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WADESBORO HEALTH & REHAB CENTER	2051 COUNTRY CLUB ROAD WADESBORO, NC 28170

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E 000	Initial Comments An unannounced recertification survey was conducted on 05/15/23 through 05/18/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # AHKN11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey was conducted from 05/15/23 through 05/18/23. Event ID# AHKN11.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to accurately code the Minimum Data Set (MDS) assessments for 4 of 16 sampled residents whose MDS were reviewed (Residents #9, #31, #55 & # 60). Findings included: 1. Resident # 31 was admitted to the facility on 10/13/22. Resident #31 had a physician's order dated 2/21/23 for Seroquel (an antipsychotic medication) 100 milligrams (mgs.) give 1 tablet by mouth 3 times a day for dementia with psychosis. Resident #31 had a physician's order dated 3/2/23 to decrease the Seroquel to 100 mgs - give ½ tablet by mouth 3 times a day.	F 641	Preparation and submission of this plan of correction by Wadesboro Health & Rehabilitation does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws. F641 1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1a. Resident #60 had a modification done on 5/25/23 that accurately reflects his disposition on discharge. Submitted on	6/9/23

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

Electronically Signed | 06/08/2023

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F 641	Continued From page 1 The significant change in status MDS assessment dated 4/3/23 indicated that Resident #31 had received an antipsychotic medication during the assessment period and a gradual dose reduction (GDR) for the antipsychotic medication had not been attempted. MDS Nurse #1 was interviewed on 5/17/23 at 10:10 AM. The MDS Nurse had reviewed the physician's orders for the Seroquel and verified that a GDR had been attempted. She indicated she missed the order for the GDR and she would complete a correction MDS. The Director of Nursing (DON) was interviewed on 5/18/23 at 10:18 AM. The DON stated she expected the MDS assessments to be accurate. 2. Resident #9 was admitted to the facility on 3/9/23. The significant change in status Minimum Data Set (MDS) assessment dated 4/26/23 indicated that cognitive patterns and mood sections were "not assessed." The assessment further indicated that the resident was able to make self-understood sometimes and able to understand others sometimes. MDS Nurse #1 was interviewed on 5/17/23 at 10:10 AM. She reported that Resident #9 was nonverbal but able to answer questions by shaking/nodding his head. She stated that the Social Services Director was responsible for completing cognitive patterns and mood sections of the MDS and she expected the Social Services Director to try to interview the resident.	F 641	5/25/23. 1b.Resdient #9 had a modification on the Brief Interview for mental status (BIMS) on 5/30/23 and was submitted 5/30/2023. 1c. Resident #55 had a new Minimum Data Set assessment completed on 5/24/23 that accurately reflects sections C and D. 1d. Resident #31 had a modification completed and submitted by the Minimum Data Set Nurse on May 31, 2023 accurately reflecting the Gradual Dose Reduction. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. The administrator contact the Regional Clinical Reimbursement Specialist (RCRS) on 5/19/23 conduct an audit of all Minimum Date Set (MDS) assessments beginning from January 1, 2023 to current. 2b. The Regional Clinical Reimbursement Specialist completed a 100% audit for MDS accuracy from January 1, 2023 to current. Any inaccuracies were corrected and further education was provided on June 1, 2023. 2c. On May 24, 2023 the Regional Clinical Reimbursement Specialist completed education on coding per the Resident Assessment Instrument (RAI) Manual for the two minimum Minimum Data Set Nurses and the Social Worker. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 3a. On May 24, 2023 the Regional Clinical	

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F 641	Continued From page 2 The Social Services Director was interviewed on 5/17/23 at 10:11 AM. She reported that she was responsible for completing cognitive patterns and mood sections on the MDS assessments. She stated that the resident was nonverbal, so she did not try to interview the resident. She indicated that she was new to MDS, started 2 months ago, and she was still learning. The Director of Nursing (DON) was interviewed on 5/18/23 at 10:18 AM. The DON stated she expected the MDS assessments to be accurate. 3. Resident #55 was admitted to the facility on 9/7/22 with diagnoses that included muscle weakness and chronic kidney disease. The quarterly Minimum Data Set (MDS) assessment dated 2/21/23 indicated Resident #55 had clear speech and was able to make self-understood and understood others. The Cognitive Patterns including the Brief Interview for Mental Status (BIMS), and the Mood sections were not marked as assessed. On 5/17/23 at 1:30 PM, an interview occurred with the MDS Nurse #2, who indicated the former Social Worker had completed the cognition and mood sections on Resident #55's quarterly MDS assessment dated 2/21/23. She was unable to state why the sections were not completed correctly but an interview with Resident #55 should have been attempted for both sections. The Director of Nursing was interviewed on 5/18/23 at 10:16 AM and stated it was her expectation for all residents to be assessed accurately in the areas of cognition and mood.	F 641	Reimbursement Specialist completed education on coding per the Resident Assessment Instrument (RAI) Manual for the Minimum Data Set Nurses and the Social Worker. 3b. On May 24, 2023 the Regional Clinical Reimbursement Specialist provided a copy of the RAI Manual for the two Minimum Data Set Nurses and the Social Worker. 3c. The Minimum Data Set nurses will conduct an audit of all MDS records for correct discharge coding July 2023 and January 2024. 4.Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. Minimum Data Set Nurse #1 will audit Minimum Data Nurse #2 and vice versa on their Minimum Data Set accuracy on an assessment audit tool weekly x 12 weeks, then monthly x 12 months. Results of the audit will brought to the Quality Assurance Performance Improvement (QAPI)meeting by the Minimum Data Set Nurse for review monthly x 12 months. If any discrepancies are noted, further action will be implemented by the administrator.	

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F 641	Continued From page 3 4. Resident #60 was admitted on 12/08/22 with diagnoses which included type 2 diabetes, hypertension, and chronic obstructive pulmonary disease with exacerbation. Resident #60's discharge Minimum Data Set (MDS) assessment dated 04/01/23 indicated the resident was discharged to acute hospital setting and return was not anticipated. The discharge summary, dated 03/31/23, indicated Resident #60 participated in therapy during his stay and was discharged to another nursing home per resident/family request. The discharge instruction notes located in Resident #60's electronic medical record, dated 03/31/23, indicated the discharge destination was to another nursing home. On 05/17/23 at 1:34 PM an interview was conducted with MDS Nurse #1. She reviewed Resident #60's discharge MDS assessment dated 04/01/23 and stated the discharge was coded for acute hospital setting with return not anticipated. She reviewed the resident's discharge summary and stated the MDS assessment was coded in error. She stated the MDS assessment should have been coded to reflect the resident was discharged to another nursing home. During an interview with the Director of Nursing (DON) 05/17/23 at 3:15 PM she stated it was her expectation the MDS assessment be coded accurately.	F 641		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F 658		6/9/23

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F 658	Continued From page 4 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to transcribe the correct medication administration route for 3 of 5 residents reviewed for unnecessary medications (Residents #13, #55 and #47). The findings included: 1. Resident #13 was originally admitted to the facility on 5/16/22 with diagnoses which included gastro-esophageal reflux disease (GERD). A quarterly Minimum Data Set (MDS) assessment dated 4/1/23 indicated Resident #13 was cognitively intact and was independent after setup with eating. The active May 2023 physician orders included an order dated 3/7/23 for Tums 500 milligrams (mg) give three tablets enterally (by a feeding tube) at bedtime for GERD. All other medications were written to be provided by mouth. On 5/16/23 at 11:25 AM, an interview occurred with Nurse #1 who was working the medication cart for Resident #13's hall and had administered medications earlier. The nurse confirmed Resident #13 received all his medications by mouth and did not have a feeding tube. Nurse #1 acknowledged the Medication Administration Record (MAR) read for Tums to be provided	F 658	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. On May 18,2023 the Director of Nursing(DON) reviewed Point Click Care (PCC)orders for residents #13, 55 and 47. The orders were corrected. 2. Address how the facility identify other residents having the potential to be affected by the same deficient practice. 2a. On May 22, 2023 the DON reviewed the PCC orders for all residents in the facility and their correct administration route. No discrepancies were identified. 2b. Education for new nurse hires will be provided during orientation. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. 3a. On May 19, 2023 the DON provided education to all the nurses on entering an order or confirming an order from a prescriber to enter the correct route of administration. 3b. All admissions and readmissions orders will be double checked for accuracy 5x's/week during the morning clinical meeting. 4. Indicate how the facility plans to	

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F 658	Continued From page 5 enterally, which was inaccurate as all his medications were provided by mouth. A phone interview was conducted with Nurse #2 on 5/16/23 at 1:52 PM and confirmed Resident #13 received all his medication by mouth and did not have a feeding tube. An interview was held with the Unit Manager on 5/17/23 at 11:02 AM. She was the nurse that had confirmed the Tums order for Resident #13. The Unit Manager explained she verified the medication, dose and frequency in the Electronic Medical System but must have hit the wrong button and chose enterally for the route rather than by mouth. On 5/18/23 at 10:16 AM, the Director of Nursing (DON) was interviewed and reviewed Resident #13's physician orders. She confirmed the route for the Tums was entered as enterally instead of by mouth. The DON felt it was an oversight that the nurse chose enteral rather than by mouth. The DON stated it was her expectation for all medication administration routes to be entered correctly when the order was received and verified. 2. Resident #55 was admitted to the facility on 9/7/22 with diagnoses that included dysphagia (difficulty swallowing). A quarterly Minimum Data Set (MDS) assessment dated 2/21/23 indicated Resident #55 was able to understand others and make self-understood. She required total assistance with eating and received 51% or more of calories and 501 milliliters (ml) or more of fluids via a feeding tube.	F 658	monitor its performance to make sure that solutions are sustained. 4a. The DON or designee will run order listing report and check the 5 rights for the medications ordered 5x's a week during the morning meeting for 12 weeks. The nurse entering the order will receive re-education immediately if any discrepancies are identified. Results of the audit will be brought to the QAPI meeting monthly by the Administrator for review. If any discrepancies are noted, further action will be implemented by the Administrator.	

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Review of Resident #55's active care plan, last reviewed 3/1/23, revealed Resident #55 required a feeding tube.

The active May 2023 physician orders included the following:
" An order dated 11/30/22 for Gabapentin 300 milligrams (mg). Give one capsule by mouth three times a day for peripheral neuropathy.
" An order dated 3/27/23 for Cyanocobalamin 500 micrograms (mcg). Give two tablets by mouth one time a day for Guillain-Barre syndrome.
" Vistaril 25 mg. Give one capsule by mouth every six hours as needed for pruritis (itching).
All other medications were written to be provided through the gastric feeding tube.

On 5/16/23 at 11:23 AM, an interview occurred with Resident #55 who stated she received supplemental tube feed during the evening hours and took all her medications via the feeding tube. She explained she had a tough time swallowing at times and did not like to take her medications by mouth.

On 5/16/23 at 1:11 PM, an interview occurred with Nurse #1 who was working the medication cart for Resident #55's hall and had administered her medications earlier. The nurse confirmed Resident #55 did not take her medications by mouth but received all of them by the feeding tube. Nurse #1 was the nurse who had taken the order for Gabapentin 300mg. She reviewed the order and confirmed it should have read to take via the feeding tube and not by mouth.

Nurse #2 was interviewed by phone on 5/16/23 at

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1:52 PM and was familiar with Resident #55. She confirmed Resident #55 received all her medication via the feeding tube and not by mouth.

The Wound Nurse was interviewed on 5/16/23 at 2:00 PM. She was the nurse that transcribed the Cyanocobalamin 500 mcg order for Resident #55. The Wound Nurse explained she entered the medication, dose and frequency into the Electronic Medical System but failed to change the medication route to enterally (feeding tube).

On 5/18/23 at 10:16 AM, the Director of Nursing (DON) was interviewed and reviewed Resident #55's physician orders. She confirmed the route for the Gabapentin, Cyanocobalamin and Vistaril were entered as by mouth instead of enterally as Resident #55 preferred to receive her medications via the feeding tube. The DON felt it was an oversight and stated it was her expectation for all medication administration routes to be entered correctly when the order was received and verified.

Multiple phone calls were made to Nurse #3 who had taken the order for Vistaril 25mg and were unsuccessful.

3. Resident #47 was admitted to the facility on 9/15/2021 with diagnoses that included Guillain-Barre syndrome.

The resident's annual Minimum Data Set (MDS) dated 5/9/2023 indicated the resident was cognitively impaired and required extensive assistance with all activities of daily living including eating.

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The resident's comprehensive care plan, last revised on 5/11/2023, contained a focus for nutritional risk related to chewing difficulties and altered consistency diet. The care plan indicated the resident had a percutaneous endoscopic gastrostomy (PEG) for medications only. Interventions included administering medications via PEG tube as ordered.

Resident # 47's medical record contained the following physician orders:

Crush each tablet and empty each capsule into at least 5ml of water or other appropriate liquid. Flush the tube with at least 30 ml of water or other appropriate liquid prior to and after each medication administration via tube separately. Flush between medications. The order was dated 1/24/2023.

Give Sertraline 1 tablet by mouth every 12 hours for major depressive disorder.
Give Percocet 5-325, 1 tablet by mouth every 12 hours for chronic pain.
Give Gabapentin 600mg , 1 tablet by mouth two times a day for neuropathy.
Give folic acid, 1 tablet by mouth in the morning for supplement.
Give buspirone 15mg, 1 tablet by moth two times daily for anxiety.

On 5/17/2023 at 10:15AM an interview was conducted with Resident #47. She stated she took all of her medications via PEG tube. She further stated she took all of her meals by mouth.

On 5/17/2023 at 12:04 PM an interview was conducted with the Unit Manger. She stated she was covering the medication cart assigned to

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F 658	Continued From page 9 Resident #47. She stated she was very familiar with the resident. The resident originally had difficulty with swallowing which prompted the PEG placement for nutrition and medications. The resident had since regained some function and was taking an altered diet by mouth. However, all of her medications were still administered via the PEG tube. On 5/18/2023 at 10:00 AM an interview was conducted with the Director of Nursing (DON). She stated the resident takes nutrition by mouth and medications via PEG tube. She confirmed the resident was getting the medication via PEG tube and not by mouth. She felt is was an error in transcribing the medication order. It was her expectation all medication orders reflect the correct route of administration.	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff	F 686	1. Address how corrective action will be	6/9/23

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interviews, the facility failed to ensure the alternating pressure reducing air mattress was set according to the resident's weight for 2 of 2 residents reviewed for pressure ulcers (Residents #24 and #40).

The findings included:

1. Resident #24 was admitted to the facility on 5/23/17. Her diagnoses included dementia, fracture of left hip, and osteoarthritis.

A significant change in status Minimum Data Set (MDS) assessment dated 3/14/23 indicated Resident #24 had severe cognitive impairment. She was coded as having a pressure ulcer over a bony prominence and one stage 4 pressure ulcer. She had a pressure reducing device to the bed.

A review of Resident #24's active care plan, last reviewed 3/22/23, included the following focus areas:
- Potential for alteration in skin integrity and prevention of recurrent bruising. The interventions included an air mattress as ordered.
- Resident has impaired skin integrity related to Stage IV to the sacrum. The interventions included an air mattress as ordered.

Resident #24's weight on 5/1/23 was 129 pounds (lbs.).

A review of Resident #24's medical record from 11/21/22 to 5/16/23 revealed wound care was provided to a sacral pressure ulcer.

A review of the active May 2023 physician orders included an order for an air mattress to the bed.

accomplished for those residents found to have been affected by the deficient practice.
1a. On May 18, 2023 the Director of Nursing (DON) met with the Wound Care Nurse concerning residents #24 and #40 and their air mattress settings. Wound Care Nurse states that upon notification during the survey she immediately corrected the settings and continued to monitor them during the survey. No discrepancies identified after correction.
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.
2a. On May 19, 2023 the wound care nurse conducted an audit of all residents on an air mattress to ensure that the settings were correct.
2b. On May 26, 2023 the wound care nurse, the DON and the Administrator met and determined the two different reasons to utilize an air mattress for the resident to promote wound healing and for comfort.
2c. On May 19, 2023 the Wound Care nurse labeled all air mattress pumps with the required setting.
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur.
3a. Wound care nurse or designee to audit monthly weights to ensure air mattress settings are correct and adjust accordingly.
3b. Wound Care Nurse or designee to audit pumps 5x's a week for 12 weeks to ensure the pump's are labeled correctly and the pump is on the correct setting.

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F 686	Continued From page 11 On 5/15/23 at 10:56 AM, an observation was made of Resident #24, who was lying in bed. The alternating pressure reducing mattress machine was set at 250 lbs. per weight setting. The machine had settings of 50 lbs., 100 lbs., 150 lbs., 200 lbs., 250 lbs., 300 lbs., 350 lbs., and 400 lbs. and indicated to set according to the resident's weight per pounds. Resident #24 was observed lying in bed with her eyes closed on 5/16/23 at 11:03 AM. The alternating pressure reducing mattress was set at 250 lbs. On 5/16/23 at 11:15 AM, an interview occurred with the Wound Nurse. She explained maintenance placed the alternating air mattresses on the resident's beds as ordered but she was responsible for setting the machines and monitoring the mattresses. She further stated she normally used the lock out button so the weight settings could not be altered. An observation occurred of Resident #24's alternating air mattress and confirmed the weight setting was on 250 lbs. She verified Resident #24's weight was 129 lbs. and set the machine correctly. The Wound Nurse was unable to explain why the mattress machine had been set incorrectly for Resident #24's weight. The Director of Nursing was interviewed on 5/18/23 at 10:16 AM and stated she expected the alternating pressure reducing mattress machine to be set according to the resident's weight as indicated on the machine. 2. Resident #40 was admitted on 6/21/2022 with diagnoses that included dysphagia.	F 686	She will correct any discrepancies. 3c. Director of Nursing or designee to check orders for settings in Point Click Care (Electronic Medical Record) to ensure staff are checking settings every shift. 3d. All Certified Nursing Assistant's(CNA), nurses, Hospice staff will be educated on the air mattress settings, labels on the pumps and the air mattress settings on the Kardex on May 19, 2023 thru June 9, 2023. 4.Indicate how the facility plans to monitor its performance tomake sure that solutions are sustained. 4a. The Director of Nurse or designee will complete a Low Air Loss Mattress Audit Tool on residents weekly x 12, then monthly x 12. Results of the audit will be brought to the Quality Assurance Performance Improvement Meeting by the Administrator for review. If any discrepancies are noted, further action will be implemented by the Administrator.	

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	345392	A. BUILDING _____ B. WING _____	05/18/2023

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F 686	Continued From page 12	F 686		

The resident's significant change Minimum Data Set (MDS) dated 4/17/2023 indicated the resident was cognitively intact, required extensive assistance with activities of daily living, had a stage 3 pressure injury that was not present on admit, and had pressure reducing devices in bed.

Resident #40's comprehensive care plan was last revised 4/26/2023 had a focus for impaired skin integrity related to impaired mobility. Interventions included use of pressure relieving devices as ordered.

Resident #40's medical record included a physician's order dated 4/28/2023 for air mattress to bed. The medical record also included an order dated 5/16/2023 for wound care. The order read; clean sacral wound with wound cleaner, apply calcium alginate with silver and cover with dry dressing three times weekly on Monday, Wednesday, and Friday.

On 5/15/23 at 11:00 AM, an observation was made of Resident #40 lying in bed. The alternating pressure reducing mattress machine was set at 250 lbs. per weight setting. The machine had settings of 50 lbs., 100 lbs., 150 lbs., 200 lbs., 250 lbs., 300 lbs., 350 lbs., and 400 lbs. and indicated to set according to the resident's weight per pounds.

On 5/16/2023 at 10:00AM Resident #40 was observed lying in bed watching her ipad. The alternating pressure reducing mattress was set at 250 lbs.

On 5/16/23 at 11:27 AM, an interview was conducted with the Wound Nurse. She explained maintenance placed the alternating air

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F 686	Continued From page 13 mattresses on the resident's beds as ordered but she was responsible for setting the machines and monitoring the mattresses. She further stated she normally used the lock out button so the weight settings could not be altered. The Wound Nurse confirmed Resident #40's alternating air mattress was on 250 lbs. She verified Resident #40's weight was 132 lbs. per her medical record and set the machine correctly. The Wound Nurse was unable to explain why the mattress machine had been set incorrectly for Resident #40's weight. The Director of Nursing was interviewed on 5/18/23 at 10:16 AM and stated she expected the alternating pressure reducing mattress machine to be set according to the resident's weight as indicated on the machine.	F 686		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		6/9/23

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F 756	Continued From page 14 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, Pharmacy Consultant and facility's Nurse Practitioner, the facility failed to act upon recommendations made by the Pharmacy Consultant for 1 of 5 residents whose medications were reviewed (Resident #18). The findings included: Resident #18 was most recently admitted to the facility on 11/20/22 with diagnoses which included peripheral vascular disease, heart disease, and hypertension. A review of the active physician's order revealed an order dated 11/20/22 for Apixaban (an anticoagulant) 2.5 milligrams (mg) one tablet by	F 756	1. Address how corrective action will be accomplished for those residents found to have affected by the deficient practice. 1a. On May 22, 2023 the Unit Manager discussed a Consultation Report concerning Resident #18 with the Family Nurse Practitioner (FNP).An order was received to discontinue her anti-coagulant. 2. Address how the facility will identify other residents have the potential to be affected by the same deficit practice. 2a. On May 22, 2023 the Director of Nursing (DON) and the Unit Manager audited 100% of the past 3 months of Pharmacy Consultation Report. 3. Address what measures will be put into place or systemic changes made to	

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F 756	Continued From page 15 mouth two times a day related to presence of unspecified artificial hip joint. Another active physician's orders indicated an order dated Clopidogrel (an anticoagulant) 75 mg one tablet by mouth one time a day for history for deep vein thrombosis. A Pharmacy Consultation report dated 03/22/23 indicated Resident #18 received Apixaban 2.5 mg twice a day and Clopidogrel 75 mg every day. The report indicated a reevaluation of the continued use of both agents and to consider discontinued use of Clopidogrel for history of deep vein thrombosis. The facility's Nurse Practitioner responded on 03/24/23 and checked the box that indicated "I accept the recommendations(s) above, please implement as written." Review of the March 2023 Medication Administration Record (MAR) revealed Resident #18 was administered Apixaban and Clopidogrel 3/24/23 through 3/31/23. A review of Resident #18's April 2023 and May 2023 Medication Administration Record (MAR) revealed she received both Apixaban and Clopidogrel every day. Resident #18's quarterly Minimum Data Set (MDS) assessment dated 05/21/23 indicated she was cognitively intact, and she received anticoagulant medication 7 of 7 days. An interview occurred with the Pharmacy Consultant on 05/17/23 at 1:16 PM. She stated Resident #18 could be on dual anticoagulant therapy, but she requested a recommendation to discontinue Clopidogrel in March. She stated she did not get notification of the Nurse Practitioner's	F 756	ensure that the deficient practice will not reoccur. 3a. On May 23, 2023 the Pharmacy Consultant met with the Unit Manager and provided education on how to track Pharmacy Consultation Reports completion once the Providers have addressed them. 3b. The Administrator educated the Director of Nursing (DON) on May 23, 2023 that going forward all Pharmacy Consultation Reports, after being signed by the Provider, will be reviewed by two Management RNs. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. 100% of the monthly Pharmacy Consultation reports will be double reviewed by RN's to assure that recommendations were addressed as ordered by the provider. Discrepancies identified will be corrected immediately. 4b. Results of the Pharmacy Consultation Report will be brought to the Quality Assurance Performance Improvement meeting by the Administrator or Director of Nursingfor review monthly x 12 months. If any discrepancies are noted further action will be implemented by the Administrator.	

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response to her recommendation. She stated she would speak with the facility's staff to determine if they have addressed the recommendations.

The Unit Manager was interviewed on 05/17/23 at 3:20 PM. She stated pharmacy recommendations were faxed or emailed to her by the Pharmacy Consultant. She stated she would follow up with the Medical Director or Nurse Practitioner regarding the Pharmacy Consultant's recommendations. She stated she did not process the order for Resident #18 on 3/24/23 because she thought the Medical Director wanted to continue both the Apixaban and Clopidogrel.

A phone interview was conducted with the Nurse Practitioner on 05/17/23 at 2:46 PM, who stated she agreed with the pharmacy recommendation made in March to discontinue Resident #18's Clopidogrel and she expected the facility to follow through.

The Director of Nursing (DON) was interviewed on 05/17/23 at 9:59 AM. She stated the Unit Manager received the Pharmacy Consultant's recommendations and reviewed them with the Nurse Practitioner and Medical Director. The Nurse Practitioner had the ability to discontinue medications in the resident's electronic medical record. She stated the discontinuation of the Clopidogrel recommendation would have shown up in the electronic medical record if the Nurse Practitioner put the order in, and the resident's nurse would have to acknowledge it since the order is flagged for acknowledgement in the resident's electronic medical record. She stated the discontinuation of Clopidogrel was not put in by the Nurse Practitioner. She stated she expected the pharmacy recommendation for

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F 756	Continued From page 17 Resident #18 to be completed if the Nurse Practitioner agreed with the recommendation.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs	F 758		6/9/23

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F 758	Continued From page 18 are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to limit the timeframe for a psychotropic medication (any drug that affects the brain activities associated with mental processes and behavior) ordered to be given on an as needed (PRN) basis for 2 of 2 residents whose medications were reviewed (Residents #31 & #28). Findings included: 1. Resident #31 was admitted to the facility on 10/13/22 with multiple diagnoses including anxiety disorder. Resident #31 had a physician's order dated 3/31/23 for Lorazepam (an antianxiety drug) 0.5 milligrams (mgs) - 1 tablet by mouth 3 times a day for anxiety. This order was discontinued on 4/3/23. The significant change in status Minimum Data Set (MDS) assessment dated 4/3/23 indicated that Resident #31 had moderate cognitive	F 758	1. Address corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. On May 19, 2023 the Unit Manager clarified Resident #28 and #31 for psychotropic meds with a stop date. 1b. On May 19, 2023 the DON educated the Hospice Nurse on residents #28 and #31 to clarify the stop dates for as needed (PRN) psychotropic meds requirement and/or reassessment to be provided. 1c. On May 19, 2023 the Hospice Nurse created a PRN medication order form with the resident name, medication, and stop date. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On May 19, 2023 the Unit Manager conducted an audit of 100% resident in the facility receiving prn psychotropic medications. One resident was found to be affected. The Unit Manager contacted	

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F 758	Continued From page 19 impairment and she had received an antianxiety medication for 6 days during the assessment period. Resident #31 had a physician's order dated 4/11/23 for a Lorazepam 0.5 mgs by mouth every 6 hours PRN for anxiety. The order did not have a stop date. The April 2023 Medication Administration Records (MARs) revealed that Resident #31 had received Lorazepam on 4/14/23 at 8:53 PM and on 4/19/23 at 1:31 AM. The May 2023 MARs revealed that Resident #31 had received Lorazepam on 5/3/23 at 7:54 AM, 5/5/23 at 8:01 PM, 5/6/23 at 8:12 AM, 5/8/23 at 2:11 PM, 5/10/12 at 11:54 PM, 5/11/23 at 8:06 PM, 5/12/23 at 12:55 PM, 5/13/23 at 7:42 AM, 5/14/23 at 8:36 AM, 5/15/23 at 7:10 AM and 7:56 PM and on 5/17/23 at 2:00 PM. Nurse #4 was interviewed on 5/17/23 at 1:10 PM. The nurse reported that she had received an order from the hospice nurse for a Lorazepam 0.5 mgs by mouth every 6 hours PRN on 4/11/23 and she transcribed it into the computer. The Nurse stated that she was aware that an order for PRN psychotropic medication required a stop date of 14 days, but she forgot to ask the hospice nurse for a stop date. The Director of Nursing (DON) was interviewed on 5/18/23 at 10:18 AM. The DON stated she would have expected orders for PRN psychotropic medications including Lorazepam to have a stop date even for hospice residents.	F 758	the Hospice Nurse and an order to correct was received immediately. 3.Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 3a.On May 19, 2023 the DON provided education to 100% of the nursing staff on the required regulation for a stop date. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. The DON or designee will review the Point Click Care dashboard during the daily morning meeting for a stop date on all PRN psychotropic medications 5x week for 12 weeks. 4b. The DON or designee will audit PRN psychotropic medications weekly for 12 weeks then monthly for 12 months. Results of the audit will be brought to the QAPI meeting for review monthly for 12 months. If any discrepancies are noted it will be corrected immediately and the nurse transcribing the order will be reeducated.	

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2. Resident #28 was admitted to the facility on 4/27/23 with multiple diagnoses including anxiety disorder.

Resident #28 had a physician's order dated 4/27/23 for a Lorazepam 0.5 mgs by mouth every 6 hours PRN for anxiety. The order did not have a stop date.

The admission MDS assessment dated 5/4/23 indicated that Resident #28 had memory and decision-making problems and she had received an antianxiety medication for 4 days during the assessment period.

The April 2023 Medication Administration Records (MARs) revealed that Resident #28 had received Lorazepam on 4/28/23 at 7:25 AM and on 4/29/23 at 8:39 AM and 8:23 PM.

The May 2023 MARs revealed that Resident #28 had received Lorazepam on 5/3/23 at 2:12 PM and 8:11 PM, 5/4/23 at 3:10 AM and 8:27 PM, 5/6/23 at 7:47 AM, 5/8/23 at 8:47 AM and 8:39 PM, 5/9/23 at 8:32 AM and 9:11 PM, 5/10/23 at 8:45 AM, 5/11/23 at 12:30 AM and 5:01 PM, 5/13/23 at 7:43 AM, 5/14/23 at 8:26 AM, 5/15/23 at 7:09 AM and 7:59 PM, and on 5/16/23 at 7:28 AM.

The Unit Manager was interviewed on 5/17/23 at 10:55 AM. The Unit Manager reported that Resident #28 was admitted to the facility with an order of Lorazepam 0.5 mgs by mouth every 6 hours PRN on 4/27/23 and she transcribed it into the computer. The Unit Manager stated that she was aware that an order for PRN psychotropic medication required a stop date of 14 days, but she missed it for Resident #28.

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F 758	Continued From page 21 The Director of Nursing (DON) was interviewed on 5/18/23 at 10:18 AM. The DON stated she would have expected orders for PRN psychotropic medications including Lorazepam to have a stop date even for hospice residents.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with the Nurse Practitioner and the Medical Director, the facility failed to ensure anticoagulation therapy was restarted after surgical procedure for 1 of 1 resident (Resident #40) reviewed for anticoagulant use. The findings included: Resident #40 was admitted on 6/21/2022 with diagnoses that included atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), and history of a cerebral infarct (stroke). The resident's significant change Minimum Data Set (MDS) dated 4/17/2023 indicated the resident was cognitively intact, required extensive assistance with activities of daily living, had an indwelling urinary catheter, and received anticoagulation therapy 7 out of 7 days. Resident #40's comprehensive care plan was last revised 4/26/2023 had a focus for risk	F 760	1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1a. On May 15,2023 the Director of Nursing (DON) contacted the (FNP) Family Nurse Practitioner to discuss the anti-coagulant medication orders for Resident #40. The (FNP) Family Nurse Practitioner ordered aspirin to be restarted on May 15, 2023 and restart Eliquis on May 16, 2023. 1b. On May 15, 2023 the Director of Nursing (DON)completed a medication error report. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. 2a. On May 16,2023 the Director of Nursing (DON) conducted an audit of consult sheets for 100% of the residents that have been out of the facility for an appointment or out patient procedure. No discrepancies were identified.	6/9/23

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F 760	Continued From page 22 complications related to anticoagulation therapy. Interventions included giving medication as ordered and calling Medical Director with any side effects. Resident #40's medical record included a visit summary from the surgical clinic dated 3/28/2023. The summary indicated the resident was evaluated and deemed a candidate for suprapubic catheter placement. The discharge plan included discontinuing her anticoagulant, Apixaban, three days prior to surgical procedure. The Medication Administration Record (MAR) for April 2023 revealed the anticoagulant Apixaban was discontinued on 4/17/2023. Resident #40's discharge summary from the surgical clinic dated 4/21/2023 indicated the resident had a suprapubic catheter placed. The discharge summary indicated the resident should resume taking the anticoagulant Apixaban on Monday (3 days post procedure). Nurse Practitioner (NP) #1 assessed Resident #40 on her return to the facility 4/21/2023. There was no indication she ordered the anticoagulant to be restarted 72 hours post procedure. Resident #40s MARs for April and May 2023 revealed the anticoagulant Apixaban was never restarted. A pharmacy review was conducted 4/18/2023 with no irregularities noted. A pharmacy review for May 2023 had not yet been completed. On 5/17/2023 at 10:17 AM an interview was conducted with the Medical Director. He stated he	F 760	3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. 3a. On May 19, 2023 the Director of Nursing (DON) provided education to 100% of the nurses concerning follow up orders for residents returning from an appointment or out patient procedure. The Nurses are to notify the provider of any new recommendations on the consult sheet. 4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. 4a. The Administrator or designee will complete an out of facility/out patient procedure audit tool on the residents weekly x 12, then monthly x12. The results of the audit will brought to the Quality Assurance Performance Improvement meeting by the administrator for review. If any discrepancies are noted further action will be implemented by the administrator.	

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	345392	A. BUILDING _____ B. WING _____	05/18/2023

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F 760	Continued From page 23 did not recall why Resident #40 was on an anticoagulant, he would have to go back and look at her medical record. He further stated he was not aware the anticoagulant was not restarted. On 5/17/2023 at 3:03 PM a phone interview was conducted with the Nurse Practitioner. She stated the anticoagulant was stopped due to the placement of the suprapubic catheter. She was not sure why the anticoagulant was not restarted. The resident returned from the clinic late on Friday and the discharge summary may not have been available to her at that time. She would have expected the anticoagulant to have been restarted 3 days post procedure per the surgical clinic's discharge summary. She further stated she had restarted the resident on anticoagulant 5/17/2023.	F 760		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.	F 867		6/9/23

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F 867	Continued From page 24 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or	F 867		

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F 867	Continued From page 25	F 867		

safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

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F 867	Continued From page 26 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations, Nurse Practitioner, Pharmacy Consultant, and staff interviews, the facility's Quality Assurance and Performance Improvement (QAPI) committee failed to maintain implemented procedures and monitor interventions the committee put into place following the annual recertification survey on 11/18/21. This was for four deficiencies that were cited in the areas of Accuracy of Assessments, Reporting and Acting on Reports of Drug Irregularities, Drug Regimen is Free From Unnecessary Psychotropic Meds and Significant Med Errors. The duplicate citations during two federal surveys of record shows a pattern of the facility's inability to sustain an effective QAPI program. The findings included: These citations are cross referenced to: F641- Based on record review and staff interview, the facility failed to accurately code the Minimum	F 867	1. Address how the corrective action will be accomplished for those residents found to have been affected by the deficient practice. 1. The Quality Assurance Process was re-evaluated by the Administrator and the DON on 5/31/23 including monitoring for F641,F658 F686, F758,F760, F756. The Administrator and the DON (Director of Nursing) reviewed the Federal Regulation for tags. 2. Address how the facility will identify other residents having the potential to be affected by the same deficit practice. 2a.On May 22, 2023 the Administrator and the DON reviewed the QA minutes and QA audits for the past 6 months to identify any needs for additional monitoring. 3. Address how measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur. 3a. On May 25, 2023 The Administrator	

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F 867	Continued From page 27 Data Set (MDS) assessments for 4 of 16 sampled residents whose MDS were reviewed (Residents #9, #31, #55 & #9). During the facility's recertification survey of 11/18/21, the facility failed to code the Minimum Data Set (MDS) assessments accurately in the areas of smoking and disposition for 2 of 25 sampled residents reviewed. In an interview with the Administrator on 05/18/23 at 9:40 AM, she felt the repeat citation in MDS accuracy was felt to be related to human error. F756- Based on record reviews and interviews with staff, Pharmacy Consultant and facility's Nurse Practitioner, the facility failed to act upon recommendations made by the Pharmacy Consultant for 1 of 5 residents whose medications were reviewed (Resident #18). During the facility's recertification survey of 11/18/21, the Pharmacy Consultant failed to address the use of an as needed (PRN) psychotropic medication without a stop date for 1 of 6 residents reviewed for unnecessary medications. In an interview with the Administrator on 05/18/23 at 9:40 AM, she stated this error should have been addressed by the Pharmacist Consultant because she reviewed the orders. F758- Based on record review and staff interview, the facility failed to limit the timeframe for a psychotropic medication (any drug that affects the brain activities associated with mental processes and behavior) ordered to be given on an as needed (PRN) basis for 2 of 2 residents whose	F 867	and the DON were re-educated by the Regional Vice President of Operations related to requirements of F867. 3b. On May 31,2023 the Administrator re-educated the QAPI team related to maintaining implemented procedures and follow up monitoring of the interventions or procedures that are implemented in order to sustain compliance as required. 4. Indicate how the facility plans to monitor it performance to make sure that solutions are sustained. 4a. The Administrator or designee will complete a QAPI Audit Tool monthly x 12 to ensure systems and processes continue to be monitored and follow up completed as required. Results of the audit will be brought to the Quality Assurance Performance Improvement Meeting by the Administrator for review. If any discrepancies are noted, further action will be implemented by the Administrator.	

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F 867	Continued From page 28 medications were reviewed (Residents #31 & #28). During the facility's recertification survey of 11/18/21 the facility failed to ensure an as needed (PRN) psychotropic medication was time limited in duration for 1 of 6 residents reviewed for unnecessary medications. In an interview with the Administrator on 05/18/23 at 9:40 AM, she felt like it was an oversight. F760- Based on record reviews and interviews with the Nurse Practitioner and the Medical Director, the facility failed to ensure anticoagulation therapy was restarted after surgical procedure for 1 of 1 resident (Resident #40) reviewed for anticoagulant use. During the facility's recertification survey of 11/18/21 the facility failed to ensure residents were free of significant medication errors for 1 of 1 reviewed for medication errors. In an interview with the Administrator on 05/18/23 at 9:40 AM, she stated this error should have been addressed by the Pharmacist Consultant because she reviewed the orders.	F 867		