upon their admission and during their stay at the facility and she had made her supervisors including the DON aware of these concerns and was told it was a pharmacy issue and nothing else was done.

Review of the facility Physician Assistant (PA) progress note dated 12/12/22 revealed Resident #1 had been admitted to the facility on 12/11/22 from the hospital with multiple medical diagnosis to include methicillin susceptible staphylococcus aureus infection and bacteremia with an ordered IV antibiotic for treatment to be administered every 8 hours for 18 days. The PA noted when speaking with Resident #1 he was anxious his medications had not yet arrived from pharmacy, and he was concerned he would decompensate if he had to wait much longer. The PA reviewed the medication administration record (MAR) and noted medication enroute today.
An interview conducted with Physician Assistant (PA) on 01/18/23 at 4:18 PM revealed she was familiar with Resident #1. She stated Resident #1 was admitted to the facility on Sunday 12/11/22 and she was made aware on 12/12/22 by Resident #1 his IV antibiotic had been delayed and when she checked with nursing, she was told Resident #1's medications were enroute from pharmacy and would be available later that day. She revealed this had been an ongoing issue with pharmacy and medications not being available upon resident admission and she has called the pharmacy herself about medication orders and

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had also spoken with the DON about the pharmacy issues and was told it was a pharmacy issue. The PA revealed she was not made aware of Resident #1's missed doses of his IV antibiotic on 12/19/22 and 12/20/22 and had she been told she could have investigated another way of receiving the antibiotic and ordered a culture to see if there had been any new bacterial growth. She stated Resident #1's missing doses of his IV antibiotic could have caused bacterial growth, sepsis, or to become resistant to the antibiotic. She revealed Resident #1's IV antibiotic was ordered because of his culture and the IV antibiotic ordered was specific to his treatment and not any antibiotic could have been used.

A telephone interview conducted with the facility Pharmacist on 01/18/23 at 4:57 PM revealed the pharmacy received the medication orders electronically for Resident #1 on 12/11/22 at 3:25 PM. She stated the medication order was filled and sent out to the facility on 12/12/22 at 11:00 AM. The Pharmacist revealed although Resident #1's IV antibiotic order was for 18 days, the pharmacy sent out the antibiotic in a 7-day supply. She stated the IV antibiotic was on automatic reorder and the next 7-day supply was filled at 8:22 PM on 12/19/22 and sent out to the facility between 9PM and 10PM. The Pharmacist revealed the facility should have had enough doses of IV antibiotics available on 12/19/22 for Resident #1 and should not have missed any of his doses. She stated the facility also had a back-up safe in the facility with extra medications and 1-gram bags of the IV medication ordered for Resident #1. She revealed the facility could have administered Resident #1 the 1-gram bags of IV antibiotics back-to-back to make the 2 grams and no doses would have been missed. The

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Pharmacist stated Resident #1's IV antibiotic had a half-life of 1.8 hours and missing 3 doses at a time, the IV antibiotic would be completely out of Resident #1's system and could cause bacteria growth, sepsis, or Resident #1 to become resistant to antibiotic.

An interview conducted with Administrator and Director of Nursing (DON) on 01/18/23 at 5:56 PM revealed they were both familiar with Resident #1 and had not been made aware until today of the issues with him not being administered ordered medications when admitted and during his stay due to pharmacy issues. They stated when a resident was going to be admitted to the facility, they received a list of ordered medications prior to admission but were not able to send order for medication to pharmacy until the resident was in the building. They revealed they were not aware of pharmacy delivery times on weekends but through the week medication orders and reorders had to be sent to pharmacy before 5:00 PM for late delivery. The Administrator and DON stated the facility did not have back-up contracts with the hospital or any of the local pharmacies. They revealed the pharmacy would be responsible for contacting another local pharmacy about a resident's medications and for making sure resident received their medications. They stated they were not aware of what medications had been available in the facility back-up safe and did not understand why the pharmacy did not inform nursing staff when they called on 12/19/22 about the back-up IV antibiotics being available for Resident #1 in the safe. The Administrator and DON revealed nursing staff should always check the back-up safe for medications that could have been administered to residents. They stated there

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had been on-going issues with pharmacy and medications not being available upon admission and not being reordered or sent to facility on time.

Review of Medical Director (MD) progress note dated 12/16/22 revealed Resident #1 had been admitted to the facility on 12/11/22 from the hospital with multiple medical diagnosis to include bacteremia and methicillin susceptible staphylococcus aureus infection as the cause of diseases classified elsewhere and will continue IV antibiotic through and including 12/28/22.

A telephone interview conducted with Medical Director (MD) on 01/19/23 at 3:02 PM revealed he saw residents at the facility every Friday and was familiar with Resident #1. He stated he had not been made aware of any issues with residents not receiving their medications and pharmacy not being able to provide medications upon resident admission and or during their stay at facility. He revealed he was not made aware of Resident #1 missing doses of his IV antibiotic or of his a-fib medication while at the facility, and had he been made aware he could have looked at prescribing similar medications for Resident #1 to be administered until ordered medications arrived. He stated Resident #1's IV antibiotic was ordered as a treatment for sepsis and should have been given as prescribed and by not doing so could have caused bacterial growth or for him to become septic again.

b. Review of physician order for Resident #1 from discharge summary dated 12/10/22 revealed order for Flecainide Acetate Tablet 100 milligram (MG). Give 1 tablet by mouth two times a day for atrial fibrillation (A-fib).

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Resident #1 was admitted to the facility on 12/11/22 (Sunday) with diagnoses to include sepsis due to methicillin susceptible staphylococcus aureus, chronic atrial fibrillation, and diabetes.

Review of the admission minimum data set (MDS) dated 12/18/22 revealed Resident #1 was coded for atrial fibrillation (a-fib).

Interview conducted with Nurse #1 on 01/19/22 at 12:20 PM revealed she was familiar with Resident #1 and had been responsible for completing his admission paperwork, confirming his medication orders, and sending the orders electronically to the pharmacy on 12/11/22. Nurse #1 stated she was aware Resident #1 did not have his ordered medications including his a-fib medication available upon admission and was not to receive them until the following day. Nurse #1 revealed residents not receiving their ordered medications upon admission and having to wait a day or two to receive their medications from pharmacy was an ongoing issue, especially for residents admitted on the weekends due to pharmacy not delivering medications on the weekends. She stated unless the medication for a resident was available in the facility back-up safe for them to use, resident would not receive ordered medications until they arrived from pharmacy.

Review of medication administration record (MAR) for December 2022 revealed Resident #1 was to receive Flecainide Acetate Tablet 100 MG. Give 1 tablet by mouth two times a day (8AM, 8PM) for atrial fibrillation. Resident #1 was not administered scheduled doses at 8PM on 12/11/22, 8AM on 12/12/22, 8PM on 12/12/22,

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and 8AM on 12/13/22 due to being on order from pharmacy and not available at facility.
Review of nursing note written by Nurse #2 dated 12/11/22 revealed Flecainide Acetate Tablet 100 MG. Give 1 tablet by mouth two times a day for atrial fibrillation (A-fib). On order.

A telephone interview conducted with Nurse #2 on 01/19/23 at 5:45 PM revealed she was familiar with Resident #1 and not receiving medications upon his admission on 12/11/22 until the following day. She stated when she arrived at work at 6:30 PM on 12/11/22 she was told Resident #1 was a new admission and his medication orders had been sent to pharmacy and medications would not be arriving until the following day. She revealed there have been on-going issues with pharmacy and resident's not having their prescribed medications upon admission and having to wait a day or two to receive their medications and nursing staff had expressed these issues to supervisors. Nurse #2 stated the facility does have a back-up safe for medications that can be administered to residents until they receive their medications from pharmacy. She stated she did not recall if she checked the back-up safe to see if there were any medications to include Resident #1's medications for atrial fibrillation that could have been administered to Resident #1 until his medications arrived.

A telephone interview conducted with Nurse #3 on 01/19/23 at 6:41 PM revealed she was familiar with Resident #1 and not having his medications available until the following day. She stated when she arrived at work on 12/12/22 she was told Resident #1 was a new admission and his medications had been sent to pharmacy and were waiting for arrival to the facility and none of

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his medications to include his medication for atrial fibrillation had been administered. She stated she contacted the pharmacy who stated Resident #1's medications were enroute and she informed Resident #1 and his wife. She revealed this has been an on-going issue with pharmacy not having resident medications available upon admission or not being reordered and having to wait a day or two for resident medications to arrive to be administered. Nurse #3 stated when a resident did not have their medications she would first look to see if the medications had been ordered and sent to pharmacy and then she checked to see if the medication was available in the facility back-up safe. She revealed residents not having their medications happens weekly and the issues and have been brought to supervisors' attention. She revealed she was not made aware from nursing staff who had worked the previous day of Resident #1's a-fib medication being available on 12/13/22 and believed it to still be on order from the pharmacy and not available at the facility due to not being on medication cart. Nurse #3 also revealed if she had been made aware Resident #1's a-fib medication had been available for his morning dose on 12/13/22 she would have administered the medication as ordered. She stated she did not recall if she had checked the facility back-up safe on 12/12/22 or 12/13/22 to see if medication for atrial fibrillation was available that could have been administered to Resident #1.

A telephone interview conducted with the Pharmacist on 01/23/22 at 9:45 AM revealed the pharmacy received Resident #1 order for an a-fib medication on 12/11/22 at 3:25 PM and the medication was filled and sent out to the facility on 12/12/22 at 11:00 AM with his other

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medications. She stated Resident #1's a-fib medication was available at the facility for his evening dose on 12/12/22 and his morning dose on 12/13/22 and should not have been missed due to pharmacy issues or not being available at the facility.
An interview conducted with Administrator and Director of Nursing (DON) on 01/18/23 at 5:56 PM revealed they were both familiar with Resident #1 and had not been made aware until today of the issues of him not being administered medications for atrial fibrillation (a-fib). They stated nursing staff should checked the back-up safe to see if there was a back-up supply of medications that could have been administered.

An interview conducted with Physician Assistant (PA) on 01/19/23 at 12:54 PM revealed Resident #1 was admitted to the facility with diagnosis of having atrial fibrillation (a-fib) which can cause an irregular heartbeat and was ordered an antiarrhythmic medication to be administered two times a day. The PA revealed medication for atrial fibrillation (a-fib) should have been given as prescribed and when not given could have caused the heart to get out of rhythm which could have led to cardiac arrest.
A telephone interview conducted with Medical Director (MD) on 01/19/23 at 3:02 PM revealed Resident #1 a-fib medications should had been administered as prescribed and missing doses could had resulted in irregular heartbeats.

A telephone interview conducted with Hospital Physician on 01/23/23 at 3:22 PM revealed he was familiar with Resident #1 and had treated him prior to his admission to the facility for multiple medical issues including atrial fibrillation (a-fib) which is when the heartbeat is out of

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rhythm or an irregular heartbeat. He stated he had ordered antiarrhythmic medication for Resident #1 to be administered twice daily to continue his heartbeat at a normal rhythm and administering this medication as prescribed was best practice. He revealed Resident #1 missing his doses of his a-fib medication was a potential for harm due to each resident being different in how they respond to missed doses of a-fib medication. The Hospital Physician stated every resident responds to a-fib differently and some residents might be able to miss doses of medication and have no issues and other residents may miss one dose of medication and it would send them into a-fib and they would have to be sent back to hospital and there is no way of knowing how each resident would respond. He revealed the hospital informs the facility prior to any discharge of ordered medications to ensure the medications would be available for resident at facility upon admission. He stated if the facility was not able to ensure medications would be available upon admission, then the facility would inform the hospital prior to discharge so the resident could remain at the hospital for another day and receive their ordered medication doses the following morning and then be discharged to accommodate facility being able to receive medications from pharmacy in time for next dose and keep residents from missing multiple doses of their ordered medications.

The facility was notified of immediate jeopardy on 01/19/23 at 10:10 AM.

The facility provided the following plan for IJ removal.

o Identify those recipients who have suffered, or

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are likely to suffer, a serious adverse outcome as a result of the noncompliance

Resident #1 was admitted on December 11, 2022, with a primary diagnosis of chronic respiratory failure after a hospitalization for GI Bleed, Bacteremia, and atrial fibrillation.

On December 11, 12, 19 & 20, 2022, facility failed to administer six doses of ordered intravenous (IV)antibiotic, Cefazolin, and four doses of and antiarrhythmic medication, Flecainide Acetate, to Resident #1 with adverse outcome.

*Resident #1 was at increased risk for rehospitalization as result from the deficient practice; however, resulted in no adverse outcomes.

*All other residents prescribed an intravenous (IV) antibiotic and antiarrhythmic medications are also at risk from suffering from the deficient practice.

Resident #1 was discharged home from the facility on 12/22/22 with a written order for IV antibiotic, Cefazolin, with the stop date of 12/28/22.

On 01/18/23, an audit of all residents with orders for IV medications ordered between 12/11/2022 and 01/18/2023 was conducted by the Director of Nursing (DON) with no unavailable IV medications or missed medications identified. An audit of all medications was completed on 1/19/23 for all residents from 1/12/23 to 1/19/23 by DON, ADON, and MDS Nurse to identify other missed doses. All residents/responsible parties and the physician were notified of any identified missed medications for further guidance and

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orders from the audit of 1/19/23.

o Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete.

0n 01/18/2023, the DON was educated by Regional Clinical Director on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy.

On 01/18/2023, the DON educated all licensed nurses, including agency nurses, in person or via phone on the process for obtaining medications from pharmacy, the utilization of the stat safe, the process of obtaining back up services from pharmacy and the requirement to notify the physician of any medication that cannot be obtained through the stat safe, or the backup services provided by pharmacy.

Licensed nurses and medication aides newly hired including agency will receive education prior to working their initial shift as part of their orientation. The DON or designee is responsible to ensure education occurs by obtaining a signature attestation of education.

The education consisted of the following:
" Medications must be administered as ordered by the medical provider. When a medication is

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ordered the nurse/medication aide is responsible to medicate the resident as ordered.
" If the medication is not available to be administered the nurse must notify the medical provider and document the providers response as well as an order to support the response.
" When all medications orders are confirmed electronically, between the hours of 9am - 5pm Monday through Friday, the pharmacy is electronically alerted, and medications are prepared and will arrive on the next scheduled pharmacy delivery to the facility. All medication orders confirmed electronically during the hours of 5pm - 9am, and on weekends, holidays, or any other scheduled closure, requires the individual confirming the order electronically to call pharmacy and speak with the on-call pharmacist to initiate back up services through the stat safe, an electronic emergency/stat dose medication cabinet, or other stat back up services. If prescribed medication(s) cannot be obtained by utilizing regular or back up stat pharmacy services prior to the scheduled administration time of the medication, the physician must be notified for further guidance and orders.

Alleged IJ removal date is 01/20/2023.

On 1/25/23, the facility's credible allegation for immediate jeopardy removal effective 1/20/23 was validated by the following: Staff interviews revealed they had received education on medication administration, obtaining medicine through pharmacy, and how to notify the on call or in-house provider if medicines are not available. Facility stat safe was observed in locked medication room behind nurse's station where nursing staff have a personalized code to

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F 760	Continued From page 53 enter for access to receive back-up medications for residents and staff interviews revealed if resident medication was not available on medication cart they were to utilize stat safe first and if not there then to contact pharmacy about other option for receiving medication and to notify physicians of missing medication. Audits were completed to residents who had received IV medication and missed medication for all residents in the facility.	F 760		