STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345066	A. BUILDING _____ B. WING _____	C 06/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DAVIDSON HEALTH & REHAB CENTER	4748 OLD SALISBURY ROAD LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 004 SS=F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E 004		8/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/19/2023

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 004	Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: The facility's EP plan was reviewed and did not include when the last review was completed, nor the date initiated. Other components of the EP plan were present. An interview with the Director Vice President of Operations was conducted on 6/29/23 at 10:29 AM. She indicated the facility went under new management December 2022, did not know why the EP book had not been reviewed and updated and that it should be updated at least annually.	E 004	Problem: F944 The facility failed to review their Emergency Preparedness Plan yearly Corrective action for affected resident On 7-6-2023, the interdisciplinary team reviewed the facility Emergency Preparedness Plan and signed off on the review How will the facility identify other like residents that have the potential to be affected and what corrective action will be done All residents have the ability to be effected by facility failing to review their emergency preparedness plan. What will you do to prevent this from recurring or what systemic change will you implement To prevent this from recurring the Administrator was educated by the Regional Director of Clinical Services on 7-14-2023, on the regulation to review and make updates to their Emergency Preparedness Plan yearly and to have the interdisciplinary team sign off on the review.	

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E 004	Continued From page 2	E 004	Any new administrator will receive this same education upon hire. How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 8-2-2023. The administrator will include the need to review their emergency preparedness plan with the QAPI meeting. QAPI The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-2023.	
F 000	INITIAL COMMENTS A recertification survey and complaint investigation were conducted 6/26/23 through 6/29/23. The following intakes were investigated: NC00201015, NC00197377,NC00200717, NC00201115 and NC00199940. None of the 20 complaint allegations resulted in a deficiency. One Facility Reported Incident NC00202870 resulted in a deficiency based on the recertification. See Event # MVL311.	F 000		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by:	F 641		8/2/23

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F 641	Continued From page 3 Based on record review, observation, Physician and staff interviews, the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of disposition (Resident #94), range of motion (Resident #26), and restraints (Resident #79). This was for 3 of 24 resident records reviewed. The findings included: 1) Resident #94 was admitted to the facility on 4/6/23 with diagnoses that included coronary artery disease, polyosteoarthritis and diabetes type 2. He was discharged home on 5/6/23. The Admission Minimum Data Set (MDS) assessment dated 4/12/23, indicated Resident #94 was cognitively intact, expected to be discharged to the community and active discharge planning was occurring. A nursing progress note dated 5/6/23 indicated Resident #94 was discharged home in a private vehicle with a family member. Review of the Discharge MDS assessment dated 5/6/23, revealed Resident #94 was coded as discharged to the acute care hospital. On 6/28/23 at 3:13 PM, an interview was completed with MDS Nurse #1 who confirmed the resident was marked as discharged to the hospital instead of the home setting in error. 2. Resident #26 was admitted on 4/30/2021. Her diagnoses included cerebral infarction (stroke), and contracture of the right hand.	F 641	Problem F641 Assessment Accuracy: Facility failed to accurately code section A. discharge status, G functional limitations in range of motion and P use of restraints on the MDS. Corrective action for affected resident On 6-29-2023 a modification was submitted for resident #26 correcting the coding for limitations in ROM section G of the MDS. On 6-28-2023 a modification was submitted for resident #79 correcting the coding for restrains section P on the MDS assessment. On 7-5-2023,a modification was submitted for resident #94 correcting the coding for discharge location section A on the MDS assessment. How will the facility identify other like residents that have the potential to be affected and what corrective action will be done To identify other residents who have the potential to be affected on 7/17/23 an audit was completed reviewing MDS assessments for the last 30 days for accurate coding of section A-discharge status, section G-limitation of range of motion, and section P restraints. Any issues Identified were corrected. What will you do to prevent this from recurring or what systemic change will you implement	

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F 641	Continued From page 4 The resident's comprehensive care plan was last revised 5/22/2023 and contained a focus for self-care deficit related to right sided hemiplegia and hemiparesis. Resident #26's annual Minimum Data Set (MDS) dated 5/3/2023 indicated the resident was without upper or lower range of motion impairment. On 6/29/2023 at 11:40AM and interview was conducted with the MDS nurse. She stated the resident should have been coded to reflect impairment of one upper and one lower extremity. The MDS was coded in error. 3) Resident #79 was admitted to the facility on 2/28/23 with an initial admission date of 7/5/22. Resident #79's diagnosis included stroke, hemiplegia or hemiparesis, and generalized muscle weakness. Resident #79 was discharged to the hospital on 6/26/23. Review of Resident #79's medical record showed a Side Rail Evaluation Admit/Annual assessment dated 8/16/22. The assessment showed Resident #79 used the side rails for positioning, turning, and support. The assessment also showed Resident #79 requested to have side rails and the side rails allowed him to be more independent. Review of a physician order dated 3/6/23 read may have bilateral bedrails for safety with bed mobility and transfers for stroke with left hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment dated 3/20/2023 showed Resident #79 was marked as having bed rails daily as a physical restraint.	F 641	To prevent this from recurring on 7/17/23 the Regional MDS Consultant educated the MDS coordinators on accurately coding section A, G, and P on MDS assessments per the RAI manual. All new MDS coordinators will receive this same education prior to completing MDS assessments. How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7- 24-2023, the MDS consultant or designee will audit 5 MDS assessments per week X 12 weeks for accurate completion of section A ,G, and P. QAPI The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-2023.	

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F 641	Continued From page 5 Review of Resident #79's care plan last updated on 6/23/23 showed a focus area Resident #79 was at risk for injury/immobility related to bilateral bed rails. Resident #79 had left-sided weakness and side rails helped aide in bed mobility and independence. Interventions included monitor for a decline in mobility reevaluate for continued use. An interview was conducted on 6/28/23 at 1:54 P.M. with the MDS Nurse #2. The MDS Nurse #2 reviewed Resident #79's medical record and indicated Resident #79 used the bed rails to assist him with mobility and the bed rails were not a restraint. During the interview, MDS Nurse #2 indicated the MDS restraint section was not marked accurately. An interview was conducted on 6/29/23 at 12:17 P.M. with the Director of Nursing (DON). During the interview, the DON indicated Resident #79's bed rails were used to assist him with his mobility while in bed and they were not a restraint. She further indicated the MDS was marked inaccurately.	F 641		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		8/2/23

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F 755	Continued From page 6 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 review and resident, staff, Medical Director, and Pharmacist interviews, the facility failed to acquire a medication ordered for administration for a newly admitted resident resulting in multiple doses of the prescribed medication being missed for 1 of 1 resident (Resident #545) reviewed for the provision of pharmaceutical services to meet the resident's needs. Findings Included: Resident #545 was admitted to the facility on 6/23/23 with diagnoses that included diabetes mellitus with diabetic neuropathy (weakness,	F 755	Problem F755 The facility failed provide newly admitted resident #545 with her prescribed medication upon admission 6/23/23, 6/24/23, and 6/25/23. Corrective action for affected resident Resident number #545 no longer resides in the facility How will the facility identify other like residents that have the potential to be affected and what corrective action will be done To identify other residents who have the potential to be affected, on 7-19-23 an	

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F 755	Continued From page 7 numbness, and pain from nerve damage) and peripheral vascular disease (symptoms include numbness and cramping). Physician order dated 6/23/23 read pregabalin (a medication used to treat nerve and muscle pain) oral capsule 75 milligrams (mg) by mouth two times a day for pain related to peripheral vascular disease. The start date was 6/23/23 at 9:00 P.M. Review of Resident #545's care plan initiated on 6/24/23 showed a focus area for potential for pain. Interventions included administer pharmacological interventions as ordered by physician, monitor for effectiveness, and notify medical doctor if ineffective. Review of Resident #545's Medication Administration Record (MAR) and progress notes from 6/23/23 through 6/27/23 revealed the pregabalin was documented as administered/not administered as follows: -On 6/23/23 at 9:00 P.M., the MAR showed no dose of pregabalin was administered by Nurse #2. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress notes had no note written. - On 6/24/23 at 9:00 A.M., the MAR showed no dose of pregabalin was administered by Nurse #3. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order. - On 6/24/23 at 9:00 P.M., the MAR showed no dose of pregabalin was administered by Nurse #4. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order.	F 755	audit of the last 48 hours for all new admissions was completed or availability of prescribed medications was completed by the Director of Nursing. Any issues were reported to the provider and pharmacy was contacted for medication availability. What will you do to prevent this from recurring or what systemic change will you implement To prevent this from recurring all licensed nurses and medication aides were educated by the Director of Nursing or designee by 7-21-23 on facility protocol for obtaining and administering medications for new admissions, as well as the protocol for medications that are unavailable. All new licensed nurses agency nurses, medication aides, and agency medication aides will receive this same education prior to working with residents How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7-24-23. The Director of Nursing or designee will review 5 resident records per week for availability of prescription medications following admission. The audits will be completed for 12 weeks. QAPI The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations.	

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F 755	Continued From page 8 - On 6/25/23 at 9:00 A.M., the MAR showed no dose of pregabalin was administered by Nurse #3. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order. - On 6/25/23 at 9:00 P.M., the MAR showed no dose of pregabalin was administered by Nurse #2. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the pharmacy had not received a prescription. The on-call physician was contacted and gave an order to hold tonight's dose. - On 6/26/23 at 9:00 A.M., the MAR showed a dose of pregabalin was administered by Nurse #5. - On 6/26/623 at 9:00 P.M., the MAR showed a dose of pregabalin was administered by Nurse #6. The progress note indicated the medication was not currently available. - On 6/27/23 at 9:00 A.M., the MAR showed a dose of pregabalin was administered by Nurse #5. Review of the medication receiving log showed pregabalin 75mg was received by the facility on 6/27/23. An observation on 6/29/23 at 7:35 A.M. revealed the automatic medication dispensing system was observed and had pregabalin 50mg listed as available. An interview was conducted on 6/28/23 at 3:35 P.M. with Resident #545. During the interview, Resident #545 indicated she was unsure what medications she received from staff and if she had received any medication for pain. Resident	F 755	Administrator is responsible for compliance. Date of compliance is 8-2-23.	

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#545 stated she had not had any pain since she arrived at the facility, and she completed her own care with no concerns of pain.

An interview was conducted on 6/28/23 at 3:54 P.M. with Nurse #1. Nurse #1 recalled Resident #545 arrived at the facility the afternoon of 6/23/23. Nurse #1 indicated she was the nurse who entered Resident #545's medication orders into electronic medical record before the end of her shift at 7 P.M. Nurse #1 explained when she entered the Resident #545's medication orders, she does not recall being aware Resident #545 did not have a prescription for her prescribed pregabalin in her discharge package from the hospital. The Nurse stated, if she realized there was no prescription for pregabalin to send to the pharmacy, she would have contacted the medical director, who worked until 8 P.M. or the on-call physician if the medical director was not available.

An interview was conducted on 6/28/23 at 4:49 P.M. with Nurse #2. During the interview, Nurse #2 indicated he was assigned Resident #545 on 6/23/23 from 7 P.M. until 6/24/23 at 7 A.M. Nurse #2 indicated Resident #545's pregabalin was not available for administration on 6/23/23 at 9:00 P.M. During the interview, Nurse #2 indicated he did not contact the physician because he thought the pharmacy was going to deliver the medication during his shift. When the pharmacy had not delivered the medication on his shift, he reported to the on-coming nurse Resident #545's pregabalin had not arrived. The Nurse indicated there was an automatic medication dispensing system on site at the facility that may have had pregabalin available for administration, but he did not have a login and was unable to access the

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medication. During the interview Nurse #2 indicated the next time he was assigned Resident #545, he observed Resident #545's pregabalin was not available for the schedule 9 P.M. administration. Nurse #2 contacted the pharmacy and was advised the pharmacy had not received a prescription to fill the medication. Nurse #2 contacted the on-call physician and received an order to hold the medication. Nurse #2 was unsure of the date he contacted the pharmacy about Resident #545's prescription.

An interview was conducted on 6/29/23 at 7:00 A.M. with Nurse #4, assigned Resident #545 on 6/24/23 from 7 P.M. to 6/25/23 at 7A.M. During the interview, Nurse #4 indicated on 6/24/23 as she prepared Resident #545's medications for the 9 P.M. administration, she realized Resident #545's pregabalin was unavailable in her medication cart. Nurse #4 indicated she documented the medication was unavailable and she didn't have access to the automatic medication dispensing system to see if pregabalin was available in the locked machine. During the interview, Nurse #4 further indicated she was busy during her shift and did not contact the physician for orders or ask another staff member about access into the automatic medication dispensing system. Nurse #4 stated Resident #545 had no complaints of pain during her shift.

An interview was attempted with Nurse #3 who was assigned to Resident #545 on 6/24/23 from 7 AM. to 7 P.M. and again on 6/25/23 from 7 A.M. to 7 P.M. shift but was unsuccessful.

An interview was conducted on 6/29/23 at 7:30 A.M. with Nurse #5, assigned Resident #545 on 6/26/23 7 A.M. to 7 P.M. and on 6/27/23 from 7

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A.M. to 7 P.M. During the interview, Nurse #5 indicated when she was preparing Resident #545's medications for the 9 A.M. medication pass on 6/26/23 and 6/27/23, she observed Resident #545's pregabalin was not in the medication cart. Nurse #5 indicated she went to the automatic medication dispenser and retrieved one pregabalin capsule to administer to Resident #545. When asked what dose of pregabalin she retrieved from the automatic medication dispensing system, Nurse #5 indicated she was unsure and would go look. Nurse #5 went to the automatic medication dispensing system and accessed an inventory list that showed pregabalin 50mg as available to be dispensed, pregabalin 75mg was unavailable in the locked machine. Nurse #5 indicated she had given Resident #545 the wrong dose and she should have called the physician for an order to hold the medication or to administer a dose different than the dose prescribed to the resident. During the interview, Nurse #5 indicated she had not called the physician on either day. Nurse #5 indicated on 6/26/23, she wrote the physician a note in the physician communication book kept at the nurse's desk that referenced Resident #545 needed a prescription for her prescribed pregabalin 75mg twice a day to be sent to the pharmacy.

An interview was conducted on 6/28/23 at with Nurse #6, assigned Resident #545 on 6/26/23 from 7 P.M. to 6/27/23 at 7 A.M. Nurse #6 indicated she was unable to administer Resident #545 her scheduled dose of pregabalin at 9 P.M. because the medication was not available. During the interview, Nurse #6 indicated she did not have access to medication in the automatic medication dispensing system. Nurse #6 further stated she should have contacted the on-call physician for

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additional orders since the mediation was unavailable, but she did not due to being busy. Nurse #6 indicated she does not recall Resident #545 to have any complaints of pain during her shift.

An interview was conducted on 6/28/23 at 5:02 P.M. with the Pharmacist. The Pharmacist indicated an electronic prescription for Resident #545's pregabalin was signed by the Medical Director and received by the pharmacy on 6/27/23 at 9:19 A.M. The medication was filled, sent to the facility, and signed as received by Nurse #5 on 6/27/23 at 1:39 P.M. The Pharmacist indicated staff had access to an automatic medication dispensing machine on-site at the facility that was stocked with pregabalin 50mg and staff had the option of ordering the medication through an emergency pharmacy if the order was stat.

An interview was conducted on 6/29/23 at 10:51 A.M. with the Medical Director. The Medical Director indicated he does a medication reconciliation for all newly admitted residents either the day prior to admission or the day the resident was admitted into the facility. He stated residents were not always sent from the hospital with a hard prescription for medications and staff tried to identify at admission if a resident needed a prescription. The Medical Director indicated, if the facility had contacted him prior to the end of his shift on Friday, 6/23/23, he would have entered a prescription for Resident #545. The Medical Director stated he worked in the facility on Mondays and Thursdays, and staff probably made him aware Resident #545 needed a prescription for pregabalin on Monday, 6/26/23, when he was in the facility. The Medication

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Director indicated when the medication became due on 6/23/23 at 9 P.M. and the schedule medication was not available, staff were responsible to contact a physician for an order. The physician would either hold the medication, order a different dose if the medication was available in a different dose from the automatic medication dispending system, or order a different medication based on what the facility had on hand at the facility. During the interview, the Medical Director indicated the facility worked with an emergency pharmacy that could have sent the prescription to them stat if it was determined the resident needed the medication. The Medical Director further indicated if a different dose of medication was available in the automatic medication dispensing system from the dose prescribed, staff should contact a physician for an order prior to administering the medication. The Medical Director indicated there was no harm caused to the resident for the missed medication doses or a lower dose of pregabalin being administered.

An interview was conducted on 6/29/23 at 11:54 A.M. with the Nurse Manager. During the interview, the Unit Manger indicated when a prescribed medication was not available for a scheduled medication administration time, the nurse should contact the physician or the on-call physician for additional orders. The Unit Manager indicated the physician would either hold the medication for that dose or change the order to a medication the facility had available in their automatic medication dispensing system, or have the medication sent from the pharmacy stat. The Unit Manager further explained all staff who worked in the building should have access to the automatic medication dispensing system and

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F 755	Continued From page 14 when staff were unable to access the medication in the machine, a supervisor should have been contacted for assistance. The Unit Manager explained there were several staff in the building that had privileges in the automatic medication dispensing system to set up user accounts. She explained these individuals were available during the nights shifts and on weekends to access staff with user accounts if they had been made aware a nurse did not have an active login to access the medications in the locked machine. The Unit Manager further indicated she was unaware Resident #545 had not received her pregabalin over the weekend. An interview conducted on 6/29/23 at 12:24 with the Director of Nursing (DON). During the interview, the DON indicated when Resident #545's scheduled medication was not available in the facility at an administration time, staff had the responsibility to utilize the automatic medication dispensing system if the missing scheduled dose was unavailable. The DON stated since the automatic medication dispensing system did not have Resident #545's dose of medication, staff should have contacted the emergency back-up pharmacy to obtain a medication stat and/or the physician should be contacted about a missed dose to obtain new orders, if any from the physician. The DON explained the nurse who admitted Resident #545 and had her discharge paperwork from the hospital should have identified Resident #545's needed a prescription sent to the pharmacy to obtain her medication. The DON did not provide a reason why Resident #545 had not received her prescribed medication over the weekend.	F 755		
F 760 SS=D	Residents are Free of Significant Med Errors	F 760		8/2/23

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F 760	Continued From page 15 CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and resident, staff, Medical Director interviews, the facility failed to prevent a significant medication error by failing to administer a prescribed nerve pain medication to a resident resulting in six doses of medication being missed for 1 of 1 resident (Resident #545) reviewed for medication errors. Findings Included: Resident #545 was admitted to the facility on 6/23/23 with diagnoses that included diabetes mellitus with diabetic neuropathy (weakness, numbness, and pain from nerve damage) and peripheral vascular disease (symptoms include numbness and cramping). Physician order dated 6/23/23 read Pregabalin (a medication used to treat nerve and muscle pain) oral capsule 75 milligrams (mg) by mouth two times a day for pain related to peripheral vascular disease. The start date was 6/23/23 at 9:00 P.M. Review of nursing progress notes showed an admission note dated 6/23/23 that read in part "level of consciousness alert. Cognitive status/ Orientation: alert and oriented x 3-4 ." Review of Resident #545's Medication Administration Record (MAR) and progress notes from 6/23/23 through 6/27/23 revealed the	F 760	Problem F760 The facility failed provide #545 with her pain medication upon admission 6/23/23, 6/24/23, and 6/25/23 Corrective action for affected resident Resident number #545 no longer resides in the facility. How will the facility identify other like residents that have the potential to be affected and what corrective action will be done To identify other residents who have the potential to be affected on 7-19-2023, an audit was completed on all residents with all controlled pain medication for availability for the past 48 hours by the Director of Nursing. Any issues identified were reported to the provider and pharmacy was contacted for medication refills as needed. What will you do to prevent this from recurring or what systemic change will you implement To prevent this from recurring all licensed nurses were educated by the Director of Nursing or designee by 7-21-23 on facility protocol for obtaining and administering medications for new admissions, as well as the protocol for medications that are	

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F 760	Continued From page 16 Pregabalin was documented as not administered as follows: - On 6/23/23 at 9:00 P.M., the MAR showed no dose of Pregabalin was administered by Nurse #2. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress notes had no note written. - On 6/24/23 at 9:00 A.M., the MAR showed no dose of Pregabalin was administered by Nurse #3. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order. - On 6/24/23 at 9:00 P.M., the MAR showed no dose of Pregabalin was administered by Nurse #4. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order. - On 6/25/23 at 9:00 A.M., the MAR showed no dose of Pregabalin was administered by Nurse #3. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the medication was on order. - On 6/25/23 at 9:00 P.M., the MAR showed no dose of Pregabalin was administered by Nurse #2. A chart code of "19" was documented on the MAR to indicate "Other/ See Nurse Notes". The progress note indicated the pharmacy had not received a prescription. The on-call physician was contacted and gave an order to hold tonight's dose. - On 6/26/623 at 9:00 P.M., the MAR showed a dose of Pregabalin was administered by Nurse #6. The progress note indicated the medication was not currently available. An interview was conducted on 6/28/23 at 3:35	F 760	unavailable. All new licensed nurses, medication aides, and agency nurses will receive this same education prior to working with resident regarding facility processes by 8-2-23. How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7-24-23. The Director of Nursing or designee will review 5 resident records per week for availability of controlled pain medication following admission X 12 weeks. Any issues identified will be reported to the MD and pharmacy contacted as appropriate. QAPI The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-23.	

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P.M. with Resident #545. During the interview, Resident #545 indicated she was unsure if staff had administered her Pregabalin over the weekend. Resident #545 stated she had not experienced any pain since her admission into the facility on 6/23/23.

An interview was conducted on 6/28/23 at 4:49 P.M. with Nurse #2. During the interview, Nurse #2 indicated he was assigned Resident #545 on 6/23/23 from 7 P.M. until 6/24/23 at 7 A.M. Nurse #2 stated when he prepared Resident #545's medications to be administered on 6/23/23 at 9 P.M., Resident #545's Pregabalin was not available in the medication cart. The nurse indicated he expected the pharmacy to deliver the medication later in his shift. Nurse #2 indicated Resident #545's Pregabalin had not arrived by the end of his shift, and he reported this to the on-coming nurse. During the interview, Nurse #2 indicated later that weekend, on 6/24/23 or 6/25/23 during the 7 P.M. to 7.A.M. shift, he was assigned to provide care to Resident #545. He observed when he prepared Resident #545's schedule 9 P.M. medications, her Pregabalin was not available. Nurse #2 stated he contacted the pharmacy and learned the pharmacy had not received a prescription. He contacted the on-call physician and received an order to hold Resident #545's 9 P.M. dose of Pregabalin.

An interview was conducted on 6/29/23 at 7:00 A.M. with Nurse #4, assigned Resident #545 on 6/24/23 from 7 P.M. to 6/25/23 at 7A.M. During the interview, Nurse #4 indicated on 6/24/23 when she prepared Resident #545's medications for the 9 P.M. administration, Resident #545's Pregabalin was unavailable in her medication cart to administer. Nurse #4 stated she documented

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the medication being on order because that was the information the off-going nurse told her during the shift report. Nurse #4 stated Resident #545 had no complaints of pain during her shift.

An interview was attempted with Nurse #3 who was assigned to Resident #545 on 6/24/23 from 7 AM. to 7 P.M. and again on 6/25/23 from 7 A.M. to 7 P.M. shift but was unsuccessful.

An interview was conducted on 6/28/23 at with Nurse #6, assigned Resident #545 on 6/26/23 from 7 P.M. to 6/27/23 at 7 A.M. Nurse #6 indicated Resident #545 did not received her scheduled dose of Pregabalin at 9 P.M. because the medication was not available in the medication cart to be administered to the resident. Nurse #6 indicated she does not recall Resident #545 to have any complaints of pain during her shift.

An interview was conducted on 6/29/23 at 10:51 A.M. with the Medical Director. The Medical Director stated he worked in the facility on Mondays and Thursdays, and staff probably made him aware on 6/26/23, when he was in the facility, Resident #545 had not received her Pregabalin and needed a prescription for the medication to filled by pharmacy. The Medication Director indicated when the medication became due on 6/23/23 at 9 P.M. and the scheduled medication was unavailable, staff had the responsibility to contact a physician for an order. The Medical Director indicated there was no harm caused to the resident for the missed medication doses.

An interview was conducted on 6/29/23 at 11:54 A.M. with the Nurse Manager. During the

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F 760	Continued From page 19 interview, the Unit Manger indicated when a prescribed medication was not available for a scheduled medication administration time, the nurse should contact the physician or the on-call physician for additional orders. The Unit Manager further indicated she was unaware Resident #545 had not received her Pregabalin over the weekend. An interview conducted on 6/29/23 at 12:24 with the Director of Nursing (DON). During the interview, the DON indicated when Resident #545's scheduled medication was not available in the facility at an administration time, staff had the responsibility to utilize the automatic medication dispensing system if the missing scheduled dose was unavailable or contact the emergency back-up pharmacy to obtain a medication stat and/or the physician should be contacted about a missed dose to obtain new orders. The DON did not provide a reason why Resident #545 had not received her prescribed medication over the weekend. The DON confirmed Pregabalin at a different dose was in the automatic medication dispensing system.	F 760		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training.	F 947		8/2/23

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F 947	Continued From page 20 §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility filed to provided required dementia management training for 1 of 5 (NA#1) Nurse Assistants (NA) reviewed for required training. The findings included: Paper documents provided by the facility indicated NA#1 was hired May 24, 2023. NA#1's new hire orientation and onboarding was conducted 5/25/2023. There was no indication NA#1 received training on dementia care or managing residents with dementia. Attempts to contact NA#1 were not successful. On 6/29/23 at 9:36 AM an interview was conducted with the Director of Nursing (DON). She stated she had been employed at the facility for three months. She was not aware dementia training was not part of the new hire orientation. She further stated she called corporate and requested dementia training be added to the new hire orientation.	F 947	Problem F947 Facility failed to provide staff with Dementia training prior to working with residents. Corrective action for affected resident Certified Nursing Assistant #1 completed dementia training on 7-13-2023. How will the facility identify other like residents that have the potential to be affected and what corrective action will be done An audit was conducted on 7-17-2023 by the human resources director on all staff for completion of dementia training. All staff identified have completed their dementia training by 7-18-2023. What will you do to prevent this from recurring or what systemic change will you implement To prevent this from recurring the human resources director was educated 7-14-2023, by the administrator on the requirement for all staff to received dementia training during new hire	

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F 947	Continued From page 21	F 947	orientation. All new hires will receive dementia education during new hire orientation prior to working with residents. All new human resources directors will receive this same education prior to participating in new hire orientation All new staff and agency staff will received dementia orientation prior to working with residents How will you monitor and maintain ongoing compliance To monitor and maintain ongoing compliance beginning 7-24-2023. The administrator or designee will review 5 staff records per week for completion of Dementia training for 12 weeks. QAPI The results of the audits will be forwarded to the facility QAPI committee for further review and recommendations. Administrator is responsible for compliance. Date of compliance is 8-2-2023.	