STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMERSTONE HEALTH AND REHABILITATION CENTER	485 VETERANS WAY KERNERSVILLE, NC 27284

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 10/24/23 through 10/27/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #R2BS11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 10/24/23 through 10/27/23. Event ID# R2BS11. The following intake was investigated: NC00208787. One (1) of 1 complaint allegation did not result in deficiency.	F 000		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.	F 585		11/25/23

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

Electronically Signed | 11/24/2023

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F 585	Continued From page 1	F 585		

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident

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F 585	Continued From page 2 right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, resident, and staff interviews the facility failed to ensure the Resident's right to file a grievance and receive a written decision regarding the grievance investigation. This occurred for 1 of 1 resident reviewed for the grievance process (Resident	F 585	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will	

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F 585	Continued From page 3 #61). The findings included: Resident #61 was admitted to the facility on 6/5/2023. A review of the quarterly Minimum Data Set (MDS) dated 7/28/2023 revealed Resident #61 was cognitively intact. An interview was conducted with Resident #61 on 10/24/2023 at 9:27 a.m. and he revealed he had shared a grievance about the quality of food at the facility and the inconsistent times meal trays were delivered. He added he filed a grievance with the head dietary staff member on several occasions. He was unsure of her name. He stated he had not been informed of the outcomes of the grievance. A review of the facility grievance log was conducted for the period of July 2023 through October 25, 2023. There was not a grievance for Resident #61 for food quality or time variations in meal tray delivery. An interview was conducted with Dietary Aid #1 on 10/26/2023 at 1:54 p.m. and she revealed she had worked with Resident #61 several times regarding his meals, his likes, and his dislikes. She stated he had told her he had a grievance regarding fruit, the quantity of the food, the quality of the food, and other areas. She added, in response to the Resident's grievance she began to check his tray at each meal to ensure he received preferences. She stated she was not sure of what happened when she was not at work. She revealed she had not shared the	F 585	take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F585 The facility failed to ensure the Resident□s right to file a grievance and receive a written decision regarding the grievance investigation. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/21/2023 resident #61 was assessed/interviewed by the Dietary manager, Unit manager and the SW for any and all concerns. Results: No further concerns were identified. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected. On 11/21/2023 and 11/22/2023 the Director of Nurses/Unit managers/Social Worker interviewed all residents with BIMS 13 or above to learn if residents had unanswered concerns in the past 14 days. The RPs of residents who could not be interviewed were contacted by the Director of Nurses /Unit managers/Social Worker to learn if they had unanswered grievances in the last 14 days. On 11/21/2023 the administrator reviewed the last 14 days of grievances and Resident Council minutes for the month October to identify any unanswered grievances.	

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F 585	Continued From page 4 Resident's grievance with the Dietary Manager, Social Worker, or Administrator. She revealed she had received education on the facility grievance process. She added she documented the Resident's food preferences on his meal ticket but had not reported the other areas he had shared with her. An interview was conducted with the Dietary Manager on 10/26/2023 at 2:02 p.m. and she revealed she was familiar with Resident #61 but had not been informed the Resident had voiced a grievance about several concerns. She stated it was her expectation that a grievance form be completed when a grievance was shared with a member of her staff. An interview was conducted with the Administrator on 10/26/2023 at 2:16 p.m. and she stated she had not been made aware Resident #61 had been placing oral grievances with Dietary Aid #1. She added it was her expectation that a grievance be completed in written form and filed on behalf of a resident if they place an oral grievance with the staff member.	F 585	Results: 8 out of 92 residents reported sharing information in the past 14 days with no formal follow-up. Formal grievances were written for these 8 residents. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/19/2023, the Director of Nurses, Staff development coordinator and Nurse Consultant began education of all full time, part time, as needed, agency staff on the grievance process. Education for all staff will be completed by 11/24/2023, at which time all of the above must be in-serviced prior to working. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Director of Nurses or Designee will monitor compliance utilizing the F585 Resident Grievance Quality Assurance Tool weekly x 2 weeks then monthly x 3 months or until resolved. Audits will occur on various shifts and days of the week to ensure grievances are being documented and answered according to facility policy. The Administrator/Director of Nurses/Social Worker will monitor that residents are being treated in a dignified manner by auditing resident satisfaction with grievance response time weekly x 2 and monthly x 3. This will include auditing 4 alert residents on various halls and contacting 3 Responsible Parties for those	

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F 585	Continued From page 5	F 585	residents with a Brief Interview for Mental Status below 13. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/25/2023	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and record review the facility failed to protect resident's right to be free from abuse for 1 of 2	F 600	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the	11/25/23

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F 600	Continued From page 6 residents reviewed for physical abuse from Resident #48 (Resident #25). On 10/16/23 Resident #48 struck Resident #25 on the nose after a verbal altercation. The findings included: Resident #48 was admitted to facility on 2/1/23 with diagnoses that included schizophrenia, unspecified dementia of unspecified severity with agitation, psychotic disturbance, and mood disturbance. The significant change Minimum Data Set (MDS) assessment dated 5/8/23 indicated Resident #48 had moderate cognitive impairment. He had no behavior during the MDS review period. Resident #48 required the supervision to limited assistance of one person for walking in room, walking in corridor, and locomotion on/off the unit. Resident #48's Care Plan updated on 6/6/23 included the focus area, "I have potential to demonstrate physical/ verbal behaviors related to history of confrontation with fellow residents. At times, I am argumentative toward the roommate. The interventions for Resident #48 included, in part, "I will not harm self or others x 90 days, analyze key times, places, circumstances, triggers, and what de-escalates behavior and document, cognitive assessment, monitor/document/report to MD of danger to self and others, psychiatric/psychogeriatric consult as indicated, staff to check on resident frequently to promote safety. The plan of care for Resident #48 also included the focus area, "When I become agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation; If response is aggressive,	F 600	alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F600 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #25 was hit by resident #48 on 10/16/2023 in the commons area. Resident #25 did not sustain injury. The facility initiated an investigation 10/16/2023. There were no adverse effects related to this alleged deficient practice. Resident #48 was seen by psychiatric services on 10/16/2023 and placed on 1:1 until 10/27/2023. Resident #48 was seen by Psychiatry on 10/16/2023 and 10/24/2023 for follow-up and medication monitoring and reports of auditory hallucinations. Resident will be seen at least monthly to monitor effectiveness of medication to prevent abuse. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 10/16/2023, the Director of Nurses identified residents who were identified as having potential physical, verbal or sexual altercations/interactions with anyone	

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F 600	Continued From page 7 staff to walk calmly away, and approach later." Resident #25 was admitted on 5/23/23 from an acute hospital with diagnoses which included: multiple fractures of pelvis, bipolar disorder, current episode mixed, severe, without psychotic features Alzheimer's disease, unspecified dementia with other behavioral disturbance, delusional disorders, atrial fibrillation, and moderate protein-calorie malnutrition. Reside #25 did not reside in the facility at the time of the survey. Review of the Quarterly Minimum Data Set (MDS) dated 9/9/23 revealed Resident #25 was admitted on 5/23/23 with severely impaired cognition. She was total dependent with one-person physical assist with activities of daily living. Review of Resident #25's care plan dated 7/20/23 included the focus area of potential to demonstrate verbally abusive behaviors related to dementia. At times she yelled out and cursed at the staff. The interventions for Resident #50 included, in part, she would try to control verbally abusive behavior for 90 days. Staff were to analyze key times, places, circumstances, triggers, and what de-escalated behavior and document. Assess and anticipate the Resident's needs: food, thirst. toileting needs, comfort level, body positioning, and pain. Staff were to provide positive feedback for good behavior. Emphasize the positive aspects of compliance and intervene before agitation escalates. Guide away from source of distress and engage calmly in conversation; If response was aggressive, staff were to walk calmly away, and approach later.	F 600	including resident #48. Residents with a BIMS 13 or above were interviewed and residents with BIMs less than 13 received skin assessments. Audits were unremarkable for abuse or negative encounters. On 10/16/2023, the Staff Development Coordinator began education of all staff from all departments on Recognizing and Reporting Abuse. Resident #48 was seen by psychiatric services on 10/16/2023 and placed on 1:1 until 10/27/2023. Resident #48 was seen by Psychiatry on 10/16/2023 and 10/24/2023 for follow-up and medication monitoring and reports of auditory hallucinations. Resident will be seen at least monthly to monitor effectiveness of medication to prevent abuse. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10/16/2023 the Staff Development Coordinator began educating all full time, part time, agency, and PRN staff in all departments on Recognizing and Reporting Abuse. This information has been integrated into the standard orientation training will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 11/24/2023, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. This information has been integrated into the standard orientation training will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 11/24/2023 at	

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F 600	Continued From page 8 The facility investigation file for an allegation of resident abuse related to the incident between Resident #25 and Resident #48 on 10/16/23 was reviewed. The report revealed Resident #25 and Resident #48 were in the commons after lunch. The residents were observed talking loudly to themselves. Per the investigation report a written statement by a nurse aide who witnessed the interaction between Resident #48 and Resident #25 revealed Resident #48 told Resident #25 to shut up and they argued. The investigation report revealed a nurse aide went over to intervene and before she could get there Resident #48 struck Resident #25 in the face. The nurse aide separated the residents. Resident #48 had a small amount of blood coming from her nose. She was removed from the common area and assessed. Resident #48 was removed from the area and placed on 1:1 monitoring. The investigation report documented the results of a facial x-ray for Resident #25 was negative for fracture. Review of a 24-hour report dated 10/16/23 revealed an allegation Resident #48 had hit Resident #25 in the face in the commons area on 10/16/23. Resident #48 was placed on 1:1 for an undefined duration. Resident was scheduled for a tele visit at 4:45 PM and a psychiatric consult for that day. The 24-hour report was signed by the Administrator on 10/16/23. The allegation type was classified as resident abuse. A review was completed of the 5-working day investigation report dated 10/20/23. The review revealed the allegation of resident abuse when Resident #48 hit Resident #25 in the face on 10/16/23 was investigated and unsubstantiated. The summary of the investigation documented	F 600	11pm, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F600 Quality Assurance (QA) Tool weekly x 2 weeks then monthly x 3 months or until resolved by the QA committee. The Administrator will monitor compliance with incontinence care to ensure incontinence care does not rise to the level of neglect. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Nurse, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/24/2023	

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F 600	Continued From page 9 Resident #25 was sitting in the dayroom talking to herself when Resident #48 heard her say shut up and he went over and hit her. The residents were separated, and Resident #48 was placed on 1:1. Resident #25 was evaluated, and an x-ray was ordered. In-house psych services and the nurse practitioner were contacted for Resident #48 for a change in condition. Resident #48 was evaluated by psych services on 10/16/23 and received an order to increase his Risperdal due to increased impulsivity. The Administrator documented negative facial bone x-ray results were reviewed by the nurse practitioner. She further documented no signs of mental anguish, no facial bruising or swelling. The investigation report included Resident #48 would remain on 1:1 until his mood stabilized. The Administrator concluded she was unable to substantiate the allegation of physical abuse based on Resident #48's diagnosis of schizophrenia and dementia with agitation and psychotic disturbance as well as his cognition, his triggers and impulsivity. She added due to Resident #48 talking to himself it was unclear what voices he heard or what the voices may have instructed him to do.	F 600		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff, and resident interviews the facility failed to accurately code Minimum Data Set assessments in the areas of Accidents and Nutrition for 2 of 6 residents reviewed (Resident #41 and #61).	F 641	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state	11/24/23

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F 641	Continued From page 10 The findings included: 1. Resident #41 was admitted to the facility on 11/9/2022. A review of the fall incident reports revealed Resident #41 had a fall on 7/5/2023. A review of the quarterly Minimum Data Set (MDS) dated 9/29/2023 revealed Resident #41 had severe cognitive impairment and required assistance of one staff member for activities of daily living (ADL) care needs. She was only able to stabilize with staff assistance during transfers and while walking. She was coded to have no falls since the prior assessment. An interview was conducted with MDS Coordinator #2 on 10/26/2023 at 4:25 p.m. She reviewed the MDS dated 9/29/2023 and stated She had completed the MDS assessment. She then revealed the Resident was coded to have not had a fall since the prior assessment dated 6/29/2023. She reviewed the fall incident report dated 7/5/2023 and stated the assessment was inaccurate and should have reflected the fall. 2. Resident #61 was admitted to the facility on 6/5/2023 with diagnoses that included a fracture to the spine and atrial fibrillation. A review of Resident #61's weight history revealed an admission weight of 128 pounds (lbs.) on 6/6/2023. On 7/1/2023 Resident #61 was discharged to an acute care hospital.	F 641	regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F641 The facility failed to accurately code Minimum Data Set assessments in the areas of Accidents and Nutrition for 2 of 6 residents reviewed (Resident#41 and #61). F641 Accuracy of Assessments 1. Corrective action for resident(s) affected by the alleged deficient practice: For resident # 61 a corrective action was obtained by modifying and correcting the Minimum Data Set MDS) assessment for assessment reference date (ARD) of 9/29/2023. Coding of question J1800 (Falls) was corrected to accurately reflect that resident did have a fall since the prior assessment reference date (ARD) 6/29/2023. Modification of the Minimum Data Set (MDS) assessment was completed by the Minimum Data Set Coordinator (MDSC) that was submitted and accepted into the state data base on 10/27/2023. For Resident #61 Minimum data set quarterly assessment with Assessment Reference date of 7/28/2023 reviewed and resident did not have 5% weight loss in the 30 days coded on the MDS. Dietary Review UDA corrected 10/27/2023. Minimum data set assessment with Assessment reference date of 7/28/2023	

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F 641	Continued From page 11 On 7/13/2023 Resident #61 was readmitted to the skilled nursing facility. On 7/26/2023, Resident #61 had a documented weight of 116.9 lbs. in the electronic medical record. This was a weight loss of 8.67%. since admission. There were no other weights for the month of July, prior to the 7/26/2023 weight. A review of a dietary assessment dated 7/28/2023, written by a corporate dietary consultant, documented Resident #61 had 5% or more weight loss in the last month and was not on a prescribed weight loss regimen. A progress note on the assessment read: Resident #61 had a weight loss of 9.3% x 30 days. A review of quarterly Minimum Data Set (MDS) dated 7/28/2023, under the section titled nutrition, documented Resident #61 did not have weight loss of 5% over one month or 10% over 6 months. This assessment was completed by MDS coordinator #2. An interview was conducted with MDS Coordinator #2 on 10/26/2023 at 4:30 p.m. She reviewed the MDS dated 7/28/2023, under the section titled Nutrition, and stated it was documented the Resident did not have weight loss over 5% in one month or 10% in 6 months. She reviewed the weight loss documented in the electronic medical system and stated the Resident had weight loss of 8.67% prior to the assessment dated 7/28/2023 and the assessment should have reflected the weight loss.	F 641	was modified and corrected by the facility MDS Nurse on 11/20/2023 to reflect accuracy at the time of the Assessment reference date look back timeframe of the assessment. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. An audit of current residents with Minimum Data Set (MDS) assessments within the past 3 months was completed for accurate coding in section J1800 and K0300. This audit was conducted by the Clinical Reimbursement Consultant on 11/16/2023 and 11/21/2023. Audit Results: Fifty Three (53) Resident Minimum Data Set records were reviewed with the Assessment Reference Dates (ARD) within the last 92 days with dates between 8/15/2023 through 11/16/2023. " Zero (0) residents were identified out of the fifty three (53) records reviewed as being coded inaccurately in section J1800, Any Falls Since Admission/Entry or Reentry or Prior Assessment (OBRA or Scheduled PPS). 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 11/16/2023, the Clinical Reimbursement Consultant completed an in-service training for the facility Minimum	

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F 641	Continued From page 12	F 641	Data Set (MDS) nurse(s) that included the importance of thoroughly reviewing the medical record, interviewing staff and resident during the assessment window before coding the Minimum Data Set (MDS) assessment. Special emphasis was highlighted on: " The importance of thorough review of the medical record including progress notes, risk management console, therapy notes and nursing notes during the 92 day lookback for completion of Minimum Data Set (MDS) Assessment. This information is located in the Resident Assessment Instrument (RAI) manual in Chapter 3, page J-34 through J-35. On 11/20/2023, the Senior Nutrition Service Coordinator will complete an in-service with the Certified Dietary Manager Consultant and Dietary Manager that included the importance of thoroughly reviewing each resident□s medical record in order to ensure that the assessment is coded accurately. Special emphasis will be placed on coding Section K and completing Dietary Review UDA per MDS schedule. The monitoring procedure to ensure that the plan of correction is effective and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the coding of MDS item J1800 and K0300 utilizing the Audit Tool provided.	

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F 641	Continued From page 13	F 641	This audit will be done weekly x 4 weeks and then monthly x 2 months. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Support Nurse, Therapy, Health Information Manager, Dietary Manager and the Activity Director. The title of the person responsible for implementing the acceptable plan of correction; Administrator and /or Director of Nursing. Date of Compliance: __11/23/2023_____	
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to prevent a significant medication error when an additional dose of an intravenous (IV) antibiotic was administered to 1 of 1 sampled resident (Resident #27) reviewed. Findings included: Resident #27 was admitted to the facility on 9/25/23 with diagnoses which included:	F 760	Past noncompliance: no plan of correction required.	

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intraspinal abscess and granuloma, bacteremia, and methicillin-resistant staphylococcus aureus (MRSA).

The physician's order dated 9/25/23 indicated the pharmacy would adjust the intravenous (IV) vancomycin (antibiotic) dosage for Resident #27 based on the lab results of the vancomycin troughs (lowest level of the antibiotic while in the therapeutic range). A Trough level was to be drawn 30 minutes before the next dose was due and helped determine if the next dose needed to be adjusted, depending on the results. In some cases, the next dose could be skipped, or the dose would be decreased for patient safety.

The care plan dated 9/26/23 revealed Resident #27 received antibiotic therapy related to diagnoses of MRSA, bacteremia, and spinal abscess. Interventions included: administering medication as ordered; monitoring every shift for adverse reactions; and reporting pertinent laboratory results to the physician.

The admission minimum data set dated 10/1/23 indicated Resident #27 was cognitively intact and received intravenous antibiotic medication.

Resident #27's October 2023 medication administration record (MAR) was reviewed. The physician's order for Resident #27 to receive 750mg (milligram) vancomycin, intravenously every 12 hours (9:00 a.m. and 9:00 p.m.) was changed to 1500mg/15ml vancomycin intravenously, daily (9:00 a.m.) on 10/21/23. The medication was documented on the MAR as administered by Staff Nurse #1 at 9:00 a.m. on 10/21/23.

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Review of the nurse's note dated 10/22/23 indicated Pharmacy was notified that Resident #27 mistakenly received an additional dose of vancomycin on 10/21/2023, during the evening shift. The pharmacist ordered a "hold" on the 10/22/23 dose and to check the Trough level on 10/23/2023. The on-call nurse practitioner was notified and instructed the staff to follow the pharmacist's orders.

During interviews on 10/24/23 at 10:40 a.m. and 10/26/23 at 1:31 p.m., Resident #27 revealed she received an additional dose of her IV medication on Saturday (10/21/23).When asked if she knew which medication and how often it was given that day, the resident stated she received the medication twice on Saturday and the medicine was "that up there" pointing to the empty bag hanging from the IV pole next to the resident's bed. Written documentation on the empty bag read: Vancomycin 1.5g (grams) per 300ml (milliliters) was written on the empty IV bag. Resident #27 stated that two female staff (unsure of names) were in her room looking at the IV pump when she overheard one of them state "she's already had one dose". The resident insisted no one ever informed her that she received an additional dose of her medication.

An interview was conducted with the Nurse Practitioner (NP) on 10/26/23 at 2:19p.m. The NP stated that he was notified on 10/23/23 the Resident #27 may have received an additional dose of vancomycin on 10/21/23. He revealed on 10/21/23 the on-call provider was notified the resident received 1500 ml (milliliters) of vancomycin twice that day (10/21/23) and was ordered to "hold" the next day's dosage. He concluded he was not aware of any harm to the

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resident as result of the additional dose; the resident's creatinine clearance was normal based on her weekly laboratory results.

During an interview on 10/26/23 at 3:37 p.m., Staff Nurse #1 stated Resident #27 had an order for IV vancomycin and was to receive a vancomycin Trough on Mondays and Thursdays (30 minutes before her morning dose); and depending on the Trough results, pharmacy would either increase or decrease the dosage and/or frequency. On 10/21/23, the order was for the resident to receive 1500 ml via IV, once per day which was administered at 9:00 a.m. However, when she (Staff Nurse #1) was to administer the vancomycin to the resident on 10/22/23 at 9:00 a.m., she noticed the empty vancomycin bag hanging from the IV pole in the resident's room. She contacted the second shift nurse who informed her that she (Staff Nurse #2) administered the vancomycin to the resident the night of 10/21/23 at 9:00 p.m. Staff Nurse #1 stated she reminded Staff Nurse #2 the resident was only to receive the vancomycin once a day, at 9:00 a.m. Staff Nurse #1 revealed she stopped the IV and notified the pharmacy who gave the order to hold the vancomycin (10/22/23) until the Trough was completed on 10/23/23. The on-call NP was notified and gave the order to follow the pharmacy order follow-up with the Trough on 10/23/23. The manager on duty was notified and instructed Staff Nurse #1 to follow the orders. Staff Nurse #1 also indicated that because of this incident all of the facility's licensed nursing staff and medication aides received an in-service on medication errors.

During an interview on 10/27/23 at 8:50 a.m., Staff Nurse #2 acknowledged she administered

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1500 ml vancomycin, intravenously to Resident #27 at 9:00 p.m. on 10/21/23. She confirmed she was notified via phone by Staff Nurse #1 that she (Staff Nurse #2) shouldn't have administered the vancomycin at 9:00 p.m. on 10/21/23 because the order had changed. Staff Nurse #2 indicated she was reprimanded and was in-serviced on medication errors.

On 10/26/23 at 5:11 p.m., the Director of Nursing stated she was made aware Resident #27 had received an additional dose of the vancomycin medication. She indicated the resident was monitored and her vital signs were checked every day.

The facility submitted the following corrective action plan with a completion date of 10/23/23.

1.Corrective action for resident(s) affected by the alleged deficient practice:
On 10/22/2023 Resident #27 was identified to have received an additional dose dose of Intravenous (IV) Vancomycin. Resident was assessed on 10/22/2023. Nurse Practitioner (NP) on call was notified. Pharmacy called and new orders received to hold the Vancomycin 10/22/2023 dose. Resident made aware. Responsible Party updated. Resident #27 was monitored per policy for any negative outcomes. There was no negative outcome for resident #27. On 10/23/2023 at the 3pm IDT meeting, the interdisciplinary team reviewed components of the plan of correction for resident #27 and any other potentially affected residents.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice:

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On 10/23/2023 the Director of Nursing identified residents that were potentially impacted by this practice by completing a 100% audit on all current residents with Intravenous (IV) Medications for accuracy of medication administration. This was completed on 10/23/2023. The results included: 3 of 3 residents with IV medications received medication as ordered. On 10/23/2023 the DON implemented corrective action for those residents which included: no corrective action needed, no deficient practice. On 10/23/2023 All nurses and med aids were interviewed to ensure they administered all medications and treatments per order on 10/21/2023. The results included all reviewed medications or treatments were administered per orders. No corrective action needed, no deficient practice.

3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice:
Education: On 10/23/2023, the Staff Development Clinician began in-servicing all Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) , and medication aids, (including agency) on Medication Error policy. This training included all current staff including agency. This training included:
"Following the 6 rights
The right person
The right medication
The right dose
The right time
The right route
The right documentation
The Director of Nursing ensured that any of the above identified staff who did not complete the in-service training by 10/23/2023 would not be allowed to work until the training is completed.

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4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.
The Interdisciplinary team met on 10/23/2023 to review the components of the plan of correction at daily stand-down. This meeting consisted of the facility QAPI team members. The DON or designee will monitor medication/ treatment order administration weekly for 2 weeks and monthly for 3 months for using the Quality Assurance (QA) monitoring tool. Reports will be presented to the weekly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, DON, Minimum Data Set Coordinator, Therapy, Health Information Management, and the Dietary Manager.

Date of Compliance: 10/23/2023

The facility's corrective action plan was validated on 10/27/23 by the following: Record review of in-services given to staff and audits completed by staff management. Validation was also evidenced by interviews of nursing staff. The facility's education was reviewed and included documentation of completion. The facility's audits were also reviewed. There was documentation that audits had been completed. Staff members from various were interviewed and reported that they had attended in-service training on medication errors. The staff attendance was verified on the attendance logs. Training included "How to Avoid Medication Errors during

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F 760	Continued From page 20 administration. The 6 rights: the right patient, right route, right drug, right dose, right time, and the right documentation." The completion date of 10/23/23 for the corrective action plan was validated.	F 760		
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.	F 867		11/25/23

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F 867	Continued From page 21 §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy,	F 867		

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F 867	Continued From page 22 resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345039	A. BUILDING _____ B. WING _____	C 10/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 23 available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews and record review, the facility Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and interventions put into place after recertification surveys completed on 5/27/21 and 7/21/22. The deficiencies were in the areas of abuse, accuracy of assessments, residents are free from significant med errors, and accurately coding Minimum Data Set assessments and were recited on the the recertification survey of 10/27/23. The continued failure of the facility during three consecutive federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings included: This citation is cross referenced to: 1. F600 Based on resident interview, staff interview, and record review the facility failed to protect resident's right to be free from abuse for one of one resident reviewed for physical abuse (Resident #25) from Resident #48. On 10/16/23 Resident #48 struck Resident #25 on the nose after a verbal altercation. The facility was cited during the 5/27/21 recertification survey for failure to provide incontinent care for 1 of 1 sampled resident who required extensive assistance and who had requested incontinent care on 2 occasions because she had soiled herself. 2. F641 - Based on record review, observations,	F 867	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F867 The facility□s Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor interventions put in place to prevent Abuse, significant medication errors and inaccuracy in MDS assessments. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 11/22/2023, the Regional Director of Operations educated the facility Administrator on how to sustain an overall effective Quality Assessment and Assurance (QAA) program including Accidents (F689), (F641), Accurately coding assessments and (F600)Abuse. This deficiency was cited again on the Annual recertification survey completed on 10/24/2023 2. Corrective action for residents with the potential to be affected by the alleged deficient practice:	

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F 867	Continued From page 24 staff, and resident interviews the facility failed to accurately code Minimum Data Set assessments in the areas of Accidents and Nutrition for 2 of 6 residents reviewed (Resident #41 and #61). The facility was cited during the 7/21/22 recertification survey for failure to accurately code the Minimum Data Set (MDS) assessment in the areas of weight loss and medications for 2 of 33 residents reviewed. During the current survey, the facility failed to obtain a physician's order for an indwelling catheter. The facility was cited during the 5/27/21 recertification sand complaint investigation survey for failure to accurately code the Minimum Data Set (MDS) assessment for 2 of 5 residents reviewed for unnecessary medications. 3. F760 - Based on record reviews and staff interviews, the facility failed to prevent a significant medication error when additional doses of an intravenous (IV) antibiotic was administered to 1 of 1 sampled resident (Resident #27) reviewed. The facility was cited during the 7/21/22 recertification survey the facility failed to hold the administration of antihypertensive medications when a resident ' s blood pressure / heart rate were outside of the parameters indicated by his physician orders. During the current survey, the facility failed to ensure residents were free of significant med errors. During an interview with the Administrator on 10/27/23 at 4:00 PM, the Administrator stated the QAA Committee met monthly and identified, developed, and implemented plans of action to	F 867	Corrective action has been taken for the identified concerns in the areas of: Accidents (F689.) Abuse (F600) Accurately coding Minimum Data Set Assessments (641) The Quality Assurance Performance Improvement (QAPI) committee held a meeting on 11/22/2023 to review the deficiencies and citations the Annual Survey ending on 10/24/2023. On 11/22/2023, the RDO in-serviced the facility Administrator on the functions of the QAPI Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies related to the area of Accidents,(F689), Minimum Data Assessment coding (F641) and Abuse (F600). 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 11/22/2023 the administrator completed in-servicing with the QAPI team members that include the Administrator, Director of Nurses, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager, on the appropriate functions of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies in the areas of Accidents, (F689), Minimum Data Assessment coding (F641) and Abuse (F600). This in-service was incorporated in the	

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F 867	Continued From page 25 correct identified quality deficiencies. The Administrator also stated that after the previous recertification survey, corrective actions were put in place and until this survey, she felt the facility was in substantial compliance regarding a former citation.	F 867	new employee facility orientation for the QAPI Committee team members identified above. This will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any QAPI committee team member who does not receive scheduled in-service training will not be allowed to work until training has been completed by 11/24/2023 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The Administrator or designee will monitor compliance utilizing the F867 Quality Assurance Tool weekly x 5 weeks then monthly x 2 months. The tool will monitor facility identified concerns that need to be addressed by the QA Committee. Reports will be presented to the weekly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance with the accident process. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/24/2023	