STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345302	A. BUILDING ______ B. WING ______	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	**417 CLOVERDALE ROAD** **SYLVA, NC 28779**

(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 000	Initial Comments An unannounced COVID-19 Focused Infection Control Survey was conducted on 6/7/2023. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	E 000		
F 000	INITIAL COMMENTS The survey team entered the faciltiy on 05/30/23 to conduct an unannounced complaint investigation. The survey team was onsite 05/30/23 throughh 06/01/23. Additional information was obtained offsite 06/02/23 through 06/07/23. Therefore, the exit date was 06/07/23. Event ID# JF7J11. The following intakes were investigated: NC00203264, NC00202755, NC00202555, NC00202114, NC00199037, NC00202544, NC00202189, NC00197864, NC00200034, and NC00197499. 16 of 36 allegations resulted in deficiency.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to provide a	F 558	F 558 Reasonable Accommodations Corrective action was taken to correct this	7/5/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 06/28/2023

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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F 558	Continued From page 1 bariatric cushion for a resident's wheelchair for 1 of 3 residents reviewed for accommodation of needs (Resident #8). Resident #8 reported the wheelchair was uncomfortable to sit in without a cushion which resulted in her not wanting to get up out of bed. Findings included: Resident #8 was admitted to the facility on 06/23/21. Her diagnoses included complete immobility due to severe disability or frailty not caused by spinal cord damage or stroke. The quarterly Minimum Data Set (MDS) dated 03/20/23 revealed Resident #8 had intact cognition. She had impairment of both sides of the lower extremities and used a wheelchair for mobility. During an observation and interview on 05/30/23 at 1:13 PM, Resident #8 voiced she would like to get up out of bed on occasion but she did not have a cushion for her wheelchair and the wheelchair was too uncomfortable to sit in for any length of time without a cushion. She explained she used to have a cushion for her wheelchair but did not recall how long ago that was or what had happened to the wheelchair cushion. Resident #8's wheelchair was placed at the foot of her bed up against the wall with no wheelchair cushion observed on the seat or in her room. During an interview on 06/01/23 at 4:20 PM, the Rehab Manager revealed they used to have a supply of wheelchair cushions but currently did not have any in stock. She stated they had ordered more to have on hand but had not received them. She explained they have had	F 558	alleged deficient practice by the Rehabilitation Director preplacing Resident #8 a wheelchair cushion 6-1-2023. The facility recognizes that all residents requiring Wheelchair cushions could be affected by this Alleged deficient practice. On 6-8-2023 a Facility audit was conducted of residents requiring Wheelchair cushions by the Rehabilitation Director. The audit did not produce any identified medical necessity. Measures put into place to ensure that this Alleged deficient does not recur includes: Re-education was provided to the Management team on 6-8-2023. This education was completed by the Administrator and the Corporate Executive. On 6-8-2023 focused education was provided to the Rehabilitation Director, Central Supply and the Director of Nursing regarding communication expectations of necessary equipment needs. The Rehabilitation Director will maintain a list of cushions and equipment needed for Therapeutic interventions. A list will be compiled and maintained by Central Supply, Rehabilitation Department and Nursing to ensure that the Facility maintains the necessary equipment Identified. This list was completed by the Rehabilitation Director on 6-8-2023. The department managers will have a list of residents that require wheelchair cushions.	

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F 558	Continued From page 2 issues with getting equipment and supplies ever since the facility switched to the current medical supplier. The Rehab Manager stated another resident needed a bariatric wheelchair cushion for their wheelchair and since Resident #8 was not getting up out of bed she took Resident #8's wheelchair cushion for the other resident to use. The Rehab Manager could not recall if she had informed Resident #8 she was taking her wheelchair cushion or if she had ordered Resident #8 another one. During an interview on 06/01/23 at 11:11 AM, the Central Supply staff member confirmed they currently did not have any extra wheelchair cushions in stock and explained wheelchair cushions were usually ordered as requested from therapy with the specific type, material and dimensions needed. The Central Supply staff member explained he was only allowed to purchase supplies from one medical supplier and when he contacted the medical supplier, they did not have the wheelchair cushions in stock. During a telephone interview on 06/02/23 at 2:37 PM, Administrator #1 revealed she was unaware Resident #8 did not have a cushion for her wheelchair and she wasn't informed of the issues with getting wheelchair cushions ordered from the facility's current medical supplier until just a few days ago. She stated they received confirmation from the Corporate Executive yesterday to order wheelchair cushions from a different medical supplier.	F 558	During the Department Manager daily rounds Identified residents will be checked for the presence of their necessary cushions. This will be reported during Morning management rounds to ensure wheelchair cushions are being provided as needed. Monitoring will be completed by the Central Supply Director and the Director of Rehabilitation maintaining a list of available cushions to ensure availability. This list will be reviewed by the Rehabilitation and Central Supply Directors on a weekly basis to ensure availability. An equipment list will be provided to the Department Managers for daily auditing during morning room rounds. This monitoring will be completed weekly for 4 weeks and then monthly for 3 months. The Central Supply Director will compile a list of equipment supplies to include the availability of the wheelchair cushions and present a report to the Monthly Quality Assurance and Process Improvement Committee for 3 months or until a pattern of compliance has been maintained. Date Certain: 7-5-2023	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination.	F 561		7/5/23

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F 561	Continued From page 3 The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident and staff the facility failed to provide the resident with preferred method of bathing for 1 of 1 resident reviewed for choices (Resident #28). The findings included: Resident #28 was admitted to the facility on 03/06/21 with diagnoses including cerebrovascular accident, dementia, and	F 561	F561 #1 Resident #28 was interviewed regarding her preferences on 6/02/23. #2 The facility recognizes the all residents have the potential to be affected by the same deficient practice. On 6/25/23 an audit was completed by the Unit Nurse Manager with the facility	

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F 561

Continued From page 4

rheumatoid arthritis.

The annual Minimum Data Set (MDS) dated 02/28/23 assessed Resident #28's cognition as being intact, and she required total assistance with bathing.

The care plan last revised on 05/22/23 identified Resident #28 was alert and oriented and able to make daily decisions including decisions about her care with the potential for indecisiveness. Interventions included to offer Resident #28 choices with her care and observe for a decline in her decision-making abilities.

During an interview on 05/30/23 at 11:33 AM Resident #28 revealed she received 1 bed bath and 1 shower each week and stated staff were good about giving those as scheduled. Resident #28 revealed she did miss getting a tub bath and stated it had been several months since she had one. Resident #28 revealed she was told she couldn't have a tub bath because the bathtub the facility currently had no longer functioned, and staff did not know when it would be fixed.

An interview was conducted on 06/01/23 at 1:18 PM with the Director of Nursing (DON). The DON confirmed the facility did not have a bathtub that was operational and stated the plan was to have the bathtub removed because it is obsolete, and no one could fix it based on the age of the bathtub and to her knowledge there are no plans to replace it.

An interview on 06/01/23 at 4:22 PM was conducted with the Corporate Executive/Owner of the facility. The Corporate Executive/Owner stated the bathtub the facility currently had was

F 561

residents to obtain bathing preferences. All residents voiced satisfaction with their current bathing choices.
#3
The Social Services Director will interview all new residents to ascertain bathing preferences. The preferences will be discussed during the AM Meeting when completing the new admission checklist.
The
Therapy department did ascertain a vendor to have
The current tubs verified regarding the ability to repair them. As an alternative to the current bath tubs the facility ordered a portable tub gurney that is suitable for residents up to 600 pounds to add a bathing option. This piece of equipment was ordered by the
Central Supply Director on 6-28-2023.

The facility management staff were re-educated by the Administrator regarding the regulation and plan of correction on 6/28/23 at the monthly Quality Assurance Process Improvement Meeting. Department Managers includes: Director of Nursing, Nursing Unit Manager, Social Work Director, Activities Director, MDS Coordinator, Maintenance Supervisor, Rehabilitation Director, Environmental Services Director, Dietary Manager and the Medical Director received this inservice.
#4
An audit of new resident bathing preferences will be completed by the Director of Nursing 5x/week for 4 weeks, then weekly for 8 weeks.

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F 561	Continued From page 5 old and not functioning and their attempts to fix it were unsuccessful. He revealed being told by multiple contractors the parts to fix the bathtub were not available and even if they were the contractor didn't have the knowledge of how to fix the bathtub. The Corporate Executive/Owner revealed his plan was to ideally not to replace the bathtub with a new one but continue trying to fix it but if that was not possible the bathtub would be replaced and reiterated the current plan was to fix it. The Corporate Executive/Owner confirmed there were no other bathtubs in the facility to honor Resident #28's choice to have a tub bath.	F 561	The results of the audit will be presented to the Quality Assurance Process Improvment Meeting by the Director of Nursing for 3 Months. The Director of Nursing is responsible for ensuring the Plan of Corrections is implemented and sustained compliance ensured by the Nursing Home Administrator. Date of Compliance: 7/05/23	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		7/5/23

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F 580 Continued From page 6 F 580

all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with the Medical Doctor and staff the facility failed to notify the physician levetiracetam (an anticonvulsant medication) was not administered as scheduled when the resident was out of the facility for 1 of 1 resident reviewed for dialysis (Resident #1).

The findings included:

Resident #1 was admitted to the facility on 01/04/23 with diagnoses including end stage renal disease.

F580 Notify of Changes

Resident #1 is no longer a resident of the facility.
Immediate action to address the alleged deficient
Practice involved the Director Of Nursing reporting to
The Medical Director the missing doses of Levetiracetam. A medication error report was
Completed by the Unit Nurse Manager on

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F 580	Continued From page 7 Review of the physician order for levetiracetam included directions to give 500 milligrams two times a day for epilepsy started on 01/05/23. Review of the physician order revealed Resident #1 was scheduled for dialysis treatments in the morning every Monday, Wednesday, and Friday at an offsite dialysis center location. Review of Resident #1's Medication Administration Record (MAR) for April and May 2023 revealed levetiracetam 500 milligrams give 1 tablet two times a day for epilepsy was scheduled to be administered at 9:00 AM and 9:00 PM. The MAR revealed at 9:00 AM Nurse #4 had initialed on 04/03, 04/05, 04/10, 04/12, 04/17, 04/19, 04/24, 04/26, 05/01, 05/03, 05/08, 05/10 and documented #1. The MAR's chart code indicated #1 meant out of the facility. During an interview on 06/6/23 at 11:14 AM Nurse #4 revealed on Monday, Wednesday, and Friday Resident #1 went to dialysis and was not in the facility at 9:00 AM when levetiracetam was scheduled and she did not give him the medication. Nurse #4 revealed she did not notify the Medical Doctor levetiracetam was not being administered and/or given to Resident #1 on the days he went to dialysis because it would be removed from the body's system by the dialysis process, and she thought the MD was aware it was not being administered. An interview was conducted on 06/07/23 at 11:45 AM with the MD. The MD revealed levetiracetam should be administered twice a day as scheduled to maintain a therapeutic level in the body's system and if not, it was concerning Resident #1	F 580	6-2-23 for reisdent #1. On 6-2-23 the Direcor of Nursing completed a 100% medicaition audit to ensure that all medications had been administered as ordered.No futher missed medications were reported. Reeducation Was completed for Nurse #4 on 6-2-23 by the Nurse Unit Manager to review the Expectations of medication administration and Physician notification. The facility recognizes that all residents have the Potential to be affected by this alleged deficient Practice. On 6-2-2023 an audit was conducted By the Director of Nursing to ensure that all Residents received their medication prior to Leaving the facility. No further findings were reported. Measures put into place to ensure that this Alleged deficient practice does not recur includes: Inservices were provided to Nurse # 4 on 6-2-23 by the Unit Nurse Manager. On 6-9-2023, 6-12-23 additional education was	

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F 580	Continued From page 8 would have a breakthrough seizure. The MD she expected Nurse #4 to notify her or the Physician Assistant for clarification if an order was needed to hold levetiracetam or to reschedule the administration time, so the Resident #1 received the medication. An interview was conducted on 06/07/23 at 12:43 PM with the Director of Nursing (DON). The DON revealed she expected the nurses to call the MD if they were unable to give a scheduled medication for a resident that was consistently out of the facility for dialysis. The DON stated the MD needed to be notified when a resident's scheduled medications weren't administered, and she expected the nurses to call and inform the physician when that occurred. During an interview on 06/07/23 at 12:57 PM Administrator #2 revealed for a resident receiving dialysis treatments the plan of care approach should ensure scheduled medications were received and she expected the nurses discussed with the MD how to manage medications on the days a resident was out of the facility for dialysis treatments.	F 580	provided for 100% of licensed and registered clinical staff on the process of obtaining missing medications, notification expectations to be made to the Medical Director, as well as notifying administrative nursing of any Failed medication administration times. Any unscheuled nursing staff received education prior to working their shift. Newly hired licensed and registered nursing staff will receive education of notification expectations upon their new hire education. The Unit Managers will complete a review a week in advance of all residents upcoming medical appointments to identify residents in need of modifications to medication schedules. Medication administration times will be reviewed with the facility Medical Director to ensure that the resident's medication schedules are structured around the resident's medical appointments. The Unit Manager and Nurse Consultant will review the Medication Administratrion Record (MAR) and Treatment Administration Record	

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F 580	Continued From page 9	F 580	(TAR) for any medication and/or treatment variances. The resulting information is used to 1) verify that the provider has been notified and 2) to track refusals of any medication and/or treatment so the Medical Director will be informed. Monitoring will be completed by the Unit Manger and the Assistant Director of Nursing completing weekly Medication reviews for any resident That is out of the facility during the medication Passes. Notification of medication changes Will be monitored by the Unit Manager Reviewing the 24 hour report of any Clinical event involving a change in a Residents medication and/or treatment Routines and to ensure that the Medical Director has had been notified. In addition, the pharmacy consultant will complete monthly MAR to CART audits to ensure that all medications are present and are being administered as ordered. The Unit Manager will compile a report Of the weekly 24 hour nursing sheets and Present to the facility Quality Assurance Process Improvement Committee monthly x 3 monthly then quarterly until a pattern of Compliance has been achieved. Date Certain: 7-5-2023	
F 583 SS=E	Personal Privacy/Confidentiality of Records	F 583		7/5/23

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F 583	Continued From page 10 CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to protect private health information	F 583	F583	

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F 583 Continued From page 11

for 2 of 3 medication carts by leaving confidential protected health information unattended and exposed in an area accessible to the public. (Medication cart of 200 Hall and 300 Hall)

The findings included:

1. Resident #24 admitted to the facility on 10/10/18.

A continuous observation was made on 06/01/23 from 4:36 PM through 4:40 PM of an unattended medication cart on the 200 Hall. Nurse #1 left the medication cart with the Medication Administration Record (MAR) in the computer and narcotic logbook on the medication cart opened when she was away providing care in room 209. The computer screen showed the name, picture, and other private health information of Resident #24. The narcotic logbook exposed the name, quantity, and frequency of narcotic used by Resident #24. The surveyor could access other residents' protected health information easily through the computer. Nurse #1 returned to the medication cart approximately 4 minutes later at 4:40 PM.

During an interview on 06/01/23 at 4:43 PM, Nurse #1 explained she was distracted by 2 call lights triggered at the same time when she was doing medication pass. She rushed to answer one of the call lights and had forgotten to close the narcotic logbook and the computer screen before leaving the medication cart. She stated that she had Health Insurance Portability and Accountability Act (HIPAA) training at least once yearly and acknowledged that it was her oversight.

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#1Immediate action to correct the deficient practice includes:
Resident(s) #24 & #35 did not have any outcomes related to the deficient practice includes: Residents #24 & #35 did not have any outcomes related to the deficient practice. Nurse #1 was provided re-education regarding maintaining protection of Personal Health Information, (PHI) on 6-5-23 by the Unit Nurse Manager.

#2
The facility acknowledges that all Facility residents have the potential to be affected by the deficient practice. An audit of medication laptops was completed on 6/02/2023 by the Unit Manager to ascertain Personal Health Information was protected; No further observations noted.

#3 Measures put into place to ensure the alleged deficient practice does not recur:
Nursing staff who administer medications will be re-educated on Personal Health Information, (PHI) and policy by the Unit Manager. The education was initiated on 6/02/2023. Any staff not receiving the education by 7/04/2023 will not work until the education received.
All agency and new hire staff administering medications will receive the education annually and during their on-boarding upon hire.

#4 Monitoring will be completed by:
Department Managers will monitor the medication carts to observe and monitor

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

(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
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A phone interview was conducted with the Director of Nursing (DON) on 06/02/23 at 11:17 AM. She expected the nurse to turn on the privacy protection screen and close the narcotic logbook before leaving the medication cart to protect residents' confidential personal and medical information. It was her expectation for all the staff to follow the HIPAA guidelines when working in the facility.

During a phone interview conducted on 06/06/23 at 2:59 PM, Administrator #2 stated all residents' confidential personal and health information should be protected. She expected all the staff to follow the HIPAA guidelines when working in the facility.
2. Resident #25 was admitted to the facility on 05/02/23.

A continuous observation was made on 05/31/23 from 12:43 PM to 12:50 PM of an unattended computer on the 300/400 Hall medication cart. Nurse #3 left the medication cart out by the nurses' station with the computer screen visible to all that passed by, as she walked down the hall and entered another resident's room. The computer screen showed Resident #25's Protected Health Information (PHI) which included her picture, room number and list of medications.

During an interview on 05/31/23 at 12:55 PM, Nurse #3 was unaware she had left Resident #25's PHI visible on the computer screen when she left the medication cart unattended. Nurse #3 explained she was covering both 300 and 400 Halls and it was her first time working 400 Hall. Nurse #3 verified she had received Health Insurance Portability and Accountability Act

that personal health imformtaion is being protected. Any observed issues will be resolved immediately. Clinical personnel will recieve one on one teachable moment should continued issues arise.
The Unit Manager and Medical Records Licensed Practical Nurse , (LPN), will audit medication carts for compliance with protecting PHI 5x/week for 4 weeks, then weekly for 8 weeks.
The results of the audits will be presented to the Quality Assurance and Process Improvment Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
Date of Compliance: 7/05/2023

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F 583	Continued From page 13 (HIPAA) training and stated she always tried to keep the computer laptop closed when leaving the medication cart unattended but just forgot. During an interview on 06/01/23 at 12:47 PM, the Director of Nursing (DON) stated all nursing staff had received HIPPA training which included not leaving computer screens unattended with resident PHI visible. The DON stated she would have expected Nurse #3 to utilize the computer's privacy protection screen before leaving the medication cart unattended. During an interview on 06/01/23 at 3:49 PM, Administrator #1 explained Nurse #3 was overwhelmed as it was her first day assigned to 400 Hall. Administrator #1 stated Nurse #3 should not have left a resident's PHI visible on the computer screen when leaving the medication cart unattended. During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated all residents' PHI should be protected and computer screens should not be left visible and unattended on a medication cart. Administrator #2 further stated she expected all the staff to follow the HIPAA guidelines when working in the facility.	F 583		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide-	F 584		7/5/23

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F 584	Continued From page 14 §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with residents and staff, the facility failed to maintain walls and baseboards in good repair (rooms 104, 105, 107, 108, 110, 111, 211, 305, 307, 405, and 100 hallway, 300 hallway and 400 hallway); failed	F 584	F584 The facility Administrator #1, Administrator #2, Corporate Executive/Owner, Maintenance Director and Environmental Services Director met on 6-2-23 to discuss a plan	

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F 584 Continued From page 15

to maintain residents' dressers, nightstands and closet door in good repair (108, 109); failed to maintain clean and sanitary room divider curtains (rooms 104,114, 302); failed to repair the doors of residents' rooms observed to have splintered wood and jagged edges (rooms 205, 210, 211, 302, 305, 405); failed to repair holes in the bathroom wall and linoleum floor (room 307); failed to repair a toilet seat that was peeling and a toilet base with a crack on the left side (room 107); failed to ensure residents' overbed tables were sanitary and in good repair (rooms 104, 108, 302); failed to repair the seal surrounding the base of toilets that were cracked and/or had buildup of black colored debris (rooms 104, 106, 205, 210); failed to maintain clean and sanitary rooms and bathroom floors (rooms 112, 210, 302); and failed to repair carpet by the fire doors that was frayed and coming loose (300 hall) for 17 of 51 rooms and 4 of 4 halls reviewed for safe, clean and homelike environment. The facility also failed to ensure residents' wheelchairs were sanitary and in good repair for 8 of 10 wheelchairs observed (wheelchairs #1, #2, #3, #4, #5, #6, #7, #7).

The findings included:

1. a. Observations of room #104 on 05/30/23 at 10:15 AM and 05/31/23 at 9:00 AM revealed linear scrapes with exposed sheet rock on the wall to the left of the bed by the nightstand. The privacy curtain between the A and B beds had small, dark colored stains. The top of the overbed table for the B bed had areas of dried stains/debris and peeling laminate that had been taped along edges of the right side to hold it together. The caulking surrounding the base of the toilet had black colored stains and multiple

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to address the alleged deficiencies.

Rooms 104,105,107,108,110,111,211,305,307,405, and
The 100, 300, and 400 hallways have been patched and prepped for repair.
Rooms 108,109 had the divider curtains replaced on 6-19-2023 by the Environmental Services Director. The Maintenance Director has scheduled the doors to be repaired for rooms 205,210,211,302,305,and 405.

This schedule was discussed and planned on 6-2-23 with The Maintenance Director, Administrator # 1 & #2, and the Corporate Executive/Owner. The holes in the bathroom (room 307) were repaired by the Maintenance Director On 6-9-2023. The toilet seat was replaced by the Maintenance Assistant for room 107 by 6-9-2023.
The Environmental Services Director immediately cleaned The overbed tables for rooms 104,108 and 302.
The wheelchairs #1,#2,#3,#4,#5,#6,#7 and #8 were cleaned on 6-2-2023.

1.a Room #104 had the linear scrapes and exposed sheet Rock on the wall to the left of the bed repaired and Prepped for painting. The privacy curtain was removedand replaced with a curtain that had no stains. This was replaced by the Environmental Services Director on 6-5-2023.The overbed table in #104 was replaced by the Central Supply Coordinator on 6-2-2023.

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F 584	Continued From page 16 cracks. The corner of the wall next to the closet had a section of missing baseboard exposing the sheetrock. b. Observation of room # 105 on 05/31/23 at 9:02 AM revealed exposed sheetrock along the border the wall above the heating and air unit. c. Observation of room #106 on 05/31/23 at 9:03 AM revealed the caulking surrounding the base of the toilet had black colored stains. d. Observations of room #107 on 05/30/23 at 10:30 AM and 05/31/23 at 9:04 AM revealed the middle portion of the bathroom walls had areas that were patched and unpainted. The top left side of the toilet seat was peeling and flaking. The left side of the toilet base had a thin crack starting at the top of the seat to the middle of the base. The wall just inside the entry door of the room there was a section of missing wallpaper, approximately 5 inches in length, on the wall underneath the hand sanitizer unit. e. Observations of room #108 on 05/30/23 at 10:42 AM and 05/31/23 at 9:06 AM revealed the dresser was missing the bottom left drawer. There was a large patched and unpainted are on the front of the closet door. The caulking surrounding the base of the toilet had black colored stains and multiple cracks. There were several areas of unpainted sheetrock on the wall by the mirror. The overbed tables for both A and B beds had areas of dried stains and debris. f. Observations of room #109 on 05/30/23 at 11:05 AM and 06/01/23 at 12:59 PM revealed the door of the nightstand for B bed was crooked preventing the door from closing properly.	F 584	The caulking for room #104 toilet has been scheduled for Replacement by the Maintenance Director by 7-5-2023.The baseboard debris was was corrected by the Environmental Services Director on 6-2-2023. b. The sheetrock for #105 has been prepped and scheduled to have the sheetrock replaced by 7-5-2023. c. The caulking for room #106 has been scheduled for removal and replacement by 7-5-2023 by the Maintenance department. d. Room #107 had the middle portion of the bathroom walls patched and painted. The toilet seat and base has been scheduled for replacement by 7-5-2023. The missing wallpaper was repaired by adhering a Protective wall covering in which the hand sanitizerUnit adhered to. This eliminated the wall paper Covering to this area. e. The dresser in room #108 has been scheduled for repair by the Maintenance Department by 7-5-2023. The wall has been scheduled for painting by 7-5-2023.The caulking for the toilet area will be removed and replaced by 7-5-2023. Both overbed tables were Immediately cleaned by the Environmental Services Director on 6-2-2023.	

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F 584	Continued From page 17 g. Observations of room #110 on 05/30/23 at 11:10 AM and 05/31/23 at 9:09 AM revealed exposed sheetrock along the border the wall above the heating and air unit. h. Observation of room #111 on 05/31/23 at 9:11 AM revealed unpatched and unpainted scrapes on the wall behind the A bed. i. Observations of room #112 on 05/30/23 at 11:20 AM and 05/31/23 at 9:12 AM revealed on the nightstand were 3 bowls stacked inside of each other with dried food debris at the bottom of each bowl. j. Observations on 05/30/23 at 11:38 AM and 05/31/23 at 9:18 AM of the lower portion of the wall between 100 and 200 halls revealed areas of peeling and missing wallpaper. k. Observations of room #405 on 05/30/23 at 11:43 AM and 05/31/23 at 9:20 AM revealed chipped and splintered wood of the middle of the inside entry door. l. Observations on 05/30/23 11:44 AM and 05/31/23 at 9:21 AM of the wall across from room 405 on 400 hall revealed the corner of the wall had missing and exposed sheetrock from the baseboard to the handrail. m. Observations on 05/30/23 at 11:53 AM and 05/31/23 at 9:30 AM revealed a section of the carpet at the fire doors of 300 Hall was frayed and coming loose from the floor. An environmental walk through and interview were conducted on 06/01/23 from 2:55 PM	F 584	f. Room 109 had the door to the nightstand realigned by the Maintenance Director enabling the door to close. g. Room #110 had the exposed sheet rock sanded for painting and repair. The painting is scheduled to be completed by 7-5-2023. h. Room #111 had the scrapes on the wall behind bed A scheduled for repair by 7-5-2023. i.The bowls in room #112 were removed and returned to the dishwashing area for proper cleaning and sanitizing on 6-2-23. j. The lower portion of the wall between 100 and 200 halls were repaired by the Maintenance Director on 6-9-2023. k. Room #405 had the entry door scheduled for repair by 7-5-2023. l. The area across from room 405 on the 400 hall had the area identified prepped For sheet rock and wall repair. The completion Of repairs are scheduled for 7-5-2023 and is to Be completed by the Maintenance Director. m. The area identified at the fire doors of	

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F 584	Continued From page 18 through 3:17 PM with Administrator #1, Administrator #2, Corporate Executive/Owner, Maintenance Director, and Housekeeping Supervisor. The walk through revealed no changes in the environment for rooms 104, 105, 106, 107, 108, 109, 110, 111, 112, 405 and halls 100, 200, 300 and 400. The Maintenance Director stated in the bathrooms where the caulking surrounded the base of the toilet that were cracked and stained needed to be replaced and he would fix the areas of the wooden doors to be smooth without splintered and jagged edges to prevent a resident from being injured. The Maintenance Director observed the toilet seat and base in room 107 and stated he did not recall being informed of the repairs needed. He stated both the toilet seat and base would need to be replaced. The Maintenance Director stated the areas of the walls that were damaged and/or previously patched would need to be sanded and painted and the sheetrock replaced if needed. He stated the area of carpet on the 300 Hall was previously fixed but had come loose again and he would need to figure out something else to do to keep it from loosening until it could be replaced. The Maintenance Director revealed he was aware of most of the environmental issues identified and depended on staff to report repairs needed. The Corporate Executive/Owner stated they were working on a plan for remodeling the facility and the long-term goal was to repair and/or replace the peeling wallpaper on all halls. The Corporate Executive/Owner also explained overbed tables should be kept clean and when staff noticed them in disrepair, they should be removed and replaced. The Housekeeping Supervisor stated it was the responsibility of Housekeeping staff to keep the residents' rooms, bathrooms and overbed tables clean daily and as needed. He	F 584	300 hall was scheduled for replacement and will be completed by 7-5-2023 and is to be completed by the Maintenance Director. 2. a. Wheelchair #1 was power washed by the Nursing department on 6-2-2023. b. Wheelchair #2 had the armrest repaired on 6-24-23. c. Wheelchair #3 was power washed by the Central Supply Coordinator on 6-2-2023. d. Wheelchair #4 was powerwashed and the left arm rest was replaced by the nursing department on 6-2-2023. e. Wheelchair #5 had the wheelchair cushion replaced and the Wheelchair was power washed on 6-2-2023 by the nursing department. f. Wheelchair #6 was power washed on 6-2-23 by the Central Supply Coordinator. g. Wheelchair #7 was power washed on 6-2-2023 by the Central Supply Coordinator. h. Wheelchair #8 was powe rwashed on 6-2-2023 by the nursing department. 3a. Room 205 had the bathroom door and the cauling surrounding the base of the	

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further stated Housekeeping staff were responsible checking the cleanliness of privacy curtains when in the residents' rooms.

2. a. Observations of wheelchair #1 on 05/31/23 at 10:05 AM and 06/01/23 at 9:00 AM revealed thick, dried debris on the frame and armrests.

b. Observations of wheelchair #2 on 05/31/23 at 10:42 AM and 06/01/23 at 9:05 AM revealed the covering of the armrests were cracked and peeling.

c. Observations of wheelchair #3 on 05/31/23 at 11:05 AM and 06/01/23 at 9:11 AM revealed thick, dried debris on the frame.

d. Observations of wheelchair #4 on 05/31/23 at 11:32 AM and 06/01/23 at 9:24 AM revealed dried, rust colored stains on the fabric of the lower part of the top backrest and the covering of the left arm rest was cracked.

e. Observations of wheelchair #5 on 05/31/23 at 11:33 AM and 06/01/23 at 9:25 AM revealed the fabric of the wheelchair cushion was peeling and there was dried debris on the frame.

f. Observations of wheelchair #6 on 05/31/23 at 11:10 AM and 05/31/23 at 9:09 AM revealed several areas of white debris on top part of the seat.

g. Observations of wheelchair #7 on 05/31/23 at 11:26 AM and 06/01/23 at 9:27 AM revealed dried debris on the armrests.

h. Observations of wheelchair #8 on 05/31/23 at 11:37 AM and 06/01/23 at 9:30 AM revealed dried

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toilet were scheduled for Repairs by the Maintenance Director. These repairs are Scheduled to be completed by 7-5-2023. The build up of debris was cleaned and corrected on 7-5-2023 by the Maintenance Director.

b. Room 210 had the lower portion of the bathroom wooden door scheduled for repairs by 7-5-2023 by the Maintenance Director.The baseboard debris was corrected by the Maintenance Staff by 7-5-2023.

c. The sheetrock on the lower portion of the wall in Room# 211 has been repaired. Painting is scheduled To be completed by 7-5-2023.

d. The privacy curtain in room #114 was replaced by the Environmental Director on 6-8-2023.

4a. Room #307 had the wall cleaned on 6-2-2023 by theEnvironmental Services Department. The hole in the wall Was prepped for painting on 6-9-2023 and scheduled for Painting by 7-5-23.

b. Room #302 the brown smeared area was cleaned by the Environmental Services Department on 6-2-2023. The clothes hamper was removed and the soiled linen was Taken to laundry on 6-2-23. The privacy curtain was replaced On 6-2-2023 by the Environmental Services Director. The room was cleaned by the Environmental Services Director On 6-2-2023. The overbed table leg was

F 584 Continued From page 20

debris on the frame and armrests.

An environmental walk through and interview were conducted on 06/01/23 from 2:55 PM through 3:17 PM with Administrator #1, Administrator #2, Corporate Executive/Owner, Maintenance Director, and Housekeeping Supervisor. The Corporate Executive/Owner agreed the wheelchairs observed had dried debris on the frames and/or armrest and should have been cleaned. The Maintenance Director explained both he and the Rehab Manager worked together to repair wheelchairs when noticed and/or needed. He stated he relied on staff to let him know when repairs were needed.

A follow-up interview was conducted with Administrator #1, Administrator #2 and the Corporate Executive/Owner on 06/01/23 at 3:49 PM. The Corporate Executive/Owner stated the cracked armrests on several of the resident's wheelchairs could pose a risk of injury, such as a skin tear, and should have been repaired or replaced.

3a. An observation on 05/30/23 at 1:05 PM revealed in room 205 the inside lower portion of the bathroom door had 3 small areas of missing wood with splintered edges and the frame of the door the paint was scratched off and missing in multiple areas exposing the metal. The caulking surrounding the base of the toilet had black colored stains and multiple cracks. The rubber-like baseboard surrounding the lower portion of the wall had a buildup of debris.

b. An observation on 05/30/23 at 1:19 PM revealed in room 210 the lower portion on the inside of the wooden bathroom door had a hole with jagged and splintered edges. The caulking

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also cleaned by the Environmental Service Director on 6-2-2023.

c. Room 305 has the door and the drywall scheduled for repair by 7-5-2023. These repairs will be completed by the Maintenance
Director.

The facility recognizes that the all residents have the potentialTo be affected by this alleged deficient practice.
Identification of
Further facility Environmental and Maintenance issues were Identified by the Environmental and Maintenance Departments completing facility audits on 100% of the rooms and common areas within the facility.
These audits were completed on 6-12-23 by both the Environmental and Maintenance Directors.

Measures that have been put into place to ensure that this alleged deficient practice does not recur and includes the following:
All department managers received an inservice by the Administrator and Corporate Executive on 6-5-23 on the expectations of reporting of any and all concerns, in regard to ,
The facility plant and residents accommodations.
The Environmental Services Director received an inservice from the Contracting Manager on 6-12-2023 on the cleaning, Rounding and monitoring responsibilities of the
Environmental Services Department. The

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F 584	Continued From page 21 surrounding the base of the toilet was cracked in multiple areas with black colored stains. The rubber-like baseboard surrounding the lower portion of the wall had a build-up of debris and the wall by toilet had brown colored stains. c. An observation on 05/30/23 at 1:22 PM in room 211 revealed the wall by the window had two areas of missing paint. The sheetrock on the lower portion of the wall by bed A was torn and damage in several areas. The lower portion of the wooden entry door to the room had areas where the top layer wood was splintering. d. An observation on 05/31/23 at 4:22 PM in room 114 revealed the privacy curtain for bed B had 4 small dark colored stains. A walk through and interview were conducted on 06/01/23 from 2:55 PM through 3:17 PM with Administrator #2, the Maintenance Director, and the Housekeeping (HK) Supervisor. The walk through revealed no changes in the environment for rooms 205, 210, 211, and 114. The Maintenance Director observed room 205 and stated he didn't recall any report for repairs in room 205. The HK Supervisor observed the baseboard in the bathroom and stated it was the responsibility of HK staff to keep baseboards clean and remove buildup. The HK Supervisor revealed he did check resident rooms for cleanliness including the baseboards in bathrooms. The Maintenance Director stated in the bathrooms where the caulking surrounding the base of the toilet was cracked and stained it needed to be replaced and he would fix the holes in the wooden doors to be smooth without splintered and jagged edges to prevent a resident being injured. The HK Supervisor stated the walls	F 584	Environmental Services Director conducted inservices with the Environmental Services Department on 6-2-2023,6-9-2023, and 6-12-2023 to Reeducate all workers on the daily cleaning processes and Procedures. A daily cleaning check list was initiated to document satisfaction with the completion of daily cleaning Tasks. This check and balance will validate that adequate cleaning projects have been completed as expected. The Environmental Services Contracting Manager Is responsible for completing a monthly visit and walking Tour to ensure that the environmental services Meet the facility requirements and expectations. Monitoring will be completed by the following Systemic changes: All department managers have been assigned rooms and common areas to monitor daily. These observations are reported and discussed daily during the management meetings. Education was provided to the Department Managers on 6-5-23. The Nursing Unit Manager inserviced certified, licensed and registered nursing staff on the communication expectations of any environmental and maintenance concerns. This inervice was provided on 6-5-2023. The therapy department also completed a educational reminder to also report any plant observations so that proper measures can be implemented to correct any issue. The findings and observations of these daily rounds will be	

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F 584

Continued From page 22

and baseboards were part of the deep clean for a resident's room but if areas were noticed those should be cleaned anytime it was noticed. Observation of the damaged wall in room 211, the Maintenance Director revealed it was fixed within the year, but he could sand and replace the sheetrock and repaint the walls including in the bathroom. The Maintenance Director stated he did an occasional walk through and depended on staff to report environmental issues. Observation of the privacy curtain in room 114, the HK Supervisor stated HK staff were responsible to ensure privacy curtains were clean and should be checking those when in the resident's room.

4.a An observation of room 307 on 5/30/23 at 10:32 AM found in the bathroom an area (4 x 2 inches) directly above the trashcan on the wall contained a dried brown smear. The floor behind the toilet was bubbled up with an approximately ¼ inch spit in the flooring material. Additionally, in the bathroom a hole in the wall of the directly beside the door with exposed sheetrock approximately 1 x 1 inches.

On 5/31/23 at 3:32 PM an observation of room 307's bathroom revealed the room remained unchanged from the previous observation.

On 6/2/23 at 10:50 AM an observation of room 307's bathroom revealed the room remained unchanged from the previous observation.

b. Room 302 was observed on 5/30/23 at 12:43 PM and revealed a brown smeared area located on the floor at the base of the toilet. A resident's clothes hamper in the bathroom was full of dirty resident clothes and the floor in-front of the resident's shower contained multiple bath towels. It was also observed that the privacy curtain

F 584

reported daily during the facility managers meeting. This education was provided by the Director of Rehabiliation on 6-7-2023. Daily rounds of the Department Managers will be ongoing.
The Maintenance Director will be responsible for completing daily rounding to ensure that repairs and replacements of
Any facility areas are maintained as required. The Environmental Services Director will complete daily cleaning schedules and observations to ensure that proper
Cleaning procedures are being conducted. Both the Maintenance and Environmental Services Directors will Complete a monthly report and report to the monthly
Quality Assurance and Process Improvement Committee. These Reports will be presented on a monthly basis for 3 months or Until a pattern of compliance has been established.

Date certain: 7-5-2023

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divider in the room contained a large brownish stain the last 2 feet of the curtain. The floor of the room was observed to have varied debris items on the floor including a plastic wrapper and plastic cup under b-bed. The floor of the room was sticky to touch when walking in the room. Under a-bed and between a-bed and the wall, there were multiple clumps of food debris. Additionally, there was food debris on the floor in front of a-beds dresser. The overbed table leg contained a sticky to touch brownish-reddish area (2 x 1 inches).

On 5/31/23 at 3:03 PM an observation of room 302 revealed the room to be unchanged from the previous day.

On 6/2/23 at 11:00AM an observation in room 302 revealed the towels in the bathroom floor had been removed. The room remained unchanged.

An observation of room 305 on 5/30/23 at 12:58 PM revealed the inside of the bathroom door was scrapped with visible splinters across the width of the door approximately 6 inches above the base of the door. Adjacent to the bathroom door the wall had a hole with exposed drywall that went all the way through the wall (3 x 3 inches).

On 5/31/23 at 3:14 PM an observation of room 305 revealed the room remained unchanged.

On 6/2/23 at 11:07 AM an observation of room 305 revealed the room remained unchanged.

On 6/1/23 at 2:30 PM a walk around with Administrator #2 the Maintenance supervisor and Housekeeping Supervisor was conducted. Room 302, 305 and 307 were observed for

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F 584	Continued From page 24 environmental concerns. The Housekeeping Manager reported that the housekeeping staff (HK) were responsible for cleaning the baseboards, especially behind the toilets. The floors of the rooms were the responsibilities of the HK staff to sweep and mop. The HK staff should be checking the privacy curtains when the room was deep cleaned or when a resident would tell HK the curtain needed to be cleaned. The HK manager stated he wasn't aware of the privacy curtain that contained a stain, and that the laundry staff should pick up dirty clothes to be washed. The Maintenance supervisor stated the doors would be sanded down and repaired and the damaged bathroom walls would be sanded or replaced. The Maintenance supervisor was not aware of the damaged baseboard or flooring behind the toilet, and it would be repaired.	F 584		
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: Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of urinary incontinence and functional status for 5 of 15 sampled residents (Residents #11, #17, #18, #22, and #5). Findings included: 1. Resident #11 was admitted to the facility on 03/20/23. His diagnoses included benign prostatic hyperplasia (enlargement of the prostate	F 641	F641 #1 Immediate action taken to correct the alleged deficient practice included: On 6-2-23 the Minimum Data Set (MDS) Coordinator opened a significant change in status assessment was initiated and completed reflecting the deficits on #22. The MDS assessment for #5 was modified on 6-2-23 to reflect accurate coding of incontinence. The Minimum Data Set (MDS) Assessment was corrected for resident's	7/5/23

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gland that can cause difficulty with urinating) and obstructive uropathy (condition in which the flow of urine is blocked).

The admission Minimum Data Set (MDS) assessment dated 03/26/23 revealed Resident #11 had an indwelling catheter and was always incontinent of bladder.

During an interview on 06/01/23 at 1:40 PM, MDS Nurse #1 revealed urinary continence/incontinence information for MDS assessments was pulled over from the Nurse Aide point of care documentation. She explained if the resident's catheter leaked or was out at any point during the MDS look back period then urinary continence/incontinence was documented by the NAs' and rated on the MDS assessment. MDS Nurse #1 stated urinary incontinence should not have been rated if Resident #11's indwelling catheter was intact during the look back period for the annual MDS assessment dated 03/26/23.

During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated MDS assessments should be completed accurately and if a resident had an indwelling catheter, urinary incontinence should be marked as 'not rated' on the MDS assessment.

During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated she would expect for MDS assessments to be completed accurately.

2. Resident #17 was admitted to the facility on 04/05/23. His diagnoses included benign prostatic hyperplasia (enlargement of the prostate gland that can cause difficulty with urinating) and end-stage renal disease.

F 641

#11, #17, & #18 on 6-2-2023 by the MDS Coordinator.

#2 Residents with Urinary Catheters and who are incontinent and residents with impairments have the potential to be affected by the deficient practice. An Audit of residents with urinary catheters, incontinence and impairments was completed on 6/25/2023. Results were unremarkable.

#3 Measures put into place to ensure that the alleged deficient practice does not recur includes the following:
The MDS Nurses were re-educated by the Clinical Consultant on 6/26/2023 regarding accurate coding to include urinary catheters and incontinence. The MDS Director completed inservices with the MDS Assistant on the proper coding of impairments and the proper coding of urinary catheter's and incontinence.
The Director of Nursing or Registered Nurse Supervisor will complete an audit 5 times a week for 4 weeks, then weekly for 8 weeks.

The results of the audits will be presented to the Quality Assurance and Process Improvement Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
Date of Compliance: 7/05/2023

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The admission Minimum Data Set (MDS) assessment dated 04/11/23 revealed Resident #17 had an indwelling catheter and was always continent of bladder.

During an interview on 06/01/23 at 1:40 PM, MDS Nurse #1 revealed urinary continence/incontinence information for MDS assessments was pulled over from the Nurse Aide point of care documentation. She explained if the resident's catheter leaked or was out at any point during the MDS look back period then urinary continence/incontinence was documented by the NAs' and rated on the MDS assessment. MDS Nurse #1 stated urinary incontinence should not have been rated if Resident #17's indwelling catheter was intact during the look back period for the annual MDS assessment dated 04/11/23.

During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated MDS assessments should be completed accurately and if a resident had an indwelling catheter, urinary incontinence should be marked as 'not rated' on the MDS assessment.

During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated she would expect for MDS assessments to be completed accurately.

3. Resident #18 was admitted to the facility on 01/24/23. His diagnoses included diabetes with diabetic chronic kidney disease and urine retention.

a. The quarterly Minimum Data Set (MDS) assessment dated 04/11/23 revealed Resident #18 had an indwelling catheter and was always

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incontinent of bladder.

b. The quarterly MDS assessment dated 05/10/23 revealed Resident #18 had an indwelling catheter and was always incontinent of bladder.

During an interview on 06/01/23 at 1:40 PM, MDS Nurse #1 revealed urinary continence/incontinence information for MDS assessments was pulled over from the Nurse Aide point of care documentation. She explained if the resident's catheter leaked or was out at any point during the MDS look back period then urinary continence/incontinence was documented by the NAs' and rated on the MDS assessment. MDS Nurse #1 stated urinary incontinence should not have been rated if Resident #18's indwelling catheter was intact during the look back period for the annual MDS assessments dated 04/11/23 and 05/10/23.

During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated MDS assessments should be completed accurately and if a resident had an indwelling catheter, urinary incontinence should be marked as 'not rated' on the MDS assessment.

During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated she would expect for MDS assessments to be completed accurately.

4. Resident #22 was admitted to the facility on 10/24/22. Her diagnoses included hemiplegia (partial or total paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

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During an interview on 06/01/23 at 1:40 PM, MDS Nurse #1 confirmed Resident #22 had limited motion of the left upper extremity. MDS Nurse #1 was not sure why the quarterly MDS assessment dated 04/23/23 was marked as Resident #22 having no impairment in the upper extremities and stated it was an error.

During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated MDS assessments should be completed accurately to reflect impairment when a resident was unable to move an extremity independently.

During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated she would expect for MDS assessments to be completed accurately.
5. Resident #5 was admitted to the facility on 02/08/23. His diagnoses included hypertension and Benign Prostatic Hyperplasia (BPH).

The admission Minimum Data Set (MDS) assessment dated 02/14/23 revealed Resident #5 had an indwelling catheter and was coded for being frequently incontinent of bladder.

During an interview on 06/01/23 at 1:40 PM, MDS Nurse #1 revealed urinary continence/incontinence information for MDS assessments was pulled over from the Nurse Aide (NA) point of care documentation. She explained if the resident's catheter leaked or was out at any point during the MDS look back period then urinary continence/incontinence was documented by the NAs' and rated on the MDS assessment. MDS Nurse #1 stated urinary incontinence should not have been rated if Resident #5's indwelling catheter was intact during the look back period for the admission

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F 641	Continued From page 29 MDS assessment dated 02/14/23. During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated MDS assessments should be completed accurately and if a resident had an indwelling catheter, urinary incontinence should be marked as 'not rated' on the MDS assessment. During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 stated she would expect for MDS assessments to be completed accurately.	F 641		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline	F 655		7/5/23

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F 655	Continued From page 30 care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to develop a baseline care plan that addressed a resident's indwelling catheter for 1 of 1 resident reviewed for baseline care plan (Resident #5). The findings included: Resident #5 was admitted to the facility on 02/8/23 with diagnoses including Benign Prostatic Hyperplasia. The baseline care plan dated 02/8/23 revealed Resident #5 was occasionally incontinent and did not have an indwelling catheter. The Medical Director's (MD) progress note dated 2/15/23 revealed the presence of an indwelling	F 655	#1 Resident #5 no longer resides at the facility. Nurse #1 was re-educated on 6/26/23 regarding thorough assessment of new admissions to include the presence of a Urinary Catheter and documentation on baseline care plan. #2 Facility residents with urinary catheters have the potential to be affected by the deficient practice. An audit was completed on 6/25/2023 by the Unit Manager for facility residents with Urinary Catheters without any further identification of missing care plans. #3 Measures that were put into place to	

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urinary catheter which had not been mentioned in the hospital discharge summary. Resident #5 had reported to the MD that the hospital had put the catheter in.

On 5/31/23 at 2:08 PM the Medical Director was interviewed. She stated that Resident #5 had an indwelling catheter when he was admitted to the facility on 2/8/23 and it was removed prior to his discharge from the facility on 2/24/23.

During an interview on 06/01/23 at 1:40 PM, Minimum Data Set (MDS) Nurse #1 revealed the baseline care plan was completed by the receiving nurse and not by the MDS nurse.

On 6/1/23 at 1:00 PM the Director of Nursing (DON) reported that the receiving nurse for Resident #5 did not see that he had an indwelling catheter when he was admitted. The baseline care plan was completed by the receiving nurse without documenting his indwelling catheter.

On 6/5/23 at 4:52 PM a telephone interview the receiving Nurse #4 revealed that she did not recall Resident #5 or what was included on his baseline care plan.

During a telephone interview on 6/7/23 at 3:03 PM the Administrator #2 stated that the baseline care plan should have been completed accurately to reflect Resident #5's diagnoses and needs.

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prevent the alleged deficient practice for recurring are:
All new admissions will be reviewed during AM Clinical Meeting M-F to ensure any resident's admitted with a urinary catheter have appropriate baseline care plan in place.
The MDS Nurses were re-educated by the Clinical Consultant on 6/26/2023 to ensure any new admissions have a baseline care plan by the admitting licensed nurse. All licensed and registered nursing staff received education on the expectations of completing timely and accurate baseline care plans for all newly admitted residents. This education was provided by the Unit Nurse Manager on 6-2-23 and on 6-26-23. Education consisted of the requirement of accurate assessment, components of ensuring proper assessments are continued to a care plan that is reflective of the resident status. Minimum Data Nurses received reiteration of how their roles are to review baseline to assist in assuring that the assessments are accurate. The educational inservices included visual examples of the correct outcome of a desired baseline care plan. An educational instruction binder is available at each nursing station for the nursing staff to use as a reference.

The Director of Nursing or Registered Nurse Supervisor will complete an audit of the new admissions and their baseline care plans 5x/week for 4 weeks, then weekly for 8 weeks.

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F 655	Continued From page 32	F 655	#4 The results of the audits will be presented to the Quality Assurance and Process Improvement Meeting by the Director of Nursing for 3 months. The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator. Date of Compliance: 7/05/2023	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to provide nail care to 1 of 8 dependent residents reviewed for activities of daily living (Resident #26). Findings included: Resident #26 was admitted on 04/26/23 with diagnoses that included acute respiratory failure, congestive heart failure, diabetes and muscle weakness. The admission Minimum Data Set (MDS) dated 05/02/23 revealed Resident #26 had moderate impairment in cognition. Resident #26 required extensive staff assistance with personal hygiene and displayed no rejection of care during the MDS assessment period.	F 677	F677 #1 Immediate action taken to correct the alleged deficient practice: Resident #26 was provided nail care on 6/02/2023 by Unit Manager. #2 Facility residents have the potential to be affected by the same deficient practice. An audit was completed on 6/25/2023 by the Unit Manager regarding resident nail care, intervention was provided as identified. The Activity Department will include Nail/Spa programming in the monthly calendar beginning July 2023. #3 Measures put into place to ensure that	7/5/23

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Continued From page 33

A review of Resident #26's Activities of Daily Living (ADL) care plan, initiated on 05/16/23, addressed an ADL self-care performance deficit related to dementia, impaired balance, gastrointestinal bleed with shock and congestive heart failure. Interventions included: requires staff assistance with personal hygiene, check nail length, trim and clean on bath day and as necessary.

An observation and interview was conducted with Resident #26 on 05/30/23 at 11:49 AM. Resident #26 was observed lying in bed with both hands resting on top of the bed cover. All 5 of his fingernails were noted to have a dried, brown substance underneath the free edge of each nail. Resident #26 looked at his fingernails and stated they needed cleaned but when he asked staff they told him they didn't have time.

A second observation and interview was conducted with Resident #26 on 05/31/23 at 12:58 PM. Resident #26 was observed lying in bed having just finished eating his lunch. His lunch tray was on the overbed table beside his bed with approximately 75% of the meal eaten. Resident #26's fingernails were noted to have a brown dried substance underneath his nails. Resident #26 stated his hands and nails needed cleaned and would allow staff to clean his fingernails if they offered.

An interview was conducted with Nurse Aide (NA) #1 on 05/31/23 at 1:11 PM. NA #1 confirmed she delivered Resident #26's lunch tray and provided him with meal set-up assistance. NA #1 explained she typically checked a resident's hands before meals to make sure they were

F 677

the alleged deficient practice does not recur includes:
Department Manager re-education was completed on 6/26/2023 by the Administrator regarding reviewing resident nails during assigned rounds and ensuring care provided upon identification by appropriate care staff. Education and inservices were provided to the certified, licensed, and registered nursing staff on ADL care as it pertains to nail care on 6-2-23. Any new Department Managers will receive the education during their orientation on-boarding. Department Managers will report the findings of their morning ADL observations during the morning meeting.

#4 The Unit Manager will complete random audits of resident nails 5x/week for 4 weeks, then weekly for 8 weeks.
The results of the audits will be presented to the Quality Assurance Process Improvement Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
Date of Compliance: 7/05/2023

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F 677	Continued From page 34 clean; however, she did not look at Resident #26's hands prior to serving him his lunch meal and had just assumed his hands were clean since he received a shower the evening prior. An interview and observation of Resident #26's fingernails was conducted with the Director of Nursing (DON) on 05/31/23 at 1:58 PM. The DON confirmed Resident #26 had a dried, brown substance underneath the fingernails of each hand. The DON stated his fingernails should have been cleaned prior to him receiving his meal and as needed. An interview was conducted with Administrator #1 on 06/01/23 at 3:49 PM. Administrator #1 stated she would have expected for staff to have cleaned Resident #26's fingernails not just on shower days but as needed and especially before serving him a meal.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and	F 688		7/5/23

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assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident, staff and Medical Doctor (MD) interviews, the facility failed to obtain hand splints as ordered by Occupational Therapy to prevent a decline in muscle tone for 3 of 5 sampled residents reviewed for range of motion (Residents #22, #23, and #15).

Findings included:

1. Resident #22 was admitted to the facility on 10/24/22 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

Review of the Occupational Therapy progress report and updated therapy plan for the certification period 01/17/23 to 02/15/23 noted, in part, a short-term goal that Resident #22 would tolerate splint and sling wear on the left upper extremity for 2+ hour increments for decreased pain. It was noted that a sling and splint were ordered but had not arrived and an extra-large sling was located to facilitate positioning of the left upper extremity in the interim. The Occupational Therapy progress report and updated therapy plan was signed by the facility MD on 01/18/23.

The quarterly Minimum Data Set (MDS) dated 04/23/23 assessed Resident #22 with intact cognition. The MDS noted Resident #22 required

F 688

F688 Prevent Decrease in ROM/Mobility

Immediate action taken to correct this alleged deficient.
Practice included the facility obtaining the splint that was ordered by the therapy department for resident #22. This splint was obtained through another vendor due to the supply chain ordering.Issues. The splint was obtained on 6-9-2023

2. The recommended splint for resident #23 was obtained by on 6-9-2023.

3. The splints were obtained for resident # 15 by another vendor
On 6-9-2023.

The facility acknowledges that any resident requiring Splints may have the potential to be affected by this Alleged deficient practice. An audit was completed on 6-2-2023 by the Rehab Director and no additional Residents were found to not have their necessary Splints.

Measures put into place to ensure that this alleged Deficient practice does not recur includes: The Director of Rehabilitation completed a 100% audit of all residents
With orders for splints on 6-8-2023. The audit supported that all Residents listed

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F 688	Continued From page 36 extensive staff assistance with most activities of daily living and had no impairment of the upper extremities for functional range of motion. An observation and interview was conducted with Resident #22 on 05/30/23 at 10:42 AM. Resident #22 was lying in bed with her arm resting on a pillow and no splint in place. On the back of her wheelchair was a splint that had a metal base curved to fit under the forearm/wrist, a foam cylinder to support the palm, and straps to hold it in place during use. Resident #22 revealed she did not have to wear the splint when lying in bed but did wear it on her left hand/wrist when she was up out of bed. Resident #22 stated therapy had ordered her a new splint to wear but she had not received it yet. During telephone interviews on 06/01/23 at 5:59 PM and 06/02/23 at 1:56 PM, the Occupational Therapist (OT) explained when referring to "muscle tone" it meant the muscles were tighter and were unable to be straightened out without assistance or use of a splint. The degree of the muscle tone varied and if the muscles were able to be straightened out during exercises or use of splint, the muscles rebounded (retracted to a drawn up, tightened position) once the splint was removed or exercises ceased. The OT explained when Resident #22 was first placed on therapy caseload in December 2022, she had mild muscle tone and a resting hand splint was requested on 12/27/22 that was never received. She made a makeshift splint using remnants from another splint with a with foam cylinder for palm support for Resident #22 to use until the resting hand splint was ordered. The OT stated when Resident #22 was put back on therapy caseload in April 2023 she had not received the splint	F 688	had the necessary splints ordered. All Department Managers received an inservice training on 6-2-23. On the process and procedure for communicating Resident□s needs should ordered equipment not be available. The Director of Rehabilitation completed An inservcie to the therapy department on 6-2-23 on the expectations of communicating the residents requiring special equipment including splints. The Current facility vendor utilized for special equipment was contacted and put on notice of expectations Related to communicating any delay in fulfilling any Equipment order that is placed for residents Treatment to the facility Director of Nursing, Central Supply Coordinator and the Administrator. This contact was made by the Administrator on 6-25-23. The facility Certified Occupational Therapist Assistant provided inservices on applying splints, indications of ill fitting and the care of splints as well as communicating the lack of availability to the facility Nurses and C N As on 6-15-2023. An additional vendor was established to provide an option to the facility for ordering splints when needed. Monitoring will be completed by the Director of Rehabilitation maintaining a special device list of all resident□s regarding splints. This list will be updated upon any admissions and discharges. A list of residents	

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F 688	Continued From page 37 ordered on 12/27/22 and the muscle tone in her left hand had increased from mild to moderate and rebounded quicker. She added a second request for the splint was placed on 05/09/23 that had not been received. The OT explained if Resident #22 had received the splint when it was first requested on 12/27/22, the rebound in her left hand would have improved. During an interview on 06/01/23 at 11:11 AM, the Central Supply staff member confirmed he received a request to order a resting hand splint for Resident #22 on 05/09/23. The Central Supply staff member explained he was only allowed to purchase supplies from one medical supplier and when he contacted the medical supplier, they did not have the item in stock. He couldn't recall the exact date but stated it was the first part of May 2023 when he informed both the Rehab Manager and Administrator #1 the medical supplier did not have the splint and was told by Administrator #1 they would have to talk to the Corporate Executive before they could order the splint elsewhere. The Central Supply staff member stated as of date he had not received authorization to order the splint from another medical supplier. During an interview on 06/01/23 at 4:20 PM and follow-up telephone interview on 06/05/23 at 5:17 PM, the Rehab Manager confirmed a splint was requested for Resident #22 that was never received. She stated a makeshift splint was provided by occupational therapy for Resident #22 to use in the interim. The Rehab Manager revealed they have had issues with getting splints ordered ever since the facility switched to their current medical supplier and explained they used interim interventions the best they could until the	F 688	Requiring splints will be provided to all managers so that audits can be completed on a daily basis during their scheduled rounds. The findings of these daily Rounds will be presented and reviewed during the Department Managers meeting so that clinical followup can be completed. The Rehabilitation Director will compile a list of all residents requiring splints and will audit the availability of splints by all residents weekly x 4 and then monthly x 3 months. The Rehabilitation Director will be responsible for creating a report and presenting this to the monthly Quality Assurance Process and Improvement Committee x 3 months. Date Certain: 7-5-2023	

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requested splint was ordered and received, such as a rolled washcloth placed in the resident's hand to stretch the fingers.

During an interview on 06/01/23 at 3:49 PM, the Corporate Executive/Owner stated residents should get the splints they needed based on therapy evaluations. He was unable to provide an answer as to why the splint requested from therapy for Resident #22 was not ordered. He explained splints could be ordered on a case-by-case basis from a different supplier if their current supplier did not have them in stock.

During a telephone interview on 06/02/23 at 2:37 PM, Administrator #1 revealed she had not been made aware of the issues with getting the splints ordered from their current medical supplier until just a few days ago and they received confirmation from the Corporate Executive yesterday to order the splints from a different medical supplier.

During a telephone interview on 06/06/23 at 11:09 AM, the MD revealed she was not made aware of any issues with getting splints ordered for residents when requested by therapy. The MD explained the makeshift splint that was provided by therapy for Resident #22 would do the same thing to maintain range of motion and prevent contractures as one that was ordered from a medical supplier. The MD stated she was not made aware by the OT of any decline in Resident #22's range of motion or muscle tone and did not feel that the delay in receiving the splint caused her any harm or contributed to the increase in muscle tone (can limit range of motion, cause muscles to stiffen and/or lead to contractures).

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During a follow-up telephone interview on 06/07/23 at 12:05 PM, the MD revealed Resident #22 had chronic weakness and a very mild flexion contracture in the left hand but she was able to use her right hand to open and stretch the left hand and fingers and perform her own range of motion exercises. The MD explained a resident who would benefit from a splint would not be able to perform their own range of motion exercises based on their physical or cognitive limitations. The MD stated when she examined Resident #22's left hand, it appeared there weren't any further limitations of the left hand and fingers than when she was first admitted to the facility. The MD stated OT were the experts and she would go by their assessment related to Resident #22's muscle tone increasing from mild to moderate and the more they could do to help prevent progression of the contracture would be better for Resident #22. The MD stated she was not sure a splint would have much impact but it would be beneficial for Resident #22 to wear the splint when resting her left hand.

2. Resident #23 was admitted to the facility on 01/24/23 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the left non-dominant side.

The quarterly Minimum Data Set (MDS) dated 04/28/23 assessed Resident #23 with moderate impairment in cognition. The MDS noted Resident #23 required extensive staff assistance with most activities of daily living and had impairment on one side of both the upper and lower extremities.

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An Occupational Therapy treatment note dated 03/24/23 for Resident #23 read in part, provided left upper extremity passive range of motion to increase engagement in acts and prevent contractures. Resident #23 tolerated 15 to 20 minutes with rest and max assistance to don left hand splint.

An Occupational Therapy treatment note dated 05/31/23 for Resident #23 read in part, provided passive range of motion to left upper extremity with emphasis on shoulder/elbow flexion due to presentation of increased tone. Resident #23 tolerated less than 5 minutes of passive range of motion on this date.

During telephone interviews on 06/01/23 at 5:59 PM and 06/02/23 at 1:56 PM, the Occupational Therapist (OT) explained when referring to "muscle tone" it meant the muscles were tighter and were unable to be straightened out without assistance or use of a splint. The degree of the muscle tone varied and if the muscles were able to be straightened out during exercises or use of splint, the muscles rebounded (retracted to a drawn up, tightened position) once the splint was removed or exercises ceased. The OT explained the splint Resident #23 was admitted with could not be adjusted and only she and one other therapist were able to get the splint on by flexing his wrist so that his fingers would open; however, he was not able to tolerate wearing the splint for very long. The OT stated since starting with therapy services, Resident #23 had an increase in muscle tone and on 05/09/23, she placed an order for a new resting hand splint that had not been received to prevent further decline and would improve the rebound in his left hand/wrist.

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During an interview on 06/01/23 at 11:11 AM, the Central Supply staff member confirmed he received a request to order a resting hand splint for Resident #23 on 05/09/23. The Central Supply staff member explained he was only allowed to purchase supplies from one medical supplier and when he contacted the medical supplier, they did not have the item in stock. He couldn't recall the exact date but stated it was the first part of May 2023 when he informed both the Rehab Manager and Administrator #1 the medical supplier did not have the splint and was told by Administrator #1 they would have to talk to the Corporate Executive before they could order the splint elsewhere. The Central Supply staff member stated as of date he had not received authorization to order the splint from another medical supplier.

During an interview on 06/01/23 at 4:20 PM and follow-up telephone interview on 06/05/23 at 5:17 PM, the Rehab Manager confirmed a splint was requested for Resident #23 that was never received. The Rehab Manager revealed they have had issues with getting splints ordered ever since the facility switched to their current medical supplier and explained they used interim interventions the best they could until the requested splint was ordered and received, such as a rolled washcloth placed in the resident's hand to stretch the fingers.

During an interview on 06/01/23 at 3:49 PM, the Corporate Executive/Owner stated residents should get the splints they needed based on therapy evaluations. He was unable to provide an answer as to why the splint requested from therapy for Resident #23 was not ordered. He explained splints could be ordered on a

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case-by-case basis from a different supplier if their current supplier did not have them in stock.

During a telephone interview on 06/02/23 at 2:37 PM, Administrator #1 revealed she had not been made aware of the issues with getting the splints ordered from their current medical supplier until just a few days ago and they received confirmation from the Corporate Executive yesterday to order the splints from a different medical supplier.

During telephone interviews on 06/06/23 at 11:09 AM and 06/07/23 at 12:05 PM, the MD revealed she was not made aware of any issues with getting splints ordered for residents when requested by therapy. The MD stated if therapy noticed a decline or increase in muscle tone, they typically let her know and she had not been made aware of any concerns. The MD stated OT were the experts and she would go by their assessment related to a resident's muscle tone increasing from mild to moderate. She indicated the more they could do to help prevent progression of a contracture would be beneficial for the resident.

3. Resident #15 was admitted to the facility on 03/19/23 with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke) affecting the right dominant side.

The admission Minimum Data Set (MDS) dated 03/25/23 assessed Resident #15 with severe impairment in cognition. The MDS noted Resident #15 required extensive staff assistance with most activities of daily living and had

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impairment on one side of both the upper and lower extremities.

An Occupational Therapy progress note dated 03/31/23 read in part, provided therapeutic activities with emphasis on passive range of motion in order to prevent contractures and manage discomfort in right upper extremity. Therapist observed decreased range of motion in right wrist and Resident #15 expressed pain during extension of right wrist.

During telephone interviews on 06/01/23 at 5:59 PM and 06/02/23 at 1:56 PM, the Occupational Therapist (OT) explained when referring to "muscle tone" it meant the muscles were tighter and were unable to be straightened out without assistance or use of a splint. The degree of the muscle tone varied and if the muscles were able to be straightened out during exercises or use of splint, the muscles rebounded (retracted to a drawn up, tightened position) once the splint was removed or exercises ceased. The OT states since starting with therapy services, Resident #15 had an increase in muscle tone and on 05/09/23, she placed an order for a resting hand splint that had not been received to prevent further decline and would improve the rebound in her right hand/wrist.

During an interview on 06/01/23 at 11:11 AM, the Central Supply staff member confirmed he received a request to order a resting hand splint for Resident #15 on 03/30/23. The Central Supply staff member explained he was only allowed to purchase supplies from one medical supplier and when he contacted the medical supplier, they did not have the item in stock. He couldn't recall the exact date but stated it was the

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F 688	Continued From page 44	F 688		

first part of May 2023 when he informed both the Rehab Manager and Administrator #1 the medical supplier did not have the splint requested and was told by Administrator #1 they would have to talk to the Corporate Executive before they could order the splint elsewhere. The Central Supply staff member stated as of date he had not received authorization to order the splint from another medical supplier.

During an interview on 06/01/23 at 4:20 PM and follow-up telephone interview on 06/05/23 at 5:17 PM, the Rehab Manager confirmed a splint was requested for Resident #15 that was never received. The Rehab Manager revealed they have had issues with getting splints ordered ever since the facility switched to their current medical supplier and explained they used interim interventions the best they could until the requested splint was ordered and received, such as a rolled washcloth placed in the resident's hand to stretch the fingers.

During an interview on 06/01/23 at 3:49 PM, the Corporate Executive/Owner stated residents should get the splints they needed based on therapy evaluations. He was unable to provide an answer as to why the splint requested from therapy for Resident #15 was not ordered. He explained splints could be ordered on a case-by-case basis from a different supplier if their current supplier did not have them in stock.

During a telephone interview on 06/02/23 at 2:37 PM, Administrator #1 revealed she had not been made aware of the issues with getting the splints ordered from their current medical supplier until just a few days ago and they received confirmation from the Corporate Executive

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F 688	Continued From page 45 yesterday to order the splints from a different medical supplier. During telephone interviews on 06/06/23 at 11:09 AM and 06/07/23 at 12:05 PM, the MD revealed she was not made aware of any issues with getting splints ordered for residents when requested by therapy. The MD stated if therapy noticed a decline or increase in muscle tone, they typically let her know and she had not been made aware of any concerns. The MD stated OT were the experts and she would go by their assessment related to a resident's muscle tone increasing from mild to moderate. She indicated the more they could do to help prevent progression of a contracture would be beneficial for the resident.	F 688		
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 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-	F 755		7/5/23

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F 755	Continued From page 46 §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 interviews with resident, staff, Pharmacy Manager, and the Medical Director (MD), the facility failed to acquire medications ordered for administration resulting in multiple doses of the prescribed medication being missed for 1 of 2 residents reviewed for the provision of pharmaceutical services to meet residents' needs. (Resident #3) The findings included: Resident #3 was admitted to the facility on 07/26/22. His cumulative diagnoses included multiple sclerosis (MS), postherpetic trigeminal neuralgia, and chronic facial pain. Review of Resident #3's history of primary payers revealed he was covered by Medicare from 07/26/22 through 10/13/22. He became private pay from 10/14/22 through 03/31/23. Started from 04/01/23, Resident #3 was covered by Medicaid of North Carolina. According to the medication records, Resident #3 was his own Power of Attorney.	F 755	F755 #1 Resident #3s medications were audited by the Unit Manager on 6/02/2023, all prescribed medications available. On 6/02/2023 a Medication Error Report was completed by the Unit Manager regarding the missed doses of medication identified during the survey. After the medication error report was reviewed by the Medical Director it was determined that there was no adverse affects. Two payor sources were secured for resident #3 to ensure that the $9000.00 medication remains available. #2 Facility residents receiving medications have the potential to be affected by the deficient practice. An audit of resident medication orders, Medication Administration Record (MAR), and available medications on Medication Cart was initiated on 6/25/2023 without any identification of further missing	

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Review of physician orders dated 07/27/22 revealed Resident #3 had an order to receive one capsule of fingolimod 0.5 milligram (mg) by mouth once daily. This medication was indicated to treat the relapsing forms of MS by slowing down some disabling effects and decreasing the number of relapses of the disease. The average counter price of this medication was over $9,000 for 30 capsules.

The care plan for MS initiated on 07/29/22 revealed Resident #3 had experienced pain due to MS. The goals were to remain free from unrelieved pain or to maintain pain at an acceptable level. Interventions included providing and administering medications as ordered, monitoring pain medications for effectiveness and side effects, and documenting verbal and non-verbal signs and symptoms of pain.

Review of facility's morning meeting minutes dated 02/22/23 revealed medication hold (discontinuation of medications) imposed by the pharmacy for Resident #3 due to non-payment was discussed in the meeting. The Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Manager (UM), and the Minimum Data Set (MDS) Coordinator had attended the meeting. The Social Worker (SW) and the Business Office Manager (BOM) were not listed in the meeting minutes.

Review of Resident #3's electronic Medication Administration Record (MAR) from 04/15/23 through 05/15/23 revealed he had not received fingolimod as ordered on the following dates:
- On 04/24/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. A chart

F 755

medications. Our LICENSED PRACTICAL NURSES (LPN), and Medication Aides were re-educated on 6/25/2023 regarding policy on missing medications. Any staff not receiving education by 7/04/2023 will not be allowed to work until education is received. Any agency and new facility licensed nurse/medication aide will receive the education during orientation on-boarding. The Unit Manager and Medical Records LPN will audit 5 residents each 5x/week for 4 weeks, then 5 residents each weekly times 8 weeks to ensure ordered medications are available.
#4
The results of the audits will be presented to the Quality Assurance Process Improvement Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
Date of Compliance: 7/05/2023

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code of "8" was documented on the MAR to indicate "Other". The progress notes indicated the medication was unavailable.
- On 04/29/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. A chart code of "4" was documented on the MAR to indicate "Hold medication".
- On 05/01/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. No chart code was documented, and it was blank on the MAR.
- On 05/04/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. A chart code of "4" was documented on the MAR to indicate "Hold medication".
- On 05/08/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. A chart code of "8" was documented on the MAR to indicate "Other" without any documentation to explain it.
- On 05/10/23 at 9:00 AM, the MAR showed no dose of fingolimod was administered. A chart code of "4" was documented on the MAR to indicate "Hold medication".

The MDS dated 04/26/23 assessed Resident #3 with intact cognition. He was coded with adequate hearing and vision with clear speech. He received scheduled and "as needed" pain medications and was taking opioid 4 days in the 7-day assessment periods.

Physician's progress notes dated 04/26/23 revealed there had been a mix-up regarding Resident #3's insurance. He was unable to pay for his medication being billed but discovered that he had coverage through the Veterans Affairs (VA). The physician planned to continue fingolimod as it was essential and discussed

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tapers on other medications. The physician was contacted later that evening and informed that the VA could have all his medications shipped. The physician recommended continuing all medications as ordered.

Nurse's progress notes dated 05/04/23 revealed Resident #3 was experiencing confusion after lunch. Nurse #2 called the physician and obtained order to send Resident #3 to emergency room (ER) for evaluation. ER indicated Resident #3's symptom was consistent with MS flare. Resident #3 returned to the facility on the same day around 9:30 PM with new order of prednisone 20 mg twice daily. On the same day, the DON documented she had contacted VA staff for fingolimod prescription. VA staff confirmed prescriptions were processed on 04/27/23 but had not shipped the medications. VA staff stated they had entered an emergency refill request.

Review of hospital discharge summary dated 05/04/23 revealed Resident #3 arrived ER at 3:32 PM for evaluation due to decreased mental status starting that day. Resident #3 had no fever or chills and was stable. Physical exam revealed the symptoms was consistent with MS flare. The discharge instructions ordered to treat supportively and discharge to the facility in that evening.

During an interview conducted on 05/30/23 at 3:11 PM, the UM stated she began to receive fax notification from the pharmacy in January 2023 (about 3 months before the pharmacy stop supplying medications) due to Resident #3's unpaid balance of over $70,000.00 dollars. When she received the notification again in mid-February, she brought the fax notification to

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Resident #3 and explained the situation to him, and he expressed understanding. She took the fax notification to the morning meeting on 02/22/23 (Wednesday) and discussed it with other staff in the meeting. she recalled the former Administrator, SW, DON, and ADON were in that meeting. She was not sure about the BOM. She stated Resident #3 had shown symptoms of MS at times prior to 05/04/23 even though he was getting fingolimod continuously. Resident #3 was sent to ER due to confusion and weakness. He was stable without distress and returned to the facility a few hours later.

An interview was conducted with Resident #3 on 05/30/23 at 4:28 PM. He stated when he was out of fingolimod intermittently in early May, he was able to eat and talk, and he denied having any pain or difficulty eating in those few days. The only change he had was having double vision when looking at the clock on 05/04/23. He was made aware of the outstanding bills with the pharmacy through a facility staff about 3 months prior to medication hold started.

During an interview conducted on 05/31/23 at 9:33 AM, Nurse #2 stated she was alerted by a rehab staff telling her that Resident #3 was unable to do any therapy on 05/04/23. She assessed Resident #3 immediately and noted he was having mild confusion and weakness. She called the physician and obtained order to send him to ER. She stated fingolimod was unavailable for Resident #3 on 05/04/23 and 05/10/23.

An interview was conducted with the SW on 05/31/23 at 10:27 AM. She stated Resident #3 had tried to apply for Medicaid after Medicare coverage was ended. The application was

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F 755	Continued From page 51 pending due to incomplete banking information. She did not know Resident #3 was a VA patient and the medication hold until facility staff began to work on getting his fingolimod around late April. She could not recall any discussion with other staffs regarding medication hold in the morning meeting back in February. She denied receiving any notification from the pharmacy regarding medication hold as they would normally contact the nursing or BOM. During an interview conducted on 05/31/23 at 11:29 AM, the DON confirmed the SW and the BOM were in the morning meeting on 02/22/23 to discuss Resident #3's medication hold. On 04/24/23, she was notified by nursing staff that fingolimod was out for the first day. Nursing attempted to order it from the pharmacy unsuccessfully. When she called VA neurologist on 04/27/23 to get prescription for fingolimod, the neurologist told her that missing some doses of fingolimod was not very concerning. On the same day, VA staff indicated that they were overnighting fingolimod to the facility. As she did not receive fingolimod on 04/28/23, she tried to notify VA staff that day but was unable to reach anyone. On 05/01/23, she contacted VA staff to inform them that fingolimod did not arrive the facility. She stated a nurse found a few capsules of unexpired fingolimod brought in by Resident #3 during admission after 04/24/23. Those fingolimod were being administered intermittently before the shipment arrived from VA on 05/11/23. She explained all the "Hold" and "Other" in MAR for fingolimod indicated it was unavailable. She stated the non-clinical staff included the BOM and SW should coordinate and address the issues proactively and provide follow-up as necessary as appropriate to avoid the medication hold. It was	F 755		

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her expectation for all the residents to receive medication as ordered in timely manner without disruptions.

An interview was conducted with the MD on 05/31/23 at 1:41 PM. She stated Resident #3 was noted with double visions intermittently a few months ago and had MS flare several times in the past even though fingolimod was available. She stated Resident #3's symptoms of confusion and weakness were inconsistent with MS flare. She explained MS mainly affecting neurological reactions and very unlikely would trigger symptoms of confusion or weakness. Resident #3 did not experience any pain, difficulty swallowing or other MS related symptoms when he was out of fingolimod intermittently. She disagreed with ER discharge summary indicating Resident #3 was having MS flare on 05/04/23. The MD stated MS patient should be clinically okay without fingolimod for up to 2 weeks due to its long half-life and slow drug absorption.

During a phone interview conducted on 06/01/23 at 12:21 PM, the Consultant Pharmacist stated when the pharmacy decided to impose medication hold to Resident #3 due to non-payment, he was not notified as it was a non-clinical issue. He was made aware of the matter after the medication hold was in place. The DON contacted him about a month ago to ask for assistance to obtain the costly fingolimod. He directed the DON to seek help through patient assistance programs or contact the drug manufacturer. He stated when he made a follow-up call a few days later, the DON told him that the issues had been resolved.

A phone interview was conducted with the

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F 755	Continued From page 53 Pharmacy Manager on 06/01/23 at 3:07 PM. He stated the medication hold due to non-payment was started on 04/12/22. The pharmacy had made multiple attempts to contact the facility prior to the medication hold. On 01/12/23, the pharmacy left a voicemail for the former Administrator and faxed the first notice of discontinuation. On 02/14/23, the pharmacy called the facility and left a voicemail for the former BOM and faxed the second notice of discontinuation. On 03/20/23, the pharmacy faxed the final notice and spoke with the DON who stated she would follow-up with the matter. He stated the pharmacy called Resident #3 on 01/12/23, 02/14/23; and 03/20/23 and all attempts were reached a voicemail. During an interview conducted on 06/01/23 at 4:24 PM, Administrator #1 stated the facility had proposed a payment plan for the outstanding balance for Resident #3 but was rejected by the pharmacy as they wanted to have a full payment. She stated nursing staff should alert and coordinate with the non-clinical staff and took proactive actions before the medication hold was put in place by the pharmacy. It was her expectation for the facility to ensure all the residents to receive medication as ordered without disruptions. During a phone interview conducted on 06/01/23 at 5:21 PM, the former BOM stated her last day with the facility was 03/27/23. She could not recall she had attended the morning meeting in February to discuss medication hold for Resident #3.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		7/5/23

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§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 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

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F 758	Continued From page 55 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 interviews with the Pharmacy Consultant and staff, the facility failed to provide an adequate indication for the use of quetiapine (an antipsychotic medication) and failed to limit its use to 14 days or provide a rationale for the continuation of the medication administered as needed and failed to limit the use to 14 days or provide a rationale for the continuation of lorazepam (an anxiolytic medication used to treat increased anxiety) administered as needed for 1 of 2 residents reviewed for unnecessary psychotropic medications (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/04/23 with diagnoses including end stage renal disease, panic disorder, and diabetes mellitus. A diagnosis for major depressive disorder was added on 04/03/23. Review of the physician's order for quetiapine 25 milligrams (mg) provided directions to give every four hours as needed for agitation with a start date of 01/05/23 and a discontinue date of 04/03/23.	F 758	F758 #1 Resident #1 no longer resides at the facility. #2 Facility residents with prescribed Psychotropic Medications have the potential to be affected by the deficient practice. An audit was completed on 6-2-23 and 6/25/2023 by the Unit Manager for previous 30-day admissions to ascertain any prescribed psychotropic medications and stop dates, or justification for continuance. Results were unremarkable. #3 Measures put into place to ensure that the alleged deficient practice does not recur includes: The Unit Nurse Manager and Nursing Consultant completed a 100% resident review to ensure that any resident receiving psychotropic medications have the proper diagnoses and stop dates for administration. This 100% review was completed on 6-2-2023 by the facility nurse managers. EDUCATION to the clincial licensed, registered nurses and	

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F 758	Continued From page 56 Review of the physician's order for lorazepam 0.5 mg provided directions to give every eight hours as needed for anxiety with a start date of 01/05/23 and discontinue date of 04/18/23. A new order was written on 04/18/23 for lorazepam 0.5 mg give every eight hours as needed for 14 days with a discontinued date of 05/02/23. Review of the Pharmacist Consultant monthly medication review for Resident #1 dated 01/09/23 read in part, "if the antipsychotic quetiapine order was to continue, please update the medical record to include: 1) the specific diagnosis/indication requiring treatment that is based upon an assessment of the resident's condition and therapeutic goals; 2) a list of the symptoms or target behaviors including their impact on the resident or others, and 3) documentation that other causes and medications have been considered, that individualized nonpharmacological interventions are in place, and that ongoing monitoring has been ordered. Please discontinue as need quetiapine or add a stop date that does not exceed 14 days from initiation. If the as needed antipsychotic cannot be discontinued at this time, the prescriber should directly examine the resident to determine if the antipsychotic was still needed and document the specific condition being treated prior to issuing a new as needed order. Please discontinue as needed lorazepam, tapering as necessary and if the medication cannot be discontinued at this time, document the indication for use, the intended duration of therapy, and the rationale for the extended time period." Review of the January Medication Administration Record (MAR) revealed as needed lorazepam 0.5	F 758	medication aids was completed on 6-2-23. This education was provided by the facility nurse manager. New orders including Psychotropic medications will be reviewed during the Clinical Meeting for 14- day stop dates and justification. The Unit Nurse Manager provided education to the licensed and registered nurses on the expectations of management of psychotropic medications. Education was provided by the Clinical Consultant to the Medical Director, Nurse Practitioner, Consultant Registered Pharmacist, Nursing Administration team and Social Services Director regarding regulation including 14-day stop dates and justification for continued use. This education was provided on 6-28-23. #4 Monitoring will be completed by conducting an Audit of all newly prescribed Psychotropic Medications will be completed by the Director of Nursing 5x/week for 4 weeks, then weekly for 8 weeks. The results of the audits will be presented to the Quality Assurance and Process Improvement Meeting by the Director of Nursing for 3 months. The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator. Date of Compliance: 7/05/2023	

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mg was administered on 01/22/23 and quetiapine 25 mg was not administered in January.

Review of the February MAR revealed as needed quetiapine 25 mg was administered on 02/07/23 and lorazepam 0.5 mg was administered on 02/05/23, 02/25/23, and 02/28/23.

Review of the 02/28/23 Pharmacy monthly medication review revealed no recommendations were made by the Pharmacist Consultant for Resident #1.

Review of the March MAR revealed as needed quetiapine 25 mg was not administered and lorazepam 0.5 mg administered on 03/01/23, 03/03/23, 03/04/23, 03/05/23, and 03/07/23.

Review of the Pharmacist Consultant monthly medication review for Resident #1 dated 03/30/23 read in part, If the antipsychotic order quetiapine was to continue update the medical record to include: 1) the specific diagnosis/indication requiring treatment based on an assessment of Resident #1's condition and therapeutic goals, 2) provide a list of symptoms or target behaviors including their impact on the resident or others and, 3) documentation that other causes and medications had been considered, individualized nonpharmacological interventions were in place and ongoing monitoring had been ordered. To discontinue lorazepam tapering as necessary and if unable to discontinue document the indication for use, the intended duration of therapy, and the rationale for the extended time period.

Review of the admission Minimum Data Set (MDS) dated 04/05/23 assessed Resident #1's cognition as intact and with no behaviors. The

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MDS revealed Resident #1 received antianxiety medication for 7 days and no antipsychotic medication during the lookback period.

Review of the April MAR revealed as needed quetiapine 25 mg was not administered and discontinued on 04/03/23. The April MAR revealed lorazepam 0.5 mg was not administered and discontinued on 04/18/23 and restarted on 04/18/23 as needed for anxiety for 14 days.

Resident #1's care plan last reviewed on 04/17/23 identified the use of antianxiety medications to treat anxiety disorder with interventions including to administer antianxiety medications as ordered by the physician, monitor for side effects, and effectiveness every shift. The care plan identified agitation behaviors demonstrated by Resident #1 and included interventions to provide psychiatric services as needed and notify the Medical Doctor of significant changes in behaviors.

During an interview on 06/01/23 at 3:28 PM the Unit Manager (UM) revealed an automatic 14-day stop date was used for antipsychotic and psychotropic medications if ordered as needed unless the physician provided an order to administer for a longer period. The UM revealed the quetiapine and lorazepam were started on 01/05/23 as an admission order on Resident #1's hospital discharge summary and continued as needed from the date of admission through April 2023. The UM revealed the March 2023 recommendations made by the Pharmacy Consultant were addressed by the Medical Doctor (MD) and the Psychiatric Nurse Practitioner (NP). The UM revealed the Psychiatric NP discontinued the quetiapine on 04/03/23 and the MD discontinued and wrote a new order for

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lorazepam 0.5 mg as needed to include a 14-day stop date on 04/18/23.

An interview was conducted on 06/02/23 at 1:04 PM with the Pharmacy Consultant. The Pharmacy Consultant revealed he made recommendations for Resident #1 in January that included a request for a diagnosis for quetiapine and stated agitation was not an appropriate diagnosis for the use of the medication. The Pharmacy Consultant revealed he also recommended a 14 day stop date be added or a rational to address the use of quetiapine and lorazepam with an active physician order to administer as needed. The Pharmacy Consultant revealed he did not make recommendations for Resident #1 in February as he wanted to give the facility enough time to respond to his previous one. He stated both medications were still active physician orders in March, and he made another recommendation since enough time was given for the facility to address his previous recommendations.

During an interview on 06/05/23 at 10:43 AM the Director of Nursing (DON) revealed the Pharmacy Consultant sent the January 2023 recommendations for Resident #1 to the previous DON and the facility did not receive it. The DON revealed she started her position on 01/16/23 and since she had received the monthly medication reviews with the Pharmacy Consultant recommendations. The DON revealed she provided the recommendations to the MD and followed up to ensure a response was given and recommendations were corrected, and she kept a log of the monthly reviews and what was done. The DON revealed the Pharmacy Consultant recommendations for quetiapine and lorazepam

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F 758	Continued From page 60 were received by her on 03/31/23 and Resident #1's quetiapine was discontinued on 04/03/23 and a new physician's order with a 14 day stop date was provide for lorazepam and the medication was restarted due to Resident #1 having increased anxiety and then discontinued. During an interview on 06/07/23 at 12:57 PM the Administrator revealed when the Pharmacy Consultant made recommendations in January 2023, she expected the facility would follow up and make the necessary changes to Resident #1 medical record and physician orders. The Administrator stated when the current DON received the second recommendations from the Pharmacy Consultant on 03/31/23 those were addressed by the facility.	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 review and interviews with the Medical Doctor and staff the facility failed to prevent a significant medication error by not administering 12 doses of levetiracetam (an anticonvulsant medication) as ordered by the physician for 1 of 1 resident reviewed for dialysis (Resident #1). The findings included: Resident #1 was admitted to the facility on 01/04/23. Resident #1's diagnoses included end stage renal disease and epilepsy (abnormal	F 760	#1 Resident #1 no longer resides at the facility. On 6/02/2023 a Medication Error Report was completed by the Unit Manager regarding the missed doses of medication identified during the survey. #2 Facility residents with prescribed medications have the potential to be affected by the same deficient practice. An audit was completed on 6/26/2023 by	7/5/23

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electrical activity in the brain that causes an involuntary change in body movement or function).

Review of the physician order for levetiracetam included directions to give 500 milligrams two times a day for epilepsy started on 01/05/23.

Review of the physician order revealed Resident #1 was scheduled for dialysis treatments in the morning every Monday, Wednesday, and Friday at an offsite dialysis center location.

Review of the admission Minimum Data Set (MDS) dated 01/10/23 revealed Resident #1's cognition was assessed as being moderately impaired and he received dialysis treatments.

The care plan initiated on 01/19/23 revealed Resident #1 had a seizure disorder and included the intervention to give medications as ordered.

Review of Resident #1's Medication Administration Record (MAR) for April and May 2023 revealed levetiracetam 500 milligrams give 1 tablet two times a day for epilepsy was scheduled to be administered at 9:00 AM and 9:00 PM. The MAR revealed at 9:00 AM Nurse #4 had initialed on 04/03, 04/05, 04/10, 04/12, 04/17, 04/19, 04/24, 04/26, 05/01, 05/03, 05/08, 05/10 and documented #1. The MAR's chart code indicated #1 meant out of the facility.

Review of the Physician Assistant (PA) progress note revealed she saw Resident #1 on 04/25/23 for the chief complaint of heel ulcers, diabetes, and labs. The PA's note indicated no acute concerns were voiced by Resident #1 or the nursing staff.

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the Unit Manager regarding any missed medications. Results produced no further negative findings. This medication audit was to review all medications of all residents. The findings revealed that all residents did have all their medications available. Identified residents that have appointments out of the facility will receive their medications prior to the routine schedule and at regularly scheduled times on dates that there are no scheduled appointments.

#3 Measures put into place to ensure that this alleged deficient practice does not recur includes:
The four nursing units will review the Medication Administration Records on a weekly rotating basis (MAR)Meeting to validate all doses that were administered. The Unit Nurse Manager will audit the 24 hour report and missing medication reports to ensure that all medications have been administered.

Education was initiated on 6/25/2023 by the Unit Manager with all Licensed Nursing Staff and Medication Aides regarding medication administration including missed doses. Any staff not receiving the education by 7/04/2023 will not be allowed to work until they receive the education. The Administrator contacted the Pharmacy Consultant to request that a monthly MAR to CART audit be completed to ensure that all medications are being adminsitered as ordered.
Random Audits of the MAR, ten (10)

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Review of a PA progress note revealed she saw Resident #1 again on 05/09/23 to follow-up on a reported fever when he arrived at dialysis. The note indicated Resident #1 appeared at baseline with no other symptoms being reported since he returned to the facility and his vital signs were stable and the last recorded temperature was 98.1. The PA continued Resident #1's current medications and made no changes.

During an interview on 06/6/23 at 11:14 AM Nurse #4 revealed on Monday, Wednesday, and Friday Resident #1 went to dialysis and was not in the facility at 9:00 AM when levetiracetam was scheduled and she did not give him the medication. Nurse #4 revealed she did not notify the Medical Doctor levetiracetam was not being administered and/or given to Resident #1 on the days he went to dialysis because it would be removed from the body's system by the dialysis process, and she thought the MD was aware it was not being administered.

An interview was conducted on 06/07/23 at 11:45 AM with the MD. The MD revealed levetiracetam should be administered twice a day as scheduled to maintain a therapeutic level in the body's system and if not, it was concerning Resident #1 would have a breakthrough seizure and she considered this as significant medication error. The MD revealed Resident #1 had not suffered a breakthrough seizure but expected Nurse #4 to notify her or the PA for clarification if an order was needed to hold levetiracetam or to reschedule the administration time, so Resident #1 received the medication.

An interview was conducted on 06/07/23 at 12:43

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weekly will be completed by the Unit Manager and Medical Records Licensed Practical Nurses, (LPN) 5x/week for 4 weeks, then weekly for 8 weeks.

#4
The results of the audits will be presented to the Quality Assurance and Process Improvement Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
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F 760	Continued From page 63 PM with the Director of Nursing (DON). The DON revealed she expected the nurses to call the MD if they were unable to give a scheduled medication for a resident that was consistently out of the facility for dialysis. The DON stated the MD needed to be notified when a resident's scheduled medications weren't administered, and she expected the nurses to call and inform the physician when that occurred. During an interview on 06/07/23 at 12:57 PM Administrator #2 revealed for a resident receiving dialysis treatments the plan of care approach should ensure scheduled medications were received and she expected the nurses discussed with the MD how to manage medications on the days a resident was out of the facility for dialysis treatments.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		7/5/23

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locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observations, record review, and interviews with the Medical Doctor, resident, and staff the facility failed to safely secure a bottle of medicated antifungal powder and barrier creams observed being stored in clear sight in resident rooms for 2 of 2 residents reviewed for medication storage (Resident #28 and #8).

The findings included:

1. Resident #28 was admitted to the facility on 03/06/21.

The annual Minimum Data Set (MDS) dated 02/28/23 assessed Resident #28's cognition was intact, and she required extensive assistance with bed mobility, transfer, toileting, and personal hygiene.

Review of the physician orders revealed no active order for miconazole nitrate (an antifungal medication) powder.

Review of the physician's order revealed an active order for barrier cream with directions to apply after each incontinence episode with a start date of 03/06/21.

Review of the medical records revealed no

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#1 IMmediate action taken to correct the alleged deficiency.

On 6/02/2023 the medications were removed from the bedside of Resident #8 and #28.

#2

Facility residents with prescribed medications have the potential to be affected by the same deficient practice. An audit was completed on 6/25/2023 by the Unit Manager regarding medications left at the beside; no further observations noted. This audit was completed on 100% of facililty residents.

#3 Measures

Education was initiated on 6/25/2023 by the Unit Manager with all Licensed Nursing Staff and Medication Aides regarding medication administration including safety and not leaving at beside. Any staff not receiving the education by 7/04/2023 will not be allowed to work until they receive the education. Education regarding the proper labeling and storage of drugs and biologicals will be provided to all new hires upon onboarding. Residents

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documentation to indicate Resident #28 was assessed for self-administering medications.

During an observation and interview on 05/30/23 at 11:33 AM in the room of Resident #28 a 3-ounce bottle labeled anti-fungal powder with miconazole nitrate 2% with an expiration date of 10/2024 was placed on the overbed table in clear sight. Resident #28 revealed the Nurse Aide (NA) staff used the powder and applied it under her breast and between the skin folds on her abdomen. Resident #28 was unable to recall how often the powder was applied and stated when they remember to do it. Resident #28 revealed she was unable to apply the powder herself.

A second observation and interview on 05/30/23 at 4:13 PM revealed the bottle of miconazole nitrate antifungal powder continued to be in clear sight and placed on the overbed table. A tube of barrier cream with 12 % zinc oxide was also observed in clear sight placed on the overbed table. Resident #28 revealed the NA staff used the barrier cream as part of incontinence care.

During an interview on 05/30/23 at 4:21 PM NA #4 revealed she was assigned to provide care for Resident #28 and observed the bottle of antifungal powder and tube of barrier cream with zinc oxide place on top of the overbed table and stated it was usually kept there. NA #4 revealed she doesn't apply the antifungal powder the nurses did but she did apply the barrier cream and had used it earlier during incontinence care for Resident #28.

An observation and interview were conducted on 05/30/23 at 4:31 PM with Nurse #2. Nurse #2 revealed she was the assigned nurse for

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that request treatment creams at bedside will be care planned by the Interdisciplinary team. This care plan will ensure that the resident meets the capability to manage proper applicatoin and adminsitration. All residents requesting this will receive a written order by the Medical Director.

#4 Monitoring
Monitoring will be completed for on a daily basis by the Department Managers completing and reporting the results of daily rounding of each room during the daily management meetings. During shift change the clinical nurses will report off to the oncoming shift the absence of any in room drugs or biologicals. This will be documented on the nursing shift reports for validation.
The results of the audits will be presented to the Quality Assurance and Process Improvement Meeting by the Director of Nursing for 3 months.
The Director of Nursing is responsible for ensuring the Plan of Correction is implemented and sustained compliance ensured by the Nursing Home Administrator.
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Resident #28 and responsible for administering treatments that would included applying an antifungal powder. Nurse #2 observed the bottle of antifungal powder with miconazole nitrate and revealed she was not aware it was being stored on top of the overbed table in the resident's room. Nurse #2 observed the tube of barrier cream with zinc oxide and was unsure if could remain in the resident's room and stated she would need to ask the Unit Manager (UM) and left it in place. Nurse #2 removed the bottle of miconazole powder from the room and stated she would inform the UM.

An interview was conducted on 05/30/23 at 4:34 PM with the Unit Manager (UM). The UM stated antifungal powder with miconazole nitrate should not be stored on top of the overbed table in Resident #28's room instead should be kept in treatment cart and was applied by the nurses. The UM revealed she asked Nurse #2 to throw away the bottle of miconazole powder since it was in the room of Resident #28 and there was no active physician's order to use it. The UM revealed the tube of barrier cream with zinc oxide was included in the facility's standing orders and could be left in the resident's room.

During an interview on 05/30/23 at 4:44 PM the Director of Nursing (DON) revealed a physician's order was needed for the use of an antifungal powder with miconazole nitrate and it was stored in the treatment cart and the nurses were responsible for applying a medicated powder based on the directions of the physician's order.

During an interview on 06/01/23 at 12:47 PM, the Director of Nursing (DON) explained they did not complete a self-administration assessment as the skin protectant creams were left at bedside for

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NA staff to use after incontinence care was provided. The DON stated they would need to rethink their process and use a skin protectant that does not contain zinc oxide or use another non-medicated cream in order for the skin protectants to remain stored in resident rooms.

During an interview on 06/01/23 at 4:22 PM, Administrator #1 stated Resident #28's antifungal powder with miconazole nitrate should not be stored at the bedside in clear sight and there should be a physician's order in place and if self-administering and Resident #28 would be assessed for the ability to safely do so.

During an interview on 06/07/23 at 11:45 AM the Medical Doctor (MD) stated antifungal powder with miconazole nitrate was a medication and Resident #28 would need a physician's order for it to be used and kept at the bedside.
2. Resident #8 was admitted to the facility on 06/23/21. Her diagnoses included dysuria (pain, burning or discomfort when urinating) and a complete immobility due to severe disability or frailty not caused by spinal cord damage or stroke.

Review of Resident #8's medical record revealed the following physician orders:
07/19/22: apply barrier cream after each incontinent episode, every shift.
11/15/22: apply zinc oxide to right gluteal crease/thigh, every shift.

The quarterly Minimum Data Set (MDS) dated 03/20/23 revealed Resident #8 had intact cognition. She required extensive staff assistance with toileting and was always incontinent of both bladder and bowel during the

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	345302	A. BUILDING ______ B. WING ______	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VERO HEALTH & REHAB OF SYLVA	417 CLOVERDALE ROAD SYLVA, NC 28779

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 68 MDS assessment period. Review of Resident #8's medical record revealed no documentation she had been assessed for self-administration of medication. An observation of Resident #8's room on 05/31/23 at 11:10 AM revealed one 7-ounce (oz.) tube and two 3.5 oz. tubes of skin protectant containing zinc oxide stored on the seat of her wheelchair. Additional observations of Resident #8's room on 05/31/23 at 9:30 AM and 06/01/23 at 11:45 AM revealed the one 7 oz. tube and two 3.5 oz. tubes of skin protectant containing zinc oxide remained stored on the seat of her wheelchair. During an interview on 06/01/23 at 12:47 PM PM, the Director of Nursing (DON) explained they did not complete a self-administration assessment on Resident #8 as the skin protectant creams were left at bedside for Nurse Aides to use after incontinence care was provided. The DON stated they would need to rethink their process and use a skin protectant that does not contain zinc oxide or use another non-medicated cream in order for the skin protectants to remain stored in resident rooms. During an interview on 06/01/23 at 3:49 PM, Administrator #1 stated when using skin protectant creams containing zinc oxide or other medication, there needed to be a physician order for self-administration or to leave stored at bedside.	F 761		
F 835 SS=E	Administration CFR(s): 483.70	F 835		7/5/23

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F 835	Continued From page 69 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and interviews with residents, staff and Medical Doctor, the facility failed to provide effective leadership and implement effective systems to ensure the facility was able to obtain splints and wheelchair cushions to meet residents' needs. This failure resulted affected 4 of 6 residents reviewed for range of motion and accommodation of needs (Residents #8, #22, #23, and #15). The findings included: This tag is cross referred to: F558: Based on observations, record reviews, resident and staff interviews, the facility failed to provide a bariatric cushion for a resident's wheelchair for 1 of 3 residents reviewed for accommodation of needs (Resident #8). Resident #8 reported the wheelchair was uncomfortable to sit in without a cushion which resulted in her not wanting to get up out of bed. F688: Based on observations, record review, resident, staff and Medical Doctor (MD) interviews, the facility failed to obtain hand splints as ordered by Occupational Therapy to prevent a decline in muscle tone for 3 of 5 sampled residents reviewed for range of motion (Residents #22, #23, and #15).	F 835	F835 Administration Immediate action taken to correct this Alleged deficient practice included the The Departments of Rehabilitation, Nursing And Central Supply to review and Reeducate these managers on the specific Duties and expectations of ensuring that Equipment was being obtained for all residents That are admitted to this facility. All department managers received education on The expected process of communication on 6-2-2023 by the Corporate Executive and Administrator #1. The facility recognizes that all residents that Require supplies to provide effective clinical Services have the potential to be affected by this Alleged deficient practice. Measures put into place to ensure this Alleged deficient practice does not recur	

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F 835	Continued From page 70 During a telephone interview on 06/06/23 at 2:00 PM, the Accounts Payable staff member revealed they have had issues with getting splints, wheelchair cushions and other supplies from the facility's medical supply vendor. She explained the medical supply vendor the facility utilized was a third-party vendor and when orders were placed, the medical supply vender reached out to other vendors to locate and obtain the items ordered by the facility. She recalled sometime around the end of 2022 and first part of 2023, therapy had ordered some splints that were never received and the medical supply vender just told her they would look into it when she had contacted them to inquire on the status of the order. She couldn't recall the date but stated she had spoken with the Administrator and Corporate Executive/Owner about the issues they were having with getting supplies and at one point they had looked into getting an account with another medical supply vender but for whatever reason, it did not work out. The Accounts Payable staff member explained corporate had to approve any purchases outside of the facility's current medical supply vendor and they never received confirmation to order the splints requested by therapy from another vendor. During a telephone interview on 06/06/23 at 2:59 PM, Administrator #2 revealed she did not realize staff were having issues with getting supplies from the facility's current medical supply vendor or that they never received approval to order the supplies elsewhere. Administrator #2 stated going forward, she expected staff to communicate when they were having difficulty obtaining supplies from the facility's medical supply vendor so they could obtain the items from	F 835	includes: Daily review of available and needed equipment is discussed with the interdisciplinary team during the Morning Management Meetings. This discussion Encompasses the current status of available equipment to ensure that necessary supplies are made available . This practice was reinitiated on 6-2-2023 by Administrator #1. The IDT team then documents their findings so that proper communication And follow up is ensured. Monitoring will occur by the Administrator reiveiwing and compiling a report on the availability of needed supplies. The administrator will compile a report and will conduct random review of all necessary equipment on a weekly basis for 3 weeks and then monthly basis for 3 months. A report will be completed and reported to the Quality Assurance Process Improvement Committee Monthly for 3 months or until a pattern of compliance has Been achieved. Date Certain: 7-5-2023	

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F 835	Continued From page 71 another supplier. Administrator #2 further stated she and the Corporate Executive/Owner have spoken about the issue and were working on getting agreements with other medical supply vendors.	F 835		