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F 000	INITIAL COMMENTS	F 000		

The surveyor entered the facility on 11/27/23 to conduct a complaint survey and exited on 11/29/23 Additional information was obtained on 11/30/23, 12/1/23 and 12/4/23 through 12/8/23. Onsite validation of the immediate jeopardy removal plan was conducted on 12/8/23. Therefore the survey exit date was changed to 12/8/23.

The following intakes were investigated. NC 209478; NC 207420, NC 208776; and NC 206135.

Two of the sixteen complaint allegations resulted in a deficiency.

Immediate Jeopardy was identified at:

CFR 483.10 at tag F580 at a scope and severity J
CFR 483.25 at tag F684 at a scope and severity J

The tag F684 constituted Substandard Quality of Care.

Immediate Jeopardy began on 9/27/23 and was removed on 12/7/23. A partial extended survey was conducted.

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F 557 SS=D	Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2)	F 557		

§483.10(e) Respect and Dignity.
The resident has a right to be treated with respect and dignity, including:

§483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 12/19/2023

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

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F 557	Continued From page 1 as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on record review, resident interview, and staff interview the facility failed to ensure a resident's personal possessions were retained when her belongings were packed by staff when she was moved to a different room. This was for one (Resident # 4) of one sampled resident who had personal items packed away without the resident being present. The findings included: Resident # 4 was admitted to the facility on 8/4/22. Review of the record revealed Resident # 4 was moved to another room within the facility on 7/19/23 from a room in which she had resided since her admission date of 8/4/22. Review of a grievance form, dated 7/25/23, revealed a grievance was filed by a family member on Resident # 4's behalf. The form included information that multiple personal items had not been returned to Resident # 4 following her move. These included her phone, television, clothing, refrigerator, and hygiene items. There were documented facility efforts to return items and resolve issues on the form. On 8/16/23 another grievance was filed by Resident # 4 when she reported that her phone chargers and remote were missing. The grievance form included facility documentation the items were returned.	F 557	Past noncompliance: no plan of correction required.	

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On 11/2/23 another grievance form was completed for Resident # 4 during a care plan meeting. The grievance form noted Resident # 4 reported she was still missing bras, clothing, and a clock. The grievance form noted Resident # 4 was stating the items had been missing since her room change. The grievance form included facility documentation the facility had made efforts to replace items and resolve the issue.

Resident # 4's Minimum Data Set assessment, dated 11/3/23, coded Resident # 4 as cognitively intact.

On 11/5/23 another grievance form included the information that Resident # 4 voiced during a resident council meeting that her photo albums had been missing since the room change.

Resident # 4 was interviewed on 11/28/23 at 4:10 PM and reported the following. She had been moved on a date in July to a temporary room. She had not been present when her things were packed. She had been told by staff they needed to clear her initial room of everything, and her things would be returned to her after the temporary move was complete. After the temporary move was over, some of her things had been returned to her and others had not been returned to her. According to Resident # 4 she was still missing the bras and photo albums which had been mentioned in the grievances.

A Maintenance Employee was interviewed on 11/18/23 at 1:40 PM and reported the following. In July, 2023, he had packed Resident # 4's belongings in a box and put them away in storage. He did not know anything about missing

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F 557	Continued From page 3 items for Resident # 4. The Administrator and the facility Social Worker were interviewed on 11/29/23 at 12:00 PM. The Social Worker reported the following. There had been an environmental issue identified in Resident # 4's room on 7/19/23. It had been explained to Resident # 4 the nature of the issue, her things would need to be packed and stored for an interim, and she would need to be moved temporarily while the issue was addressed. Because of the nature of the issue, it had been best that Resident # 4 not go back in the room after the issue was identified. Resident # 4 understood this and was in the hallway as her things were packed. The Administrator reported the following. Resident # 4's personal items had been placed in an empty storage room after being packed by the maintenance employee for her. There had never been any accounting system of Resident # 4's personal belongings and exactly what was packed away into the box prior to the move. The Administrator had just begun her position at the facility on 7/7/23, which was a few days prior to Resident # 4's issue needing to be addressed. At the time, it was a priority issue to get the environmental issue addressed. After the move, Resident # 4 and her family member repeatedly came to her to voice that personal items were missing. They stated the items had been missing since the temporary move in July, 2023. She filled out grievance forms each time and tried to address all the items. She replaced what she could by going upon what the resident reportedly said she had before the move. On 11/2/23 when yet another grievance was filed regarding missing items by Resident #4 going back to July, 2023, the Administrator recognized that there was a problem in that the facility did not	F 557		

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have an inventory sheet to account for personal items packed away if the need arose. Therefore, she initiated a plan of correction with her management team. The Administrator presented the following plan of correction she had completed.

1. Resident # 4 had a necessary room change on 7/19/23. Post room change resident stated she was missing several items. The items that were in storage were returned to her and/or purchased by the facility. On 11/2/23 the Administrator identified the facility was not keeping an inventory list of resident's personal belongings if a resident was transferred in the facility or if for any reason the facility was storing personal belongings. This was discovered due to resident # 4 stating she had photo albums that were not returned to her during a room change in July 2023. A grievance form was written and staff checked the facility and photo albums were not found at this time. This will be an on-going investigation.

2. Other residents who change rooms in the facility or who need personal belongings put into storage are determined to be at risk for lost personal belongings. Residents or responsible parties of residents who were relocated within the facility in July, when the facility had an environmental challenge, were interviewed by the Social Worker to ensure all property was returned. There were no negative findings.

3. Systemic Measures: Residents who are being discharged from the facility will have the family pack their belongings. Those residents whose belongings cannot be removed by the family or those who are transferred within the

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facility will have an inventory of the items packed up to be relocated to storage and/or the new room. This inventory will be documented along with the exact location of where belongings will be stored by the person packing the belongings. A copy of the inventory will be placed with the items and/or given to the resident as well as a copy being maintained in the housekeeping office if needed for future reference to ensure all of the personal property is returned per the inventory sheet. If there is a discrepancy when the items are returned, the discrepancy will be reported to the Administrator and the grievance policy related to lost items will be followed.

4. The implementation of this plan was discussed and agreed upon on 11/3/23 by the interdisciplinary team which includes the Administrator, Director of Nursing, Social Workers, Maintenance/Housekeeping Director, Rehabilitation Director, Admission and Marketing Team, Dietary Supervisor and Activity Director. The maintenance/housekeeping supervisor, as of 11/3/23 is monitoring this process for effectiveness for residents whose personal belongings are to be transferred to a different room or stored within the facility. The results of the monitoring of personal belongings will be presented to the quality assurance performance improvement committee for 3 months to determine effectiveness. Additional interventions will be developed and implemented by the committee as determined necessary. The facility alleged this plan of correction was completed on 11/3/23.

The facility's corrective action plan was validated on 12/1/23 by the following.

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F 557	Continued From page 6 Multiple residents were interviewed during an initial tour of the facility which took place on 11/27/23. The residents who were interviewed had no complaints regarding the safe- guarding of their items. The Administrator presented documentation of efforts to resolve Resident # 4's grievances, which led her to recognize the need for and develop a plan of correction to safeguard personal items. The Administrator presented a signed in-service sheet noting the interdisciplinary team members had attended the in-service meeting on 11/3/23 as noted in their plan of correction. The Administrator also provided an inventory sheet the facility had adopted to use to ensure the tracking and safe- guarding of personal items when they were packed. Per the Administrator, the facility was monitoring their system and as of the date of the survey, no other residents' belongings had been packed away for storage since their new plan was initiated. The facility's plan of correction with a completion date of 11/3/23 was validated.	F 557		
F 580 SS=J	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		12/21/23

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F 580	Continued From page 7 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 8 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, paramedic, and physician interview the facility failed to notify the physician regarding a significant change in condition for one (Resident # 3) of two sampled residents. On the morning of 9/27/23 Nurse Aide #1 and Nurse #3 observed signs Resident # 3 was experiencing a significant change in condition including a low blood pressure, slurred speech, sluggishness, inability to carry on a conversation per his norm, inability to help in his care per his norm, and bloody urine in his catheter. The physician was not notified when staff noted the change in condition. Resident # 3 was found in the afternoon on 9/27/23 unresponsive, with a temperature reading of 102 Fahrenheit, and using accessory respiratory muscles to breathe (muscles other than the diaphragm and muscles within the rib cage which are used in labored breathing.) Resident #3's condition had declined to the point where Emergency Medical Services (EMS) was called, and Resident # 3 was transferred to the hospital where he was admitted to the hospital Intensive Care Unit (ICU) with severe sepsis with septic shock (when a person is not getting enough blood flow through their body). Immediate Jeopardy began on 9/27/23 when staff members observed but failed to notify the physician that Resident # 3 was experiencing a change in condition which resulted in the resident's admission to the hospital ICU with sepsis and septic shock. Immediate Jeopardy was removed on 12/7/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will	F 580	1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #3 was found nonresponsive by the lead nurse on the afternoon of 9/27/23. Resident was discharged to the hospital via Emergency Medical Services at 2:53 p.m. Resident #3 is currently a resident of the facility and had no noted change of condition when assessed by the Director of Nurses when readmitted to the facility on 10/4/23 or on 12/05/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 12/5/2023, the Director of Nurses met with all floor nurses and initiated assessment of all current residents to identify any resident with any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where physician notification of the resident change in condition was delayed. 4 of 86 current residents were assessed by the assigned nurse or Director of Nurses and identified as having a new change in condition and the physician was notified on 12/5/23 by the assigned nurse or Director of Nurses. On 12/06/2023 the Regional Nurse Consultant audited all residents transferred to the hospital in the last 30 days (11/01/2023- 12/06/2023) for timely	

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remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure monitoring systems put in place are effective.

The findings included:

Resident # 3 was admitted to the facility on 3/10/22 with diagnoses which in part included spinal stenosis and functional mobility problems, and neurogenic bladder with a chronic indwelling catheter.

A review of hospital records revealed Resident # 3 was hospitalized from 7/12/23 to 7/18/23 with sepsis due to a urinary tract infection caused by obstructive nephrolithiasis (kidney stones). A stent was placed at that time.

Resident # 3's quarterly MDS (Minimum Data Set) assessment, dated 7/21/23 coded Resident # 3 as cognitively intact and as having an indwelling catheter.

According to hospital records, Resident # 3 was hospitalized again from 7/29/23 until 8/2/23 with a urinary tract infection and sepsis.

On 9/27/23 at 7:10 AM Resident # 3's vital signs were documented as the following by Nurse # 2. Temperature 98; pulse 76; respirations 18; blood pressure 128/62.

NA (Nurse Aide) # 1 was the NA who had cared for Resident # 3 on 9/27/23. NA # 1 was interviewed on 11/29/23 at 9:05 AM and reported the following. She had taken his vital signs that

F 580

notification of the physician. The physician of all 13 residents who were transferred to the hospital was notified when the change in condition was observed by the attending nurse.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 12/05/2023 the Director of Nurses/Nurse Consultant and Staff Development Coordinator began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), certified nursing assistants(CNA) and medication aides (full time, part time, and as needed, including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additional education included, if resident□s condition worsened and nurse□s assessment warrants, the nurse is to activate emergency medical services. At the time the change is observed, the Physician and family/responsible party are to be notified to ensure the resident receives the care needed to address the change. The Director of Nurses will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s, Med Aides (full time, part time, and as needed including agency) who do not complete the in-service training by 12/20/2023 will not be allowed to work until the training is completed. This

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F 580	Continued From page 10 morning and they were low. His systolic blood pressure was below 100 and his diastolic was also low. She took them twice to make sure they were registering. She did not enter them into the record. She told Nurse # 2, Resident #3's assigned nurse, about them. Usually, Resident # 3 did not eat breakfast, but he always asked for coffee and would drink it. That morning he did not ask for or drink coffee. He "seemed off." Around 10 AM, she bathed him. Normally he was very alert and would carry on a full conversation during his care. He normally would also assist to turn in the bed and hold onto the rail. That morning, "he was not doing nothing." His eyes would open a little bit and then close. He would mumble but not carry on a full conversation. He also had blood in his catheter bag. She told Nurse # 2 how he was acting and that he had blood in his catheter bag. That morning the treatment nurse also went into Resident # 3's room to do wound treatments for him. She told the treatment nurse also that Resident # 3 was "not acting right." This was before lunch. Nurse # 3 said she would tell Nurse # 1. At lunch time Resident # 3 did not eat anything and she was still concerned. She was hoping they would send him to the hospital. Nurse # 1 did come to check him in the afternoon, and he was sent out. Nurse # 1 asked her (NA # 1) why she had not let her know sooner about his condition, and she informed her that she had been alerting Nurse # 2 throughout the day. Nurse # 3 was interviewed on 11/29/23 at 10:15 AM and reported the following. She went to provide wound treatments to Resident # 3 sometime between 10 AM and lunch on 9/27/23. Usually, Resident # 3 would initiate conversation on his own when you entered his room. That morning he did not do so. She could not engage	F 580	in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and as needed including agency.) and will be reviewed by the Quality Assurance process to verify that the change has been sustained 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 DON /Designee will audit this process using the Quality Assurance Tool for monitoring compliance with the notification process for change in condition. Notification of change in condition will be monitored during the Daily Clinical Review Process. This audit will be completed Monday through Friday x 1 week and then weekly times 2 weeks, then monthly times 3 months or until resolved. Reports will be presented to the 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 Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, Dietary Manager and Medical Director.	

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him in conversation. If she would say, "Hey (Resident # 3)," he would just say, "ah ....." in a slurred way. His speech was slurred, and he was sluggish. Normally he would help them turn, but he did not help that AM turn for treatments. She knew something was not right with him. NA # 1 also told her he had not been acting right. After she left the room, she went to Nurse # 2 and told her, "You better check on (Resident # 3). He's not acting right." Nurse # 2 told her that it had taken her awhile to get him to take his morning medications, but he took them, and he was on an antibiotic. She had also said she would check on him. According to Nurse # 3, if Resident # 3 had been assigned to her then she would have called the provider at that point in the morning given the change she had seen in Resident # 3 and alerted the provider about the change. The treatment nurse stated she would have asked the physician if he wanted to do labs or send the resident out for evaluation. She thought that was what Nurse # 2 was going to do after she spoke to Nurse # 2 in the morning. Therefore, she went on to do her treatments. Later after lunch she returned, and NA # 1 again told her Resident # 3 still was not right and Nurse # 2 had not done anything. At that point, Nurse # 3 stated she went to Nurse # 1 and Nurse # 1 immediately went to check on Resident # 3.

Nurse # 1 was interviewed on 11/29/23 at 4:30 PM and reported the following. Nurse # 1 stated she was the rehabilitation nurse manager, but also served as the point of contact for the unit where Resident # 3 resided. On 9/27/23 she had been in her office when Nurse # 3 alerted her Resident # 3 was not acting right. She went right away to check on him. It was around 3:00 or 4:00 PM when she was alerted. When she assessed

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him, she found he could not talk and would not follow commands, but he did respond to a sternal rub a little. She immediately had him sent to the hospital.

Nurse # 2 was interviewed on 11/28/23 at 3:00 PM and again on 11/29/23 at 5:30 PM and reported the following. It was not unusual for Resident # 3 to be groggy or sleepy in the AM. She did not recall all the specific details of 9/27/23. She just recalled Resident # 3 took his medications that morning, throughout the day she was in and out to check on him, and he was eventually sent out because he was not responding. She did not recall if she took his vital signs as she was in and out checking on him.

There was no documentation the physician was notified of Resident # 3's change in condition which Nurse # 3 and NA # 1 had observed before lunch on 9/27/23.

On 9/27/23 at 5:03 PM, Nurse # 1 entered the following entry into the record. "Resident was found in his bed in the supine position [on his back] with mouth agape [open] and using his accessory muscles to breathe. He had blood tinge urine as well. Resident would not respond to his name or sternum rub. Writer [Nurse #1] immediately called 911 and went to grab the AED [automated external defibrillator]. Writer [Nurse #1] held pt [patient] airway opened until EMS [Emergency Medical Services] arrived. Resident BP [blood pressure] was very low and he was clammy and hot. He had a fever of 102 and BP was 82/46. NP [Nurse Practitioner] [Name of Nurse Practitioner] was notified of the emergency transfer out to the ER [Emergency Room]."

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F 580	Continued From page 13 Resident # 3's 9/27/23 EMS records revealed EMS received the facility's call at 2:53 PM and arrived on the scene at 3:02 PM. They noted the following in their EMS assessment. At 3:05 PM Resident #3's vital signs were BP 84/53; pulse 94; respirations 19 and oxygen level 93%. The resident's temperature was 102.1 degrees Fahrenheit. There was visible blood in Resident # 3's catheter. Upon initial EMS arrival, Resident # 3 was unresponsive, and his skin was hot. He was moved to the stretcher, and once on the stretcher, he opened his eyes briefly. Several IV (intravenous attempts) were made, and a successful IV was established. The resident began to respond to voice, but only with one-word answers. The Lead Paramedic that had responded on 9/27/23 was interviewed on 12/4/23 at 4:30 PM and reported the following. She had been concerned he might not live given his condition. Review of Resident # 3's emergency room notes revealed the physician documented EMS reported, "they [EMS] state staff at facility was unable to answer most of her [the paramedic's] questions about what baseline is." Resident # 3's hospital admission history and physical revealed the physician noted the following information on 9/27/23. In the Emergency Room Resident # 3's blood pressure was 64/36; heart rate 118, respirations 23 and temperature 39.6 degrees Celsius. (103.28 Fahrenheit). His WBC (white blood count) was high at 28 (normal range 4.2 to 10.9). The physician noted Resident # 3 was obtunded and met the criteria for septic shock. The physician also noted his hypotension did not respond to fluid resuscitation and he was given Levophed (a medication that can raise the blood	F 580		

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pressure in septic shock). A central line (a catheter line placed in the large vein above the heart for fluids and medications) was placed and the resident was given antibiotics. Resident # 3 was hospitalized for treatment in the Intensive Care Unit. He remained In ICU until 10/1/23. He remained hospitalized until 10/4/23.

Resident # 3's 10/4/23 hospital discharge summary listed Resident # 3's first two discharge diagnoses as septic shock and urinary catheter associated urinary tract infection. The discharge summary also noted, "His AMS [altered mental status] was resolved after receiving antimicrobials, etiology due to sepsis." (The reason for the altered mental status was due to sepsis.)

On 10/4/23, Resident # 3 was transferred back to the facility for care.

Resident # 3's physician was interviewed on 12/4/23 at 11:11 AM. NA # 1 and Nurse # 3's 9/27/23 observations were shared with the physician. The physician reported the following. Based on the observations of NA # 1 and Nurse # 3, it did appear Resident # 3 experienced a change in condition on the AM of 9/27/23 and he should have been notified in the morning of 9/27/23. Resident # 3's physician was interviewed regarding possible danger if the facility staff delayed in notifying the provider about changes in condition in residents. According to the physician the outcome of a delay in physician notification could be different on a case-by-case scenario.

On 12/5/23 at 2:56 PM the Administrator was informed of Immediate Jeopardy and subsequently provided the following Immediate

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F 580	Continued From page 15 Jeopardy removal plan. Removal Plan F580 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #3 was found nonresponsive by the lead nurse on the afternoon of 9/27/23. Resident was discharged to the hospital via Emergency Medical Services at 2:53 p.m. Resident #3 is currently a resident of the facility and had no noted change of condition when assessed by the Director of Nurses when readmitted to the facility on 10/4/23 or on 12/05/2023. Current residents are at risk of experiencing a change in condition that requires assessment and notification of the physician. On 12/5/2023, the Director of Nurses met with all floor nurses and initiated assessment of all current residents to identify any resident with any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where physician notification of the resident change in condition was delayed. 4 of 86 current residents were assessed by the assigned nurse or Director of Nurses and identified as having a new change in condition and the physician was notified on 12/5/23 by the assigned nurse or Director of Nurses. On 12/06/2023 the Regional Nurse Consultant audited all residents transferred to the hospital in the last 30 days (11/01/2023- 12/06/2023) for timely notification of the physician. The physician of all 13 residents who were transferred to the hospital was notified when the change in condition was observed by the attending nurse.	F 580		

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F 580	Continued From page 16 Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 12/05/2023 the Director of Nurses/Nurse Consultant and Staff Development Coordinator began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), certified nursing assistants and medication aides (full time, part time, and as needed, including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additional education included, if resident's condition worsened and nurse's assessment warrants, the nurse is to activate emergency medical services. At the time the change is observed, the Physician and family/responsible party are to be notified to ensure the resident receives the care needed to address the change. The Director of Nurses will ensure that all licensed nurses, RN's, LPN's, and CNA's, Med Aides (full time, part time, and as needed including agency) who do not complete the in-service training by 12/06/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and as needed including agency.) Alleged date of IJ removal 12/07/2023 Onsite validation of the immediate jeopardy removal plan was completed on 12/8/23. Documentation of all the residents' assessments	F 580		

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F 580	Continued From page 17 for change in condition on 12/5/23 were reviewed and verified the physician was notified for the four residents identified with changes in condition and verbal orders were received and implemented as determined necessary by the physician. Nursing staff (licensed practical nurses, registered nurses, nurse aides, medication aides) who worked different shifts were interviewed and verified they had received training on what constituted a change in condition, the steps to take when a change in condition is first identified, and steps to take if a change in condition worsened to include activation of emergency medical services. Inservice sign-in logs verified the education was provided as indicated. This education was confirmed to be added to the new employee facility and agency orientation for licensed and unlicensed nursing staff. The facility's immediate jeopardy removal date of 12/7/23 was validated.	F 580		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff, paramedic, and physician interview the facility failed to effectively assess and address a significant change in condition for one (Resident # 3) of two sampled residents whose condition	F 684	1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #3 was found nonresponsive by the lead nurse on the afternoon of 9/27/23. Resident was discharged to the	12/21/23

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necessitated Emergency Medical Services (EMS) to be called. Resident # 3 had a history of sepsis (when an infection triggers widespread inflammation in a person's body which can lead to organ damage) and on the morning of 9/27/23 Nurse Aide #1 and Nurse #3 observed Resident # 3 was experiencing a change in condition prior to the lunch meal that included: a low blood pressure, slurred speech, sluggishness, inability to carry on a conversation per his norm, inability to help in his care per his norm, and bloody urine in his catheter. Resident # 3 was found in the afternoon on 9/27/23 unresponsive, with a temperature reading of 102 degrees Fahrenheit, and using accessory respiratory muscles to breathe (muscles other than the diaphragm and muscles within the rib cage which are used in labored breathing). EMS was called at 2:53 PM. Upon their arrival, EMS also found Resident # 3 to be unresponsive and with what appeared as an undissolved pill in the resident's mouth. Resident # 3 was transferred by EMS to the hospital where he was admitted to the hospital Intensive Care Unit (ICU) with severe sepsis with septic shock (when a person is not getting enough blood flow through their body).

Immediate Jeopardy began on 9/27/23 when staff failed to comprehensively assess Resident # 3 after a significant change in condition was noted to determine if medical interventions were necessary. Immediate Jeopardy was removed on 12/7/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a scope and severity level of D (not actual harm with the potential for more than minimal harm that is not immediate jeopardy) for the facility to complete staff training and to ensure

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hospital via Emergency Medical Services at 2:53 p.m. Resident #3 is currently a resident of the facility and had no noted change of condition when assessed by the Director of Nurses when readmitted to the facility on 10/4/23 or on 12/05/2023.

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

On 12/5/2023, the Director of Nurses met with all floor nurses and initiated assessment of all current residents to identify any resident with any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where physician notification of the resident change in condition was delayed. 4 of 86 current residents were assessed by the assigned nurse or Director of Nurses and identified as having a new change in condition and the physician was notified on 12/5/23 by the assigned nurse or Director of Nurses.

On 12/06/2023 the Regional Nurse Consultant audited all residents transferred to the hospital in the last 30 days (11/01/2023- 12/06/2023) for timely notification of the physician. The physician of all 13 residents who were transferred to the hospital was notified when the change in condition was observed by the attending nurse.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient

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monitoring systems put in place are effective. The findings included:

Resident # 3 was admitted to the facility on 3/10/22 with diagnoses which in part included spinal stenosis and functional mobility problems. Additionally, the resident had a diagnosis of neurogenic bladder with a chronic indwelling catheter.

A review of hospital records revealed Resident # 3 was hospitalized from 7/12/23 to 7/18/23 with sepsis due to a urinary tract infection caused by obstructive nephrolithiasis (kidney stones). A stent (a tube used to hold open a bodily passage) was placed at that time.

Resident # 3's quarterly MDS (Minimum Data Set) assessment, dated 7/21/23 coded Resident # 3 as cognitively intact and as having an indwelling catheter. Resident # 3 was also coded as having clear speech, able to feed himself after set up, able to perform his oral care with supervision, and required substantial/maximum assistance with bathing and bed mobility.

According to hospital records, Resident # 3 was hospitalized again from 7/29/23 until 8/2/23 with a urinary tract infection and sepsis.

On 8/2/23 Resident # 3 was ordered to receive Methenamine Hippurate 1 gram two times per day. (A medication used to prevent returning urinary tract infections). This remained as an active order through 9/27/23.

Resident # 3's care plan, updated on 8/10/23, revealed staff had noted Resident # 3 had recurrent urinary tract infections and included this

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practice:
On 12/05/2023 the Director of Nurses/Nurse Consultant and Staff Development Coordinator began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), certified nursing assistants(CNA) and medication aides (full time, part time, and as needed, including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additional education included, if resident□s condition worsened and nurse□s assessment warrants, the nurse is to activate emergency medical services. At the time the change is observed, the Physician and family/responsible party are to be notified to ensure the resident receives the care needed to address the change. The Director of Nurses will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s, Med Aides (full time, part time, and as needed including agency) who do not complete the in-service training by 12/20/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and as needed including agency.) and will be reviewed by the Quality Assurance process to verify that the change has been sustained

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on the care plan update of 8/10/23. One of the interventions was to monitor the resident for symptoms of altered mental status, behavioral changes, and hematuria (bloody urine).

On 9/27/23 at 7:10 AM Resident # 3's vital signs were documented as the following by Nurse # 2. Temperature 98; pulse 76; respirations 18; blood pressure 128/62.

NA (Nurse Aide) # 1 was the NA who had cared for Resident # 3 on 9/27/23. NA # 1 was interviewed on 11/29/23 at 9:05 AM and reported the following. She had taken his vital signs that morning and they were low. His systolic blood pressure was below 100 and his diastolic was also low. She took them twice to make sure they were registering. She did not enter them into the record and instead reported them to Nurse # 2 as this was the normal protocol. Usually, Resident # 3 did not eat breakfast, but he always asked for coffee and would drink it. That morning he did not ask for or drink coffee. He "seemed off." Around 10 AM, she bathed him. Normally he was very alert and would carry on a full conversation during his care. He normally would also assist to turn in the bed and hold onto the rail. That morning, "he was not doing nothing." His eyes would open a little bit and then close. He would mumble but not carry on a full conversation. He also had blood in his catheter bag. She told Nurse # 2, Resident # 3's assigned nurse, how he was acting and that he had blood in his catheter bag. That morning the treatment nurse, Nurse #3, also went into Resident # 3's room to do wound treatments for him. She also told Nurse # 3 that Resident # 3 was "not acting right." This was before lunch. Nurse # 3 said she would tell Nurse # 1. At lunch time Resident # 3 did not eat anything and she

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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 DON /Designee will audit this process using the Quality Assurance Tool for monitoring compliance with the notification process for change in condition. Notification of change in condition will be monitored during the Daily Clinical Review Process. This audit will be completed Monday through Friday x 1 week and then weekly times 2 weeks, then monthly times 3 months or until resolved. Reports will be presented to the 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 Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, Dietary Manager and Medical Director.

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F 684	Continued From page 21 was still concerned. She was hoping they would send him to the hospital. Nurse # 1 did come check him in the afternoon and he was sent out. Nurse # 1, a nurse manager, asked her (NA # 1) why she had not let her know sooner about his condition, and she informed her that she had been alerting Nurse # 2 throughout the day. Nurse # 3 was interviewed on 11/29/23 at 10:15 AM and reported the following. She went to provide wound treatments to Resident # 3 sometime between 10 AM and lunch on 9/27/23. Usually, Resident # 3 would initiate conversation on his own when you entered his room. That morning he did not do so. She could not engage him in conversation. If she would say, "Hey [Resident # 3]," he would just say, "ah ....." in a slurred way. His speech was slurred, and he was sluggish. Normally he would help them turn, but he did not help that morning with turning for treatments. She knew something was not right with him. NA # 1 also told her he had not been acting right. After she left the room, she went to Nurse # 2 (Resident # 3's assigned nurse) and told her, "You better check on [Resident # 3]. He's not acting right." Nurse # 2 told her that it had taken her awhile to get him to take his morning medications, but he took them and he was on an antibiotic. She (Nurse # 2) had also said she would check on him. According to Nurse # 3, if Resident # 3 had been assigned to her then she would have called the provider at that point in the morning given the change she had seen in Resident # 3 and alerted the provider about the change. She thought that was what Nurse # 2 was going to do after she spoke to Nurse # 2 in the morning. Therefore, she went on to do her treatments. Later after lunch she returned to Resident #3's unit and NA # 1 again told her	F 684		

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F 684	Continued From page 22 Resident # 3 still was not right and Nurse # 2 had not done anything. At that point, Nurse # 3 stated she went to Nurse # 1 and Nurse # 1 immediately went to check on Resident # 3. Nurse # 1 was interviewed on 11/29/23 at 4:30 PM and reported the following. Nurse # 1 stated she was the rehabilitation nurse manager, but also served as point of contact for the unit where Resident # 3 resided. On 9/27/23 she had been in her office when Nurse # 3 alerted her Resident # 3 was not acting right. She went right away to check on him. It was around 3:00 or 4:00 PM when she was alerted. When she assessed him, she found he could not talk and would not follow commands but he did respond to a sternal rub a little. She immediately had him sent out to the Emergency Room (ER). Nurse # 2 was interviewed on 11/28/23 at 3:00 PM and again on 11/29/23 at 5:30 PM and reported the following about 9/27/23. It was not unusual for Resident # 3 to be groggy or sleepy in the morning. She just recalled Resident # 3 took his medications that morning, throughout the day she was in and out to check on him, and he was eventually sent out because he was not responding. She did not recall if she took his vital signs as she was in and out checking on him and did not recall the actions she took while checking in on him. There was no further nursing assessment, progress note, or vital signs noted in Resident # 3's record after 7:10 AM on 9/27/23 until the following note was documented at 5:03 PM by Nurse # 1. On 9/27/23 at 5:03 PM, Nurse # 1 entered the	F 684		

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F 684	Continued From page 23 following entry into Resident #3's record. "Resident was found in his bed in the supine [on his back] position with mouth agape [open] and using his accessory muscles to breathe. He had blood tinge urine as well. Resident would not respond to his name or sternum rub. Writer immediately called 911 and went to grab the AED (automated external defibrillator). Writer held pt [patient] airway opened until EMS (emergency medical services) arrived. Resident BP (blood pressure) was very low and he was clammy and hot. He had a fever of 102 and bp (blood pressure) was 82/46. NP [Name of Nurse Practitioner] was notified of the emergency transfer out to the ER." Resident # 3's 9/27/23 EMS records revealed EMS received the facility's call at 2:53 PM and arrived on the scene at 3:02 PM. They noted the following in their EMS assessment. At 3:05 PM Resident #3's vital signs were BP 84/53; pulse 94; respirations 19 and oxygen level 93%. The resident's temperature was 102.1. There was visible blood in Resident # 3's catheter. Upon initial EMS arrival, Resident # 3 was unresponsive and his skin was hot. He was moved to the stretcher, and once on the stretcher, he opened his eyes briefly. Several IV (intravenous attempts) were made, and a successful IV was established. The resident began to respond to voice, but only with one-word answers. The Paramedic further noted, "while assessing the resident, EMS noticed, what looked like an undissolved pill in the patient's mouth. The hospital was made aware of this when transferring patient care." The Lead Paramedic that had responded on 9/27/23 was interviewed on 12/4/23 at 4:30 PM	F 684		

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and reported the following. From her assessment at arrival to the facility, she had thought Resident # 3 could be septic. In route to the hospital, they had noticed what appeared to be a pill in his mouth that had not completely dissolved. She had been concerned he might not live given his condition.

Review of Resident # 3's hospital record revealed on 9/27/23 the physician documented EMS reported, "they [EMS] state staff at facility was unable to answer most of her [the paramedic's] questions about what baseline is." Resident # 3's hospital admission history and physical revealed the physician noted the following information on 9/27/23. In the Emergency Room Resident # 3's blood pressure was 64/36; heart rate 118, respirations 23 and temperature 39.6 degrees Celsius (103.28 Fahrenheit). His WBC (white blood count) was 28 (normal range 4.2 to 10.9) . The physician noted Resident # 3 was obtunded (decreased level of consciousness) and met the criteria for septic shock. The physician also noted his hypotension did not respond to fluid resuscitation and he was given Levophed (a medication that can raise the blood pressure in septic shock). A central line (a catheter line placed in the large vein above the heart for fluids and medications) was placed, and Resident # 3 was given antibiotics. Resident # 3 was hospitalized for treatment in the Intensive Care Unit. He remained In ICU until 10/1/23. He remained hospitalized until 10/4/23.

Resident # 3's 10/4/23 hospital discharge summary listed Resident # 3's first two discharge diagnoses as septic shock and indwelling catheter associated urinary tract infection. The discharge summary also noted "His AMS [altered

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mental status] was resolved after receiving antimicrobials, etiology due to sepsis." He was directed to follow up with a urologist following discharge and placed on a medication to help with hypotension (Midodrine).

On 10/4/23, Resident # 3 was transferred back to the facility for care.

Resident # 3 was interviewed on 11/28/23 at 2:10 PM. During the interview, Resident # 3 was observed to be very alert, articulate in his conversation, and capable of using his hands and arms to use his cell phone and access information during the interview. Resident # 4 reported the following. He had been concerned that the facility staff did not send him to the hospital earlier on 9/27/23. He had already had other urinary tract infections that had made him very sick. Nurse # 2 had given him his morning medications that day and he did not recall anything after that. After he recovered, NA # 1 had later told him that she could not get him to wake up during the morning on 9/27/23 and had alerted Nurse # 2 about this. He was concerned that when NA # 1 could not arouse him that nothing had been done at that point.

The DON (Director of Nursing) was interviewed on 11/29/23 at 11:00 AM and reported the following. She had reviewed Resident # 3's record and found no evidence of an assessment or vital signs being taken after the vital signs at 7:10 AM on 9/27/23. It would be her expectation that the resident would have been assessed when a change was observed, and she wished he had been sent out sooner.

Resident # 3's physician was interviewed on

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F 684	Continued From page 26 12/4/23 at 11:11 AM. NA # 1 and Nurse # 3's 9/27/23 observations were shared with the physician. The physician reported it was the expectation that an assessment needed to be done when a change in condition was noted, and from NA #1's and Nurse # 3's observations it appeared Resident # 3 had experienced a change prior to lunch on 9/27/23. On 12/5/23 at 2:56 PM the Administrator was informed of Immediate Jeopardy. The facility provided the following Immediate Jeopardy (IJ) removal plan. Removal Plan F684 Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. Resident #3 was found nonresponsive by the lead nurse on the afternoon of 9/27/23. Resident was discharged to the hospital via Emergency Medical Services at 2:53 p.m. Resident #3 is currently a resident of the facility and had no noted change of condition when assessed by the Director of Nurses when readmitted to the facility on 10/4/23 and on 12/05/2023. Current residents are at risk of experiencing a change in condition that requires assessment and notification of the physician. On 12/5/2023, the Director of Nurses met with all floor nurses and initiated assessment of all current residents to identify any resident with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked	F 684		

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F 684	Continued From page 27 change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. 4 of 86 current residents were identified by the assigned nurse or Director of Nurses as having a new change in condition. Notification of the Physician was conducted at the time the change was observed. The attending Physician gave verbal orders related the individual resident's change as he determined necessary on 12/5/23. The responsible party/family was notified of this change and new orders prescribed after speaking with the Physician. The orders were carried out as prescribed on 12/5/23. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. On 12/05/2023 the Director of Nurses/Nurse Consultant and Staff Development Coordinator began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN), certified nursing assistants and medication aides (full time, part time, and prn including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additional education included, if resident's condition worsened and nurse's assessment warrants, the nurse is to activate emergency medical services. At the time the change is observed, the Physician and family/responsible party are to be notified to ensure the resident receives the care needed to address the change.	F 684		

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F 684	Continued From page 28 The Director of Nurses will ensure that all licensed nurses, RN's, LPN's, and CNA's, Med Aides (full time, part time, and prn including agency) who do not complete the in-service training by 12/06/2023 will not be allowed to work until the training is completed. This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency.) Alleged date of IJ removal 12/07/2023 Onsite validation of the immediate jeopardy removal plan was completed on 12/8/23. Documentation of all the residents' assessments for change in condition on 12/5/23 were reviewed and verified the physician was notified for the four residents identified with changes in condition and verbal orders were received and implemented as determined necessary by the physician. Nursing staff (licensed practical nurses, registered nurses, nurse aides, medication aides) who worked different shifts were interviewed and verified they had received training on what constituted a change in condition, the steps to take when a change in condition is first identified, and steps to take if a change in condition worsened to include activation of emergency medical services. Inservice sign-in logs verified the education was provided as indicated. This education was confirmed to be added to the new employee facility and agency orientation for licensed and unlicensed nursing staff. The facility's immediate jeopardy removal date of 12/7/23 was validated.	F 684		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records	F 755		12/21/23

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F 755	Continued From page 29 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- §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, resident interview, staff interview, and pharmacy employee interview the facility failed to assure controlled substance records coincided with administration records for	F 755	1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/18 /2023 the Director of Nurses notified the physician of the missed doses	

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a controlled substance which a resident reported he did not receive as ordered. This was for one (Resident # 3) of two sampled residents reviewed for medications.

The findings included:

Resident # 3 was admitted to the facility on 3/10/22 with diagnoses which in part included spinal stenosis and functional mobility problems. Additionally, he had a diagnosis of neuropathy.

Resident # 3's Minimum Data Set assessment, dated 10/6/23, coded Resident # 3 as cognitively intact.

Review of physician orders revealed an order dated 8/2/23 for Lyrica 150 mg (milligrams) every eight hours for pain.

Review of Resident # 3's September 2023 MAR (medication administration record) revealed the Lyrica was scheduled to be given at 12:00 AM, 8:00 AM and 4:00 PM each day.

The September 2023 MAR also included documentation on 9/13/23 at 8:00 AM and 4:00 PM that the Lyrica doses were administered by Nurse # 2.

Review of Resident # 3's September 2023 controlled substance count sheets (the sheets on which a nurse must sign out a controlled substance from a supply) revealed no Lyrica was signed out on 9/13/23 at 8:00 AM and 4:00 PM when Nurse # 2 documented on the MAR it was administered. According to the controlled substance count sheets, the last dose of Resident # 3's Lyrica had been removed from the

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of the medication. No new orders were initiated.
On 12/18/2023 The Director of Nurses ensured that Resident #3's medications have been reconciled and are available in the medication cart. No concerns were identified.
On 12/18/2023 the Director of Nurses audited resident #3's electronic medical record and controlled substance sheet for the last 7 days to confirm that all ordered doses of the medication had been administered as ordered and documented per facility policy.
The results included: No concerns were identified.
On 12/18 /2023, the Director of Nurses/Regional Nurse Consultant initiated 1 on 1 education with Nurse #2 medications due to medication not being available to ensure Nurse #2 understands the steps necessary to obtain medications to be given as ordered and facility documentation policy of medications to include controlled substances.
2. Corrective action for residents with the potential to be affected by the alleged deficient practice:
All residents who receive medications have the potential of being affected by the alleged deficient practice.

On 12/ 18/2023 the Director of Nurses/ Staff Development Coordinator/ Regional Nurse Consultant initiated an audit of all current resident's receiving Lyrica for the last 7 days. (12-10-2023 through 12-17-2023). The audit consisted of a review of the EMAR and controlled

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supply at 10:00 PM on 9/12/23 for administration, which left the available supply at zero.

According to controlled substance count sheets, the next supply of Lyrica was dispensed on 9/13/23. The first Lyrica dose removed from the 9/13/23 supply was documented to be on 9/14/23 at 12:00 AM; indicating Nurse # 2 had not administered any 9/13/23 doses from the 9/13/23 supply.

A review of pain assessments for Resident # 3 revealed he was not documented to be experiencing pain during all three nursing shifts of 9/13/23.

A pharmacy employee was interviewed on 11/29/23 at 2:50 PM and reported a request for Resident # 3's Lyrica refill was not received by them until 9/13/23 at 10:42 AM, and they sent it later that afternoon to the facility.

Interview with the Director of Nursing on 11/29/23 at 1:50 PM revealed there was no Lyrica in their medication back up supply, and she could find no other Lyrica control substance sheets showing there was an available supply for Nurse # 2 to have administered the 8:00 AM and 4:00 PM doses on 9/13/23. According to the DON, the staff were to order the Lyrica when the supply got low in order that they not run out of the medication. The medication supply was marked so that the nurses knew when to let the pharmacy know to refill medications.

Nurse # 2 was interviewed on 11/29/23 at 5:30 PM. Nurse # 2 stated if she had checked that she administered the Lyrica on 9/13/23 then she would have given it. She did not have an

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substance sheets to identify any doses that were not available to be administered or were not documented as administered following facility policy. No concerns were identified.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:
On 12/18/2023, the Director of Nurses, RN Supervisor, and Regional Nurse Consultant initiated education on Medication Availability for all Licensed Nurses (RN's and LPN's), Medication Aides, Full Time, Part Time, PRN, and Agency Staff on the following education: Medication Availability/ documentation policy for medications and controlled substances and prevention of medication errors.
To include:
- The learner will understand the importance of ensuring that medications are always available to be given to the resident as ordered by the Physician.
- The learner will understand how to obtain medications from the McNeill's Long-Term Care Pharmacy during business hours and after business hours.
- The learner will understand the importance of documenting medications administered in the EMAR and if applicable on the controlled substance sheet.

All education for current staff will be completed by 12/20/2023. As of 12/20/2023 any employee who has not received this training will not be allowed to

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F 755	Continued From page 32 explanation of where she had gotten the Lyrica. Resident # 3 was interviewed on 11/27/23 at 3:30 PM and reported the following. There was a time in September, 2023 that his Lyrica was not administered. The staff told him it was not available, and they had run out of this medication. He did not understand how they would run out of a medication he needed. Interview with the Administrator and Director of Nursing on 12/5/23 at 2:33 PM revealed it was their expectation that medication administration records coincide with the controlled substance count sheets.	F 755	work until the training has been completed. This includes all Licensed Nurses and Medication Aides, full time, part time, agency nurses and as needed staff. This in-service will be incorporated into the new employee facility orientation. 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/designee will monitor compliance utilizing the Quality Assurance Tool for Medication Availability and Medication Administration Documentation during the daily clinical meeting Monday through Friday, to include weekend data. The audit will include review of the EMAR that would identify any residents who have medications that have not been administered due to not being available. As well an audit of 5 random residents receiving a controlled substance will be completed to assure that documentation of the administration has been completed per facility policy. Negative findings will be reported to the Physician if noted. Audits will be completed weekly x 4 weeks then monthly x 3 months or until resolved. Reports will be presented to the Quality Assurance Performance Improvement committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing	

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F 755	Continued From page 33	F 755	program reviewed at the weekly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, Dietary Manager and Medical Director.	
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,	F 867		12/21/23

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F 867		F 867		

Continued From page 34
including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or 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;

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F 867	Continued From page 35 consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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;	F 867		

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F 867	Continued From page 36 (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident, staff, pharmacy, paramedic, physician and the facility's Quality Assessment and Assurance (QAA) Committee interview, the facility's QAA failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 2/25/2022. This was for three recited deficiencies on the current complaint investigation survey of 12/8/2023. The deficiencies included: Notify of Changes (F580), Quality of Care/Professional Standards (F684), Pharmacy Services, Procedures, Pharmacist and Records (F755). The continued failure during two federal surveys of record showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross-referenced to: F580 Based on observation, record review, resident, staff, paramedic, and physician interview the facility failed to notify the physician regarding a significant change in condition for one (Resident # 3) of two sampled residents. On the morning of 9/27/23 Nurse Aide #1 and Nurse #3 observed multiple signs Resident # 3 was experiencing a significant change in condition including a low blood pressure, slurred speech, sluggishness, inability to carry on a conversation	F 867	1. Corrective action for resident(s) affected by the alleged deficient practice: The facility's Quality Assurance Performance Improvement Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put in place following the recertification and complaint investigation survey of 2/25/2022. This was for three recited deficiencies on the current complaint investigation survey of 12/8/2023. The deficiencies included: Notify of Changes, Quality of Care/Professional Standards, Pharmacy Services, Procedures, Pharmacist and Records. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: • Corrective action has been taken for the identified concerns in the areas of: notification of changes. • Corrective action has been taken for the identified concerns in the areas of: quality of care and notification of changes. • Corrective action has been taken for the identified concerns in the areas of: pharmacy services. • Corrective action has been taken for the identified concerns in the area of: QAPI/QAA Improvement Activities. The Quality Assurance Performance	

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F 867	Continued From page 37 per his norm, inability to help in his care per his norm, and bloody urine in his catheter. The physician was not notified when staff noted the change in condition. Resident # 3 was found in the afternoon on 9/27/23 unresponsive, with a temperature reading of 102 Fahrenheit, and using accessory respiratory muscles to breathe (muscles other than the diaphragm and muscles within the rib cage which are used in labored breathing.) Resident #3's condition had declined to the point where Emergency Medical Services (EMS) was called, and Resident # 3 was transferred to the hospital where he was admitted to the hospital Intensive Care Unit (ICU) with severe sepsis with septic shock (when a person is not getting enough blood flow through their body). During the recertification and complaint survey of 2/25/2022, the facility was cited for failure to notify the physician of the presence of an infection and when a medication was not administered to a resident. In an interview with the Director of Nursing (DON) and Administrator on 12/8/2023 at 11:14 a.m., the DON explained a 24-hour report was reviewed and clinical rounds were conducted daily to identify changes in residents. She further explained she received notification when nurses used a secure chat to notify physicians of changes in residents. The Administrator stated she had not reviewed deficiencies cited for the recertification survey on 2/25/2022. She stated when reviewing the facility's last recertification survey completed on 4/21/2023, notification of the physician was not cited as a deficiency. The DON and the Administrator both stated	F 867	Improvement (QAPI) committee held a meeting on 12/18/2023 to review the deficiencies from the November 27, 2023 to December 8, 2023 complaint investigation and partial extended survey. On 12/18/2023, the Regional Quality Assurance Nurse Consultant completed in-service of the facility administrator and the facility administrator began education with the Quality Assurance Committee on the appropriate functioning of the Quality Assurance Performance Improvement Committee and the purpose of the committee to include identifying issues and correcting repeat deficiencies. Education will be completed by 12/20/2023. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 12/ 20/2022 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 functioning of the QAPI Committee and the purpose of the committee to include identifying any issues identified including correcting repeat deficiencies. This in-service was incorporated in the 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.	

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F 867	Continued From page 38 notification of the physician had not been identified as a concern with the QAA committee, and the QAA was not monitoring notification of physician for changes in residents' condition currently. F684 Based on observation, record review, resident, staff, paramedic, and physician interview the facility failed to effectively assess and address a significant change in condition for one (Resident # 3) of two sampled residents whose condition necessitated Emergency Medical Services (EMS) to be called. Resident # 3 had a history of sepsis (when an infection triggers widespread inflammation in a person's body which can lead to organ damage) and on the morning of 9/27/23 Nurse Aide #1 and Nurse #3 observed Resident # 3 was experiencing a change in condition prior to the lunch meal that included: a low blood pressure, slurred speech, sluggishness, inability to carry on a conversation per his norm, inability to help in his care per his norm, and bloody urine in his catheter. Resident # 3 was found in the afternoon on 9/27/23 unresponsive, with a temperature reading of 102 degrees Fahrenheit, and using accessory respiratory muscles to breathe (muscles other than the diaphragm and muscles within the rib cage which are used in labored breathing). EMS was called at 2:53 PM. Upon their arrival, EMS also found Resident # 3 to be unresponsive and with what appeared as an undissolved pill in the resident's mouth. Resident # 3 was transferred by EMS to the hospital where he was admitted to the hospital Intensive Care Unit (ICU) with severe sepsis with septic shock (when a person is not getting enough blood flow through their body).	F 867	Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 12/21/2023. 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 Regional Operations Director or Regional Quality Assurance Nurse Consultant will monitor compliance with the Quality Assurance Performance Improvement program utilizing the Quality Assurance Monitoring Tool weekly x 4 weeks then monthly x 6 months. The tool will monitor facility identified concerns that need to be addressed by the Quality Assurance Committee for compliance. Reports will be presented to the 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 Quality Assurance Meeting, indefinitely or until no longer deemed necessary for compliance. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, Dietary Manager and the Medical Director.	

F 867 Continued From page 39 F 867

During the recertification and complaint survey of 2/25/2022, the facility was cited for failure to follow a physician's order to get a resident out of bed and obtain a chest x-ray as ordered by the physician.

In an interview with the Director of Nursing and Administrator on 12/8/2023 at 11:14 a.m., the DON explained documentation of a change in the resident in the electric medical record generated onto a 24-hour report that she reviewed daily and changes in residents were discussed in daily clinical rounds. The DON further explained she checked the clinical dashboard daily for physician orders that had not been activated. The Administrator stated she had not reviewed deficiencies cited for the recertification survey on 2/25/2022. She stated when reviewing the facility's last recertification survey completed on 4/21/2023, a deficiency for quality of care/professional standards was not cited. The DON and the Administrator both stated providing resident care when changes where identified had not been identified as a concern with the QAA committee, and the QAA was not currently monitoring the care provided when changes in a resident's condition occurred.

755 Based on record review, resident interview, staff interview, and pharmacy employee interview the facility failed to assure controlled substance records coincided with administration records for a controlled substance which a resident reported he did not receive as ordered. This was for one (Resident # 3) of two sampled residents reviewed for medications.

During the recertification and complaint survey of

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F 867	Continued From page 40 2/25/2022, the facility was cited for failure to obtain medications by the backup pharmacy for a resident. In an interview with the Director of Nursing and Administrator on 12/8/2023 at 11:14 a.m., the DON stated pharmacy medication requisitions were collected daily, and narcotic medications were verified received with narcotic sheets on the medication carts. The DON stated she conducted random monitoring of residents' narcotic sign out sheets and availability for narcotic medications for the residents. The Administrator stated she had not reviewed deficiencies cited for the recertification survey on 2/25/2022. She stated when reviewing the facility's last recertification survey completed on 4/21/2023, a deficiency for pharmacy services, procedures, pharmacist, and records was not cited. The DON and the Administrator both stated pharmacy services, procedures, pharmacist, and records had not been identified as a concern with the QAA committee, and the QAA was not monitoring pharmacy services currently.	F 867		
F 944 SS=E	QAPI Training CFR(s): 483.95(d) §483.95(d) Quality assurance and performance improvement. A facility must include as part of its QAPI program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI program as set forth at § 483.75. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to assure they had provided training for all their staff on the facility's QAPI (Quality	F 944	1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/18/2023 the Director of Nurses/	12/21/23

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F 944	Continued From page 41 Assurance Performance Improvement) program. The findings included: During a review of facility records on 12/8/23, there was no documentation that the facility had incorporated training for all their staff on the facility's QAPI. The Administrator was interviewed on 12/8/23 at 5:30 PM and reported the following. She began her employment as facility Administrator in June 2023. She had been working on the facility's quality improvement program since she began as the Administrator and tried to include her line staff in the quality improvement program, but she had not educated or included 100% of her staff. She had also looked through previous records from the prior Administrator's files and had found no evidence that the facility had included training and involvement from 100% of their staff regarding QAPI.	F 944	Staff Development Coordinator completed an audit of all facility staff to determine compliance with annual Quality Assurance Performance Improvement Program training. All staff will be educated on the Quality Assurance Performance Improvement program by the Director of Nurses/Staff Development Coordinator/Regional Nurse Consultant by 12/20/2023. 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 12/18/2023 the Director of Nurses /Staff Development Coordinator/Regional Nurse Consultant completed an audit of all staff to identify completion of annual Quality Assurance Performance Improvement Training. Any staff identified without completion of training on the Quality Assurance Performance Improvement Program will complete training by 12/20/2023. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/18/2023, the Director of Nurses/ Staff Development Coordinator/Regional Nurse Consultant began education of all staff on the facility policy on Quality Assurance and Performance Improvement and activities of the program. All identified staff will complete the training by 12/20/2023 at which time all staff must be in-serviced prior to working. This information has been integrated into the standard orientation training and in the	

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F 944	Continued From page 42	F 944	required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any of the identified staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 12/20/2023. 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 Director of Nurses/Administrator will monitor compliance utilizing the Quality Assurance Performance Improvement Training Audit Tool weekly x 4 weeks then monthly x 3 months. The Director of Nursing/Administrator will monitor for compliance with the completion of annual Quality Assurance Performance Improvement Program training by all staff. Reports will be presented to the 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 Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Therapy Manager, Unit Manager, Health Information Manager, Dietary Manager and Medical Director.	