STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE NURSING & REHAB	300 NORTH MAIN STREET RICH SQUARE, NC 27869

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

A complaint investigation was conducted onsite from 12/19/23 to 12/20/23 with additional information received remotely on 12/21/23 and 12/22/23. Onsite validation of the immediate jeopardy removal plans was conducted on 12/28/23. Therefore, the exit date was 12/28/23. Event ID #48ST11.

The following intakes were investigated:
NC00211011 and NC00210781.
Both intakes resulted in immediate jeopardy.
2 of the 2 complaint allegations resulted in deficiency.

Immediate Jeopardy was identifed at:
CFR 483.10 at tag F580 at a scope and severity (J)
CFR 483.25 at tag F684 at a scope and severity (K)
CFR 483.25 at tag F689 at a scope and severity (K)
CFR 483.35 at tag F726 at a scope and severity (K)
CFR 483.45 at tag F755 at a scope and severity (K)
CFR 483.45 at tag F760 at a scope and severity (K)
CFR 483.70 at tag F835 at a scope and severity (K)

The tags F684, F689, and F760 constituted Substandard Quality of Care.

Immediate Jeopardy for F689 and F726 began on 11/1/23 and was removed on 12/22/23.
Immediate Jeopardy for F755 and F760 began on 11/25/23 and was removed on 12/22/23.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/29/2024

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F 000	Continued From page 1 Immediate Jeopardy for F684 began on 12/4/23 and was removed on 12/22/23. Immediate Jeopardy for F580 began on 12/4/23 and was removed on 12/23/23. Immediate Jeopardy for F835 began on 11/1/23 and was removed on 12/23/23. A partial extended survey was conducted.	F 000		
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; (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,	F 580		1/26/24

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F 580	Continued From page 2 when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review and interviews with staff and physician, the facility failed to notify the physician of a medical emergency when Resident # 3 had seizure activity. Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. Emergency Medical Services (EMS) was contacted and the resident was transported to the Emergency Room (ER) where Vimpat (anti-seizure medication) was administered. The resident had no further seizure activity after receiving Vimpat and was discharged back to the facility the same day. This occurred for 1 of 3 residents (Resident #3) reviewed for notification of change. Immediate Jeopardy began on, 12/04/23, when the facility failed to notify the physician when	F 580	F 580 1. How corrective action will be accomplished for resident(s) found to have been affected; Resident #3 was identified as being affected by the noncompliance. The DON notified the facility Medical Director of the incident on 12/5/23. Nurse #1and nurse #2 were removed from the facility. 2. Identify other residents who have the potential to be affected: The DON and Minimum Data Set (MDS) nurse evaluated all residents to identify any changes in condition. No additional residents were identified with a significant change in status. 3. What measure will be put in place or	

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F 580	Continued From page 3 Resident #3 had seizure activity. The immediate jeopardy was removed on 12/23/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of a D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective. The findings included: Resident #3 was admitted to the facility on 3/2/23 and readmitted to the facility on 11/13/23 with diagnoses which included traumatic subdural hemorrhage, seizure disorder/epilepsy, traumatic brain injury, and gastrostomy status (a tube surgically placed into the stomach). A nurse's note written by Nurse #2 dated 12/04/23 at 2:30 pm revealed that Resident #3 was seen this morning having seizure activity by staff during this shift. Nurse #2 indicated when she arrived to his room the resident was not showing seizure activity but wasn't answering questions like he would normally do. The note stated Nurse #2 and staff stayed by his side until resident was completely alert and responding like normal. Resident #3 was in stable condition and hadn't shown anymore seizure activity as of yet. There was no documentation in Resident'#3's medical record that the physician was notified of his seizure activity on 12/4/23. An interview was conducted with agency Nurse #2 on 12/19/23 at 11:33 am who worked with Resident #3 on 12/04/23. She stated staff	F 580	systemic changes made to ensure that the identified issue does not occur in the future: All full-time, part-time, prn, and agency licensed nurses and medication aides were educated by the DON on change of condition and physician notification regulations per facility policy and procedure beginning 12/21/23. No licensed nurse or medication aide will work until education has been completed. Nurses are to contact physician via phone immediately when resident physical or mental condition is changed from baseline and additional interventions may be required. This includes abnormal behavior, vital signs, physical changes in movement or body function or consciousness such as lethargy or seizures. " All full-time, part-time, prn, and agency nurse aides and medication aides were educated by the DON on reporting observed changes in residents' condition to licensed nurses beginning 12/22/23. No nurse aide will work until education has been received. " All newly hired and agency staff (licensed nurses, nurse aides, and medication aides) will be educated on change of condition and physician notification regulations per facility policy and procedure, accordingly in orientation prior to working the floor. Human resources will ensure the packet is complete. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur: The Director of Nursing /designee will audit the twenty-four-hour summary report	

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F 580	Continued From page 4 reported Resident #3 was having seizure activity and when she arrived to his room, she did not observe seizure activity. Nurse #2 stated she and the Director of Nursing (DON) stayed with Resident #3 and continued to monitor him, to make sure he was alert and at his baseline on 12/04/23. A nurse's note written by Nurse #1 on 12/05/23 at 10:14 am revealed resident resting in bed no signs or symptoms of pain, distress, or discomfort. Alert to person. Rehabilitation Aide bathed and shaved resident at approximately 8:18 am. Resident displayed seizure like activity approximately 2 minutes or less in duration. And again at 10:10 am while working with therapy. DON notified. Will notify provider and family contact. An interview was conducted on 12/19/23 at 12:02 pm with Nurse #1. Nurse #1 stated the physician was in the facility making his rounds on 12/5/23 and as she passed him in hall notified him of Resident #3's seizure activity. She indicated he told staff to administer the Vimpat or Ativan. She stated on 12/05/23 at 1:47 pm, she observed Resident #3's contracted arm became stiff, he got still, for a minute and then he said he was okay. Nurse #1 indicated she first notified the DON on 12/05/23 Resident #3 had seizure activity and his Vimpat was not available. Nurse #1 indicated the physician ordered Ativan be given to Resident #3. She stated they could not administer Ativan as no staff had access to the emergency medication storage. Nurse #1 stated she called EMS and the physician said to send the resident out to the ER. A nurse's note written by Nurse #1 dated 12/5/23 at 3:50 pm revealed resident sent out to hospital	F 580	in clinical morning meeting 5 times a week for twelve weeks. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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F 580	Continued From page 5	F 580		

due to seizure activity. The note indicated Resident #3 had 3 episodes of seizure activity with the last event at 1:47 pm.

The Medical Director was interviewed on 12/19/23 at 1:58 pm and 2:16 pm. He indicated he could not recall the exact date, but he was told by staff that Resident #3 had seizure activity. He stated that due to the seizure activity he wanted to give the resident IM Ativan. He stated the facility staff could not get ahold of the Ativan so he sent Resident #3 out to the ER for evaluation. He stated he could not comment on the availability of Resident #3's Vimpat.

The EMS Report dated 12/05/23 indicated dispatch received the call at 2:50 pm and they arrived at the facility at 2:57 pm. The nurse informed EMS Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). When asked about the resident having seizures the nurse indicated Resident #3 had 3 seizures on this date (12/5/23) at these times: 8:18 am, 10:10 am, and 1:47 pm. EMS departed the facility at 3:25 pm and arrived at the hospital at 3:56 pm. No seizure activity was noted during transport. While giving report to the hospital nurse Resident #3 was noted to start having a seizure.

The hospital record dated 12/05/23 revealed Resident #3 presented on 12/05/23 for prior history of seizures, had three seizures on this date and had been out of Vimpat since Friday (11/24/23). He was noted as alert, verbally responsive but confused. The hospital report indicated he was treated with Vimpat 200 mg in sodium chloride 0.9 percent 50 mL via IV

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F 580	Continued From page 6	F 580		

(intravenous), and no further seizure activity was noted. The record stated, "Spoke with facility, reports medication has not been picked up from the pharmacy emphasized importance of [Resident #3] getting his medications as prescribed ..." Resident #3's diagnoses were listed as seizures, seizure disorder, and noncompliance with medication regimen.

An interview was conducted on 12/20/23 4:33 pm with the DON who indicated staff should always call the physician when any resident was observed with seizure activity and notify the physician.

The Administrator was notified of immediate jeopardy on 12/20/23 at 5:21 pm.

The facility provided the following immediate jeopardy removal plan:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;
Resident #3 was identified as being affected by the noncompliance.

The facility failed to notify the physician when Resident #3 had seizure activity on 12/4/23 at approximately 2:30 PM and on 12/5/23 at approximately 8:18 AM.

Resident #3 had 4 incidents of seizure activity on the following approximate dates and times -12/4/23 at 2:30 PM, 12/5/23 at 8:18 AM, 12/5/23 at 10:10 AM, and 12/5/23 at 1:47 PM.
The physician indicated he was first notified of the seizure activity on 12/5/23.

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F 580	Continued From page 7	F 580		

" The DON notified the facility Medical Director of the incident on 12/5/23.
" The DON and Minimum Data Set (MDS) nurse evaluated all residents to identify any changes in condition. No additional residents were identified with a significant change in status on 12/21/23.
" The DON removed the licensed nurses who were aware of significant change, but did not report it to the physician, from returning to the facility. Nurse #1 was removed on 12/8/23 and Nurse #2 was removed on 12/20/23.

2. 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.
" All full-time, part-time, prn, and agency licensed nurses and medication aides were educated by the DON on change of condition and physician notification regulations per facility policy and procedure beginning 12/21/23. No licensed nurse or medication aide will work until education has been completed. Nurses are to contact physician via phone immediately when resident physical or mental condition is changed from baseline and additional interventions may be required. This includes abnormal behavior, vital signs, physical changes in movement or body function or consciousness such as lethargy or seizures.
" All full-time, part-time, prn, and agency nurse aides and medication aides were educated by the DON on reporting observed changes in residents' condition to licensed nurses beginning 12/22/23. No nurse aide will work until education has been received.
" All newly hired and agency staff (licensed

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F 580	Continued From page 8 nurses, nurse aides, and medication aides) will be educated on change of condition and physician notification regulations per facility policy and procedure, accordingly in orientation prior to working the floor. Human resources will ensure packet is complete. Alleged date of immediate jeopardy removal: 12/23/23 Onsite validation of the immediate jeopardy removal plan was conducted on 12/28/23. The physician was notified of the incident as indicated and the evaluations of all residents by the MDS Nurse and DON were verified and revealed no concerns. Nurse #1 and Nurse #2 were removed from the facility as indicated. In service records and interviews with licensed nurses and medication aides confirmed education was provided on changes of condition and physician notification regulations per facility policy and procedure. The procedure is for nurses to contact physician via phone immediately when resident physical or mental condition is changed from baseline and additional interventions may be required. Education was also confirmed for nurse aides and medication aides on reporting observed changes in residents' condition to licensed nurses. Education as noted was added to orientation and the Human Resources Director is responsible for ensuring the education is provided prior to working on the floor. The immediate jeopardy removal date of 12/23/23 was verified.	F 580		
F 684 SS=K	Quality of Care CFR(s): 483.25 § 483.25 Quality of care	F 684		1/26/24

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F 684	Continued From page 9 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 record review and interviews with staff, Emergency Medical Services (EMS) personnel, pharmacist, and physician, the facility failed to identify the seriousness of seizure activity on 12/4/23 and the need for medical intervention for a resident with a history of seizures who had not been provided with his anti-seizure medication (Vimpat) since 11/25/23. Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. Following the fourth seizure (12/5/23) the physician ordered Ativan (an antianxiety medication commonly used as a rescue medication for seizures) via intramuscular (IM) injection and the facility staff were unable to access the emergency Ativan medication supply to treat the resident in the facility. Emergency Medical Services (EMS) was contacted, and the resident was transported to the Emergency Room (ER) and Resident #3 experienced a fifth seizure upon arrival in the emergency room (ER). Intravenous (IV) Vimpat was administered in the ER and the resident had no further seizure activity and was discharged back to the facility the same day. This occurred for 1 of 2 residents whose condition required Emergency Medical Services. Immediate Jeopardy began on 12/04/23 when the facility failed to identify the seriousness of seizure	F 684	F 684 1. How corrective action will be accomplished for resident(s) found to have been affected. Resident # 3 was sent to the hospital on 12/05/23 and received seizure medication. The Director of Nursing removed the licensed nurses who were aware of the resident's seizure but did not seek further treatment interventions, from returning to facility. 2. Identify other residents who have the potential to be affected. On 12/20/23 the Director of Nursing and floor nurses evaluated all residents with no other residents identified as needing medical interventions. 3. What measures will be put in place to ensure the identified issue does not occur in the future? All licensed nurses including agency staff were educated by the DON on identifying what is a medical emergency and the need to provide the necessary care and services for residents who require emergency medical services. Beginning 12/21/23 the Administrator, DON, and Staffing Coordinator will ensure no nurse is permitted to work prior to completing	

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F 684	Continued From page 10 activity for a resident with a history of seizures. The immediate jeopardy was removed on 12/22/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of a E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective. The findings included: Resident #3 was admitted to the facility on 10/09/23 and readmitted to the facility on 11/13/23 with diagnoses which included, traumatic subdural hemorrhage, seizure disorder/epilepsy, traumatic brain injury, gastrostomy status (a tube surgically placed into the stomach). Review of the significant change Minimum Data Set (MDS) dated 10/15/23 identified the resident as having moderately impaired cognition. The MDS coded the resident as having seizure disorder/epilepsy and for gastrostomy (G-tube) status. A nurse's note written by agency Nurse #2 dated 12/04/23 at 2:30 pm revealed that Resident #3 was seen this morning having seizure activity by staff during this shift. Nurse #2 indicated when she arrived at his room the resident was not showing seizure activity but wasn't answering questions like he would normally do. The note stated Nurse #2 and staff stayed by his side until the resident was completely alert and responding like normal. Resident #3 was in stable condition and no further seizure activity was observed.	F 684	education. " Education includes identifying changes in resident condition that indicate a medical emergency such as difficulty breathing, loss of consciousness, onset of seizures, injuries and other examples. " Beginning 12/21/23 all newly hired licensed nurses, including agency staff, will be educated on what is a medical emergency and the need to provide the necessary care and services for residents who require emergency medical services as part of their orientation prior to working the floor. The Human Resources Director will ensure each nurse has completed and was informed of the task by the Administrator on 12/21/23. 4.Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur: The Director of Nursing /designee will audit the twenty-four-hour summary report in clinical morning meeting 5 times a week for twelve weeks. The Director of Nursing /Designee will audit the Medication not Administered report in clinical morning meeting 5 times a week for twelve weeks. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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F 684	Continued From page 11	F 684		

An interview was conducted with agency Nurse #2 on 12/19/23 at 11:33 am who worked with Resident #3 on 12/04/23 from 7:00 am to 3:00 pm. Nurse #2 stated she did not recall which nurse aide reported Resident #3 was having seizure activity and when she arrived in his room, she did not observe seizure activity. Nurse #2 stated she stayed with Resident #3 and continued to monitor him, to make sure he was alert and at his baseline on 12/04/23.

An interview was conducted with Rehabilitation Aide #1 on 12/19/23 at 10:09 am. Rehabilitation Aide #1 revealed that while bathing Resident #3 on 12/05/23 his arms drew tight up against his body for 10 seconds then ended. She indicated she reported the incident to the nurse (Nurse #1) who was agency staff.

A nurse's note written by Nurse #1 on 12/05/23 at 10:14 am revealed resident resting in bed no signs or symptoms of pain, distress, or discomfort. Alert to person. Rehabilitation Aide #1 bathed and shaved resident at approximately 8:18 am. Resident displayed seizure like activity approximately 2 minutes or less in duration. And again at 10:10 am while working with therapy. DON notified. Will notify provider and family contact.

An interview was conducted on 12/19/23 at 12:02 pm with Nurse #1. Nurse #1 stated on Friday 11/27/23 she texted Resident #3's physician a prescription requesting the Vimpat, for the physician to sign and fax over to the pharmacy for refill. Nurse #1 stated when she returned to work on Tuesday 12/05/23, the Vimpat was not on the medication cart. She stated the physician was in the facility in the morning on 12/05/23 making his

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rounds and as she passed him in hall notified him of Resident #3's seizure activity. Nurse #3 indicated the physician then ordered Ativan be given to Resident #3. Nurse #1 indicated the DON began to search and found no Vimpat was in the facility. She indicated the emergency medication supply was stored in a secure medication dispensing machine and none of the staff, including the DON, had access to pull the Ativan. She stated on 12/05/23 at 1:47 pm, she observed Resident #3's contracted arm became stiff, he got still, for a minute and then he said he was okay. Nurse #1 stated as there was no Vimpat available, staff could not access the emergency medication supply for Ativan, she called EMS and the physician said to send the resident out to the ER.

A progress noted entered by the Medical Director note dated 12/05/23 revealed Resident #3 had recurrent seizure activity on 12/05/23 with known history of seizure disorder. The resident was noted to recover in between the seizure episodes. He was at high risk for status epilepticus (a recurrent seizure activity without recovery between seizures) impending. He was currently on valproic acid (anticonvulsant used in the treatment of epilepsy) plus Vimpat. The Medical Director indicated due to clinical condition he made the decision to transfer Resident #3 to the local emergency department for further definitive work up secondary to recurrent seizures since this morning.

Resident #3's Medical Director was interviewed on 12/19/23 at 1:58 pm and 2:16 pm. He indicated he could not recall the exact date, but he was told by staff that Resident #3 had seizure activity. He stated that due to the seizure activity

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he wanted to give the resident IM Ativan. He stated the facility staff could not get access to Ativan, so he sent Resident #3 out to the ER for evaluation. He stated he could not comment on the availability of Resident #3's Vimpat.

The EMS Report dated 12/05/23 indicated dispatch received the call at 2:50 pm for a resident with seizures and the EMS crew arrived at the facility at 2:57 pm and advised of Resident #3's room number. Resident #3 was found sitting up in bed and there was no nurse or medical staff available to give a report. The EMS crew had to request nursing staff to give them a report. The nurse informed EMS Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). When asked about the resident having seizures the nurse indicated Resident #3 had 3 seizures on this date (12/5/23) at these times: 8:18 am, 10:10 am, and 1:47 pm. EMS departed the facility at 3:25 pm and arrived at the hospital at 3:56 pm. No seizure activity was noted during transport. While giving a report to the hospital nurse, Resident #3 was noted to start having a seizure.

A telephone interview was conducted on 12/19/23 at 12:48 pm with EMS Personnel #1. He indicated when he arrived in the resident's room there were no staff available to give report and he had to request nursing staff to give them a report. EMS #1 reported that Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). EMS #1 stated he asked the nurse why Resident #3 went 4 to 5 days without his Vimpat, and she could not answer, just said they did not have his Vimpat.

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The hospital record dated 12/05/23 revealed Resident #3 presented on 12/05/23 for prior history of seizures, had three seizures on this date and had been out of Vimpat since Friday (11/24/23). He was noted as alert, verbally responsive but confused. The hospital report indicated he was treated with Vimpat 200 mg via IV (intravenous), and no further seizure activity was noted. The record stated, "Spoke with facility, reports medication (Vimpat) has not been picked up from the pharmacy emphasized importance of [Resident #3] getting his medications as prescribed ..." Resident #3's diagnoses were listed as seizures, and seizure disorder.

Review of the nurse's note dated 12/05/23 at 9:52 pm revealed Resident #3 returned from the hospital with no new orders.

A phone interview was conducted on 12/28/23 at 1:20 pm with the facility Pharmacist #1. She indicated Resident #3's MAR documented the Vimpat ran out on 11/25/23 and on 12/05/23 he was sent to the ER for seizure activity. The Pharmacist stated that abruptly stopping the Vimpat for 10 days Resident #3 would have the potential for seizures.

An interview was conducted on 12/20/23 at 10:16 am with the facility's current DON who took the position on 11/27/23. The DON reported she was first made aware on 12/04/23 by Nurse #2 that Resident #3's Vimpat had not been available for administration and called the pharmacy that day. She stated it was after lunch when the physician ordered IM Ativan on 12/05/23, no staff in the facility had access to the emergency medication

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supply and could not access the Ativan. The DON stated the physician saw Resident #3 on 12/05/23 and told staff if the resident continued to have seizures to send him out.

An interview was conducted on 12/20/23 4:33 pm with the DON who indicated staff should always call the physician when any resident was observed with seizure activity and notify the physician when any residents medications were not available. The DON stated the nurses needed to make sure they have enough resident medication to last through the weekend. She indicated she was not aware if the nursing staff had called the physician to notify him the Vimpat was not available or if the physician had told the nurses to monitor Resident #3 and send out if any further seizure activity occurred.

The Administrator was notified of immediate jeopardy on 12/20/23 at 1:47 pm.

The facility provided the following immediate jeopardy removal plan:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

The facility failed to identify the seriousness of seizure activity on 12/4/23 and the need for medical intervention for a resident with a history of seizures who had not been provided with his anti-seizure medication (Vimpat) since 11/25/23. The facility did not have Vimpat available in the facility and did not have access to their emergency medication supply to treat the resident in the facility. EMS was not contacted until Resident #3 had his fourth incident of

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seizure activity.

Resident #3 was identified as affected by the deficient practice.
All residents were at risk from the deficient practice.

Upon evaluation by the floor nurses and DON no other residents were identified as needing medical interventions on 12/20/23.

2. 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.

" The DON removed the licensed nurses who were aware of the resident's seizure but did not seek further treatment interventions, from returning to the facility. Nurse #1 was removed 12/8/2023 and Nurse #2 was removed 12/20/23.
" All licensed nurses including agency staff were educated by the DON on identifying what is a medical emergency and the need to provide the necessary care and services for residents who require emergency medical services. Beginning 12/21/23 the Administrator, DON, and Staffing Coordinator will ensure no nurse is permitted to work prior to completing education.
" Education includes identifying changes in resident condition that indicate a medical emergency such as difficulty breathing, loss of consciousness, onset of seizures, injuries and other examples.
" Beginning 12/21/23 all newly hired licensed nurses, including agency staff, will be educated on what is a medical emergency and the need to provide the necessary care and services for residents who require emergency medical

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F 684	Continued From page 17 services as part of their orientation prior to working the floor. The Human Resources Director will ensure each nurse has completed and was informed of the task by the Administrator on 12/21/23. Alleged date of immediate jeopardy removal :12/22/23 Onsite validation of the immediate jeopardy removal plan was conducted on 12/28/23. The evaluations of all residents by the floor nurses and DON were verified and revealed no concerns. Nurse #1 and Nurse #2 were removed from the facility as indicated. In service records and interviews confirmed education was provided on: identifying what is a medical emergency and the need to provide the necessary care and services for residents who require emergency medical services. This education was added to orientation and the Human Resources Director is responsible for ensuring each nurse receives the education prior to working on the floor. The immediate jeopardy removal date of 12/22/23 was validated.	F 684		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 689		1/26/24

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F 689	Continued From page 18 Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, the facility failed to provide safe transportation in the facility's transportation van and to ensure wheelchairs were utilized during transportation in accordance with manufacturer's instructions for 2 of 4 residents reviewed for accidents (Resident #1 and Resident #2). On 11/1/23 Transportation Assistant #1 utilized a geriatric chair (a padded chair with a wheeled base) to transport Resident #1 and during transportation the resident slid out of the chair onto the floor of the van. Resident #1 was not injured. On 11/27/23 Transportation Assistant #1 did not buckle Resident #2's seatbelt and during transportation the resident fell out of the wheelchair and onto the floor of the van. Resident #2 reported pain in her right shoulder the following day. These incidents had the high likelihood of serious harm, injury or death. Immediate jeopardy began on 11/1/23 when Transportation Assistant #1 transported Resident #1 in a geriatric chair (geri chair #1) that was not in accordance with the manufacturer's instructions and the resident fell out of the chair. The immediate jeopardy was removed on 12/22/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: 1. Review of the 4-point securement system's use and care manual (undated) found on the	F 689	F 689 1. How corrective action will be accomplished for resident(s) found to have been affected. Resident # 1 was seen evaluated by EMS with no injuries noted. Resident #2 was discharged from the facility on 12/08/23. TA #1 was terminated on 12/04/23. 2. All residents who are transported in the facility van were identified to potentially be affected by the deficient practice. 3. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? The current transportation aide has reviewed the facility's policy on transportation and completed an in-service on 12/21/23 regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. The facility will utilize wheelchairs in place of geri-chairs when transporting residents or use a medical transportation company when needed. The transportation aide was educated on ensuring residents are transferred to proper chairs for transportation and that geri-chairs are not proper chairs on 12/21/2023 by the Maintenance Director. Beginning 12/21/23 all transport aides will receive safety training upon hire and annually. Training will be conducted by the Maintenance Director and will include a return demonstration of competency. This	

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F 689	Continued From page 19 facility's transportation van's manufacturer's website included the following information: the system should only be used on front-facing wheelchair. Resident #1 was admitted to the facility on 8/29/23 with a diagnosis that included end stage renal disease. Resident #1's quarterly Minimum Data Set assessment dated 12/1/23 revealed he was cognitively intact. He was unable to walk and was assessed as dependent for transfers. Resident #1 utilized a wheelchair for mobility and received dialysis. A progress note dated 11/1/23 written by Nurse #14 revealed Transportation Assistant #1 called and reported a vehicle turned in front of the transport van and the transport aide had to press on the brakes. Resident #1 slid out of the geri chair. Emergency Medical Services were contacted. Resident #1 refused to be seen in the local emergency department. Attempts to interview Nurse #14 were not successful. Review of an Emergency Medical Services (EMS) report dated 11/1/23 revealed Resident #1 was found sitting on the floor of the facility's van. The resident had no complaints and requested assistance off the floor back into his chair. Resident #1 was being transported in a dialysis treatment chair (geri chair #1) that was not secured properly. The resident was sitting on top of three pillows and a mechanical lift pad during transport. According to the driver (Transportation Assistant #1) the resident was	F 689	training will involve a review of the transportation policy, an in-service regarding the safety and securement of residents being transported in the facility transportation van, and supervision as needed. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur: The Administrator/Designee will audit 5 van transports a week for twelve weeks to ensure proper securement of resident. The Administrator/Designee will complete one ride along observation during transport weekly for twelve weeks. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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being transported in a reclined position. When this chair was in a reclined position there was no locking device to maintain that position. When the driver applied the van brakes the chair rocked forward from the reclined position to an upright position which caused the resident to be ejected from his chair onto the floor. The resident refused to be transported to the hospital by EMS. The EMS crew lifted the resident back into the chair and supplied extra retention straps to secure the chair into a reclined position and ensured the resident was secured with a lap belt.

During an interview with Transportation Assistant #1 on 12/19/23 at 12:30 PM she reported on 11/1/23 she was transporting Resident #1 to a doctor's appointment with no other residents in the facility's transportation van. Transportation Assistant #1 reported Resident #1 was in a chair (geri chair #1) provided by the dialysis center. (Geri chair #1 was a clinical care recliner and had the capability to go into the Trendelenburg position [a position in which the resident's shoulder and legs can be reclined so his legs are above his head]). She indicated that when she secured Resident #1 into the van the seat belt was tight and the seat back of geri chair #1 was reclined. She stated that during transportation (11/1/23) another driver pulled out in front of her and she had to come to an abrupt stop and Resident #1 slid under his seat belt and slipped out of geri chair #1 onto the floor of the van seated on his butt. Transportation Assistant #1 explained the seat back of geri chair #1 did not stay in place when she hit the brakes of the van. She indicated it reclined further back than when she buckled him in. She pulled over and contacted 911. Transportation Assistant #1 stated she was unable to get him back in his

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chair. She stated she was informed at the scene by EMS staff that the chair used was not appropriate to use in the transportation van because it could not be secured in the van. She further stated the resident refused to go to the hospital and requested to proceed to his doctor's appointment. Transportation Assistant #1 stated EMS staff assisted in getting him back in the van and provided some additional straps to better secure the chair. She indicated after the incident the facility no longer transported Resident #1 in geri chair #1 and began to use one of the facility chairs (geri-chair #2). Geri chair #2 did not have the capability to go into the Trendelenburg position.

An interview was conducted with Resident #1 on 12/19/23 at 1:00 PM who stated he recalled the accident on 11/1/23. He stated when Transportation Assistant #1 hit the brakes on the facility's transportation van he suddenly flew out from under the seat belt to the floor of the van. Resident #1 stated he refused to be transported to the hospital emergency department because he was not injured. He reported he was in a reclined dialysis treatment chair (geri chair #1) when the incident occurred. Resident #1 stated after the incident he no longer utilized the dialysis treatment chair for transportation, and was instead transported in a facility owned geriatric chair (geri chair #2). He stated he was transported to dialysis on 12/19/23 in a geriatric chair (geri chair #2).

During a phone interview with Emergency Medical Services (EMS) Staff #1 on 12/19/23 at 1:10 PM he stated he reported to the scene of the accident on 11/1/23 and Resident #1 was sitting on the floor of the van. He indicated Resident #1

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was transported in a dialysis treatment chair (geri chair #1). He stated the hooks of the van's restraint system were fastened on the side of the chair. EMS Staff #1 stated there was no restraint system in the van to prevent the chair from reclining. EMS Staff #1 stated Resident #1 was assessed and had no visible injuries. He stated Resident #1 was encouraged to go to the hospital, but the resident refused. EMS Staff #1 stated the Administrator came to the scene of the accident. He reported he informed Transport Aide #1 and the Administrator chairs other than wheelchairs were not compliant with the restraint system of the van.

During an interview with the Administrator on 12/19/23 at 12:22 PM he reported on 11/1/23 Resident #1 slid out from under the seat belt when Transportation Assistant #1 hit the brakes on the van because the belt was not secure. He reported he responded to the scene of the accident and recalled being told by EMS Staff #1 that the geri chair #1 should not be used for transportation in the facility's van. He stated after the incident the facility began to utilize a facility geri chair (geri chair #2) rather than the dialysis treatment chair (geri chair #1).

A phone interview was conducted with a Dialysis Center Nurse from Resident #1's dialysis center on 12/19/23 at 1:30 PM. The Dialysis Center Nurse indicated staff at the dialysis center had sent a dialysis treatment chair (geri chair #1) approximately one month prior to 11/1/23 with Resident #1 to minimize the number of transfers he needed while he was at dialysis. She reported to receive dialysis Resident #1 needed to be in a chair that would be able to be placed in the Trendelenburg position and a mechanical lift

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had to be used to transfer him from the facility's geri chair (geri chair #2) to the dialysis treatment chair (geri chair #1) as the facility's geri chair did not have the capability to be placed in the Trendelenburg position. Dialysis Center Nuse stated the resident had an open wound on his sacrum and Resident #1 complained about the discomfort associated with use of the mechanical lift. She reported that after the van accident (11/1/23) the facility began to send Resident #1 to dialysis in geri chair #2. The Dialysis Center Nurse stated she was told by the Administrator the dialysis treatment chair (geri chair #1) could not be utilized for transportation.

An interview with Nurse Aide (NA) #1 was conducted on 12/19/23 at 11:55 AM who reported she received a phone call on 11/1/23 at approximately 1:30 PM from Transportation Assistant #1 who stated Resident #1 had fallen out of geri chair #1 in the van. She stated she was informed that Resident #1 slid out of his chair. NA #1 stated Resident #1 had been transported to dialysis for approximately one month prior to 11/1/23 in a dialysis treatment chair (geri chair #1). She indicated she was unsure of the difference between a dialysis treatment chair (geri chair #1) and the facility's geri chair (geri chair #2).

A demonstration was observed on 12/19/23 at 2:15 PM of NA #1 attempting to secure a facility geri chair (geri chair #2) in the facility's transportation van. NA #1 provided back-up transportation for the facility. The primary transporter, Transportation Assistant #2, was unavailable. The Maintenance Director was present. She (NA #1) placed the hooks of the restraint system on the side of geri chair #2. The

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observation revealed there was no restraint system in the van to prevent the chair from reclining or to prevent the resident from slipping out if reclined.

During a follow up interview with the Administrator on 12/19/23 at 3:00 PM he indicated he was aware the manufacturer's instruction stated the van should not be used with chairs other than wheelchairs. He indicated he believed transitioning from geri chair #1 to geri chair #2 after the 11/1/23 incident was sufficient.

2. Resident #2 was admitted to the facility on 11/20/23 for aftercare following joint replacement surgery.

Resident #2's admission Minimum Data Set assessment dated 11/27/23 revealed she was cognitively intact. She was coded for using a wheelchair.

A facility concern/comment report dated 11/27/23 revealed a family member expressed concern about an incident in the facility van. The findings of the investigation revealed the employee (Transportation Assistant #1) did not follow the policy in reporting the incident. The investigation was conducted by nursing, social services and the Administrator. The actions taken indicated "to properly report an incident according to facility policy." The Administrator signed the form as complete.

Review of progress notes from 11/27/23 through 12/8/23 revealed no mention of an incident involving Resident #2. Resident #2 was discharged from the facility on 12/8/23.

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During a phone interview with Transportation Assistant #1 on 12/19/23 at 12:30 PM she reported she was transporting Resident #2 and Resident #4 on 11/27/23. She reported someone pulled out in front of her and she came to an abrupt stop. Transportation Assistant #1 stated she may have not buckled Resident #2's seat belt. She stated the resident slid forward out of her wheelchair onto the floor of the van onto her buttocks. Transportation Assistant #1 stated she assisted Resident #2 back into her wheelchair, buckled the seat belt and continued to her (the resident's) doctor's appointment. She reported she contacted Nurse Aide #1 who instructed her to not report it to administrative staff if the residents didn't mention it. Transportation Assistant #1 stated the resident indicated she was fine and did not have any pain.

An interview was conducted with Nurse Aide #1 (NA #1) on 12/19/23 at 11:55 AM who reported she received the phone call on 11/27/23 from Transport Assistant #1 who stated Resident #2 had slid out of her wheelchair. She stated she did not tell Transportation Assistant #1 not to report the incident. She indicated she did went to the Administrator to report the incident but he was already aware. She explained the family met the resident at the doctor's office, the resident informed them, and then the family notified the Administrator.

A progress note by the Director of Nursing dated 11/28/23 revealed Resident #2's family member reported some concerns about shoulder pain. An x-ray was done, and the results were negative for fracture, separation and dislocation.

Review of Resident #2's medical record found no

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pain medication was administered for her shoulder.

An interview was conducted with the Director of Nursing on 12/19/23 at 12:20 PM who stated she was made aware of Resident #2's pain by a family member on 11/28/23 and contacted the Medical Director.

A phone interview was conducted with Resident #2 on 12/19/23 at 10:29 AM. She reported on 11/28/23 Transportation Assistant #1 "slammed on the brakes of the van and she slid under another resident's wheelchair [Resident #4]". She reported the wheelchair was fastened in the van, but her seat belt securing her into the wheelchair was not buckled. Resident #2 stated Transportation Assistant #1 assisted her back into her chair, buckled her in and they went to her doctor's appointment. Resident #2 reported she advised her family of the incident when she got to the doctor's office. She stated the next day she complained of shoulder pain. She stated she did not recall falling on her shoulder but the pain was new and she thought it was from the fall in the van. Resident #2 indicated pain medication was not necessary. She stated the pain resolved a few days later. Resident #2 stated x-rays were done and they did not find anything.

During an interview with Resident #4, who appeared alert to person, place, time and situation, on 12/19/23 at 12:58 PM she stated she did not recall any incidents where someone fell out of their wheelchair while being transported. She added she did not have concerns about van transportation.
Review of the investigation with an initiated date of 11/27/23 and completion date of 12/3/23

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revealed Transportation Assistant #1 failed to properly secure the resident and did not contact the facility according to policy. She was terminated from employment. The investigation was completed by the Administrator.

An interview was conducted with the Administrator on 12/19/23 at 12:22 PM who stated he was made aware of Resident #2 fell from her wheelchair when the concern came in from Resident #2's family member on 11/27/23. He stated the incident was investigated and Transportation Assistant #1 was terminated from employment for not reporting the incident and failing to properly secure the resident.

On 12/19/23 at 4:15 PM, the Administrator was informed of the immediate jeopardy.

The facility provided the following immediate jeopardy removal plan with a removal date of 12/22/23.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

When transporting Residents #1 and #2 to appointments outside the facility, Transportation Assistant (TA) #1 failed to safely secure their wheelchairs in the facility transportation vehicle. On 11/1/23, TA #1 applied the brakes on the transport van as a car came out in front of it, causing Resident #1 to slide out of his geri- chair which was not a standard wheelchair and onto the van's floor. On 11/27/2023, while being transported to a doctor's visit, Resident #2 fell out of her wheelchair onto the van's floor. Resident #2 seatbelt was not fastened by TA #1.

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Residents #1 and #2 were identified to be affected by the deficient practice.

All residents who are transported in the facility van were identified to potentially be affected by the deficient practice.

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 11/27/23 TA #1 was suspended pending investigation for violating the safety policy. She was terminated on 12/4/23.
The current transportation aide has reviewed the facility's policy on transportation and completed an in-service on 12/21/23 regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. The facility will utilize wheelchairs in place of geri-chairs when transporting residents or use a medical transportation company when needed. The transportation aide will be responsible for ensuring residents are transferred to a proper chair prior to transporting in the facility van. The transportation aide was educated on ensuring residents are transferred to proper chairs for transportation and that geri-chairs are not proper chairs on 12/21/2023 by the Maintenance Director.

Beginning 12/21/23 all transport aides will receive safety training upon hire and annually. Training will be conducted by the Maintenance Director and will include a return demonstration of competency. This training will involve a review of the transportation policy, an in-service regarding

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the safety and securement of residents being transported in the facility transportation van, and supervision as needed.

Date of immediate jeopardy removal: 12/22/23

Onsite validation of the immediate jeopardy removal plan was completed on 12/28/23. Interviews verified on 11/27/23 Transportation Assistant #1 was suspended pending investigation, and she was terminated on 12/4/23. Inservice records and interview confirmed Transportation Assistant #2 reviewed the facility's policy on transportation and completed an in-service regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. In addition, Nurse Aide #1 who was a backup driver if needed for Transportation Assistant #2, received the same education and performed a return demonstration for the Maintenance Director. An observation verified the current transportation assistant (Transportation Assistant #2) secured a wheelchair according to manufacturer's instructions. Transportation Assistant #2 reported she was educated on ensuring residents are transferred to proper chairs for transportation, that geri-chairs are not proper chairs, and that she is responsible for ensuring residents were transferred to proper chairs in accordance with the manufacturer's instructions prior to transporting a resident. The Maintenance Director stated he is responsible for safety training with verification of competency on hire and annually for any transportation aide. The immediate jeopardy removal date of 12/22/23 was validated.

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F 726 SS=K	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews and interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, the facility failed to ensure Transportation Assistant	F 726	F 726 1. How corrective action will be accomplished for resident(s) found to have been affected.	1/26/24

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F 726	Continued From page 31 #1, who was also a facility Nurse Aide, was trained by staff who was aware of the facility's transportation van's manufacturer's instructions for safe securement when Nurse Aide #1 provided her with training. Nurse Aide #1 was not aware that transporting a resident in a geriatric chair (a padded chair with a wheeled based) was not in accordance with the transportation van's manufacturer's instructions. In addition, the facility failed to verify Transportation Assistant #1's competency to ensure resident safety during transportation for 1 of 1 staff who transported residents in the facility's transportation van. On 11/1/23 Transportation Assistant #1 utilized a geriatric wheelchair (geri chair) to transport Resident #1 and during transportation the resident slid out of the chair onto the floor of the van. Resident #1 was not injured. On 11/27/23 Transportation Assistant #1 did not buckle Resident #2's seatbelt and during transportation the resident fell out of the wheelchair and onto the floor of the van. Resident #2 reported pain in her right shoulder the following day. This deficient practice had a high likelihood of resulting in serious harm, injury, or death to residents who were transported in the facility's transportation van. Immediate jeopardy began on 11/1/23 when Transportation Assistant #1 failed to demonstrate competency when she transported Resident #1 in a geriatric chair that was not in accordance with the manufacturer's instructions and the resident fell out of the chair. The immediate jeopardy was removed on 12/22/23 when the facility provided an acceptable credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not	F 726	Residents #1 and # 2 were identified to have been affected. TA #1 was terminated on12/04/23 for violating the safety policy. 2. All Residents who are transported in the facility van were identified to potentially be affected by the deficient practice. 3. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future? The current transportation aide has reviewed the facility's policy on transportation and completed an in-service on 12/21/23 regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. The facility will utilize wheelchairs in place of geri-chairs when transporting residents or use a medical transportation company when needed. . The transportation aide was educated on ensuring residents are transferred to proper chairs for transportation and that geri-chairs are not proper chairs on 12/21/2023 by the Maintenance Director. Beginning 12/21/23 all transport aides will receive safety training upon hire and annually. The training will be conducted by the Maintenance Director and will include a return demonstration of competency. This training will involve a review of the transportation policy, an in-service regarding the safety and security of residents being transported in the facility	

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F 726	Continued From page 32 immediate jeopardy) to complete education and ensure monitoring systems put into place are effective related to supervision to prevent accidents. The findings included: This tag is cross-referenced to: F689: Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, the facility failed to provide safe transportation in the facility's transportation van and to ensure wheelchairs were utilized during transportation in accordance with manufacturer's instructions for 2 of 4 residents reviewed for accidents (Resident #1 and Resident #2). On 11/1/23 Transportation Assistant #1 utilized a geriatric chair (a padded chair with a wheeled base) to transport Resident #1 and during transportation the resident slid out of the chair onto the floor of the van. Resident #1 was not injured. On 11/27/23 Transportation Assistant #1 did not buckle Resident #2's seatbelt and during transportation the resident fell out of the wheelchair and onto the floor of the van. Resident #2 reported pain in her right shoulder the following day. These incidents had the high likelihood of serious harm, injury or death. Review of a form dated 9/8/23 entitled "Transportation Aide Major Duties and Responsibilities Checklist" revealed one of the major duties was "operating the facility's transport van in a safe manner and securing residents prior to operating." This form further indicated Transportation Assistant #1 had completed training and demonstrated competence in all areas. The form was signed by NA #1.	F 726	transportation van, and supervision as needed. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur The Administrator/Designee will audit 5 residents weekly to ensure resident is in proper wheelchair and is properly secured. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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An interview was conducted with NA #1 on 12/19/23 at 11:55 AM who reported she trained Transportation Assistant #1 on how to operate the lift and restraint system on the facility's transportation van prior to Transportation Assistant #1 providing transportation to residents. She explained she had worked for the facility for 12 years and had driven the van in the past prior to becoming a medication aide. NA #1 further explained that the former transportation assistant quit suddenly. She indicated Transportation Assistant #1 was an NA at the facility and she was asked to move to the position of transportation driver. She stated that the Maintenance Director was on leave at the time of these changes. She reported that because she (NA #1) was most familiar with the van she trained Transportation Assistant #1. She stated she had Transportation Assistant #1 demonstrate how to operate the lift and restraint system prior to Transportation Assistant #1's first assigned transport.

Review of an Emergency Medical Services report dated 11/1/23 revealed Transportation Aide #1 informed the Emergency Medical Services staff when they arrived that "she was just a [nurse aide] and did not know how anything about how this transport van works, indicating that she has never received proper training for the job that she is performing."

During an interview with Emergency Medical Services staff #1 (EMS #1) on 12/19/23 at 1:10 PM he stated he reported to the scene of the accident on 11/1/23 and observed that Resident #1 was being transported in a geri chair (geri chair #2). He stated Transportation Aide #1

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informed him that she had not been trained or oriented to use the facility's transportation van.

During an interview with NA #1 on 12/19/23 at 11:55 AM she revealed she had not known that transporting a resident in a geri chair was not in accordance with the facility's transportation van's manufacturer's instructions.

An interview was conducted with Transportation Assistant #1 on 12/19/23 at 1:18 PM who indicated she was an NA and had worked in that role at the facility prior to providing transportation. She explained that the previous transportation assistant quit suddenly and she was asked to provide transportation. Transportation Assistant #1 stated Nurse Aide #1 showed her how to secure a wheelchair on the transportation van. She indicated that was the extent of her training. She reported she began providing transportation for the facility on 9/8/23. She stated she was unaware geri chair #1 was not allowed to be used for transporting residents in the facility's transportation van until she was told by Emergency Services staff #1 after Resident #1 fell from geri chair #1. She stated she thought it was acceptable to use geri chair #2. She reported her retraining on 11/3/23 consisted of reading the policy and initialing each page. The policy did not mention geri chairs. Transportation Assistant #1 stated she forgot to secure Resident #2's seat belt on 11/27/23 which resulted in her falling out of her wheelchair on 11/27/23.

An interview was conducted with the Maintenance Director on 12/19/23 at 11:40 AM. He indicated he supervised the transportation staff. He stated when Transportation Assistant #1 began work in September 2023 he was out of the office and she

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was trained by NA #1. The Maintenance Director explained NA #1 was responsible for training in his absence because she provided transportation prior to becoming a medication aide in the facility. The Maintenance Director reported that he was on leave on 11/1/23 when Resident #1 fell out of his geri chair in the facility's transportation van. He wasn't involved with any investigation and was not involved with retraining Transportation Assistant #1. He stated the only strategy the facility used to train transportation assistants was verbal instruction with hands-on demonstration.

A form entitled "Resident Transportation Policy" dated 11/3/23 revealed Transportation Assistant #1's initials on each page with her dated signature. The form provided no indication if Transportation Aide #1 was provided with re-training on the facility's transportation van's manufacturer's instructions for safe securement or if her competencies were verified.

During an interview with the Administrator on 12/19/23 at 3:00 PM he stated Transportation Assistant #1 was trained by NA #1 prior to transporting residents. He further stated he retrained Transportation Assistant #1 on 11/3/23 after the van incident in which Resident #1 fell out of his wheelchair. The retraining included a review of the facility policy which Transportation Assistant signed. There was no demonstration of competencies by Transportation Assistant #1. The Administrator revealed that when he was informed by EMS staff that geri chair #1 was not supposed to be used for transportation that he had not realized this meant all geri chairs. He explained that he thought this instruction was specific to geri chair #1. He indicated that when he provided retraining to Transportation Assistant

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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#1 he did not inform her that geri chairs were not to be used for transporting residents in the facility's transportation van. The Administrator stated that after the 2nd van incident occurred on 11/27/23, where Resident #2 fell out of her wheelchair because she was not secured, Transportation Assistant #1 was terminated.

On 12/19/23 at 4:15 PM, the facility's Administrator was informed of the immediate jeopardy.
The facility provided the following corrective action plan with a completion date of 12/22/23.
Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

When transporting Residents #1 and #2 to appointments outside the facility, Transportation Assistant (TA) #1 failed to safely secure their wheelchairs in the facility transportation vehicle. On 11/1/23, TA #1 applied the brakes on the transport van as a car came out in front of it, causing Resident #1 to slide out of his geri- chair which was not a standard wheelchair and onto the van's floor. On 11/27/2023, while being transported to a doctor's visit, Resident #2 fell out of her wheelchair onto the van's floor. Resident #2 seatbelt was not fastened by TA #1. The facility failed to ensure TA #1 was properly train and competent in transportation safety prior to providing transportation to residents.

Residents #1 and #2 were identified to be affected by the deficient practice.

All residents who are transported in the facility

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F 726	Continued From page 37 van were identified to potentially be affected by the deficient practice. 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 11/27/23 TA #1 was suspended pending investigation for violating the safety policy. She was terminated on 12/4/23. The current transportation aide has reviewed the facility's policy on transportation and completed an in-service on 12/21/23 regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. The facility will utilize wheelchairs in place of geri-chairs when transporting residents or use a medical transportation company when needed. The transportation aide will be responsible for ensuring residents are transferred to a proper chair prior to transporting in the facility van. The transportation aide was educated on ensuring residents are transferred to proper chairs for transportation and that geri-chairs are not proper chairs on 12/21/2023 by the Maintenance Director. Beginning 12/21/23 all transport aides will receive safety training upon hire and annually. The training will be conducted by the Maintenance Director and will include a return demonstration of competency. This training will involve a review of the transportation policy, an in-service regarding the safety and security of residents being transported in the facility transportation van, and	F 726		

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F 726	Continued From page 38 supervision as needed. Date of immediate jeopardy removal: 12/22/23 Onsite validation of the immediate jeopardy removal plan was completed on 12/28/23. Interviews verified on 11/27/23 TA #1 was suspended pending investigation, and she was terminated on 12/4/23. The facility has 1 current transportation aide, TA #2. Inservice records and interview confirmed TA #2 reviewed the facility's policy on transportation and completed an in-service regarding the safety and securement of all residents being transported in the facility transportation van, with a return demonstration observed by the Maintenance Director. An observation verified the current transportation assistant secured a wheelchair according to manufacturer's instructions. TA #2 reported she was educated on ensuring residents are transferred to proper chairs for transportation, that geri-chairs are not proper chairs, and that she is responsible for ensuring residents were transferred to proper chairs in accordance with the manufacturer's instructions prior to transporting a resident. The Maintenance Director stated he is responsible for safety training with verification of competency on hire and annually for any transportation aide. The immediate jeopardy removal date of 12/22/23 was validated.	F 726		
F 755 SS=K	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed	F 755		1/26/24

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F 755	Continued From page 39 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 and interviews with staff, pharmacist, and physician, the facility failed to obtain an anti-seizure medication for a resident with a history of seizures resulting in 22 missed doses of the medication and to have staff capable of accessing the emergency medication supply to treat a medical emergency. Resident #3 was ordered Vimpat two times a day for seizures and from 11/25/23 through 12/5/23 the resident did not receive the medication as it was not obtained from the pharmacy. Resident #3 had four	F 755	F 755 1. How corrective action will be accomplished for resident(s) found to have been affected Resident # 3□s Vimpat was ordered on 12/04 and received from pharmacy on 12/06. 2. Identify other residents who have the potential to be affected All other residents' medication orders were reviewed on 12/21/23 to ensure all	

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incidents of seizure activity between 12/4/23 and 12/5/23. Following the fourth seizure (12/5/23) the physician ordered Ativan (an antianxiety medication commonly used as a rescue medication for seizures) via intramuscular (IM) injection and the facility staff were unable to access the emergency medication supply. EMS was contacted and the resident was transported to the Emergency Room (ER) where Vimpat was administered. The resident had no further seizure activity after receiving Vimpat and was discharged back to the facility the same day. Upon return from the ER the resident was not administered Vimpat until the evening dose on 12/6/23 as the medication had still not been obtained from the pharmacy. This deficient practice was for 1 of 3 residents reviewed for pharmaceutical services.

Immediate Jeopardy began on 11/25/23 when the facility failed to have Vimpat available for administration for a resident with a history of seizures. The immediate jeopardy was removed on 12/22/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of a E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective.

The findings included:

Resident #3 was initially admitted to the facility on 3/2/23 and readmitted to the facility on 11/13/23 with diagnoses which included traumatic subdural hemorrhage, seizure disorder/epilepsy, traumatic brain injury, and gastrostomy status (a tube

medications were available. Any residents who had a medication with less than a week's supply available were reordered. This action was completed by the DON and MDS nurse.

3. What measure will be put in place or systemic changes made to ensure that the identified issue does not occur in the future?

All licensed nurses, including agency staff, were educated by the DON on accessing medication from the emergency dispensing system per facility policy and procedure on 12/21/23 no nurse will be permitted to work the medication cart prior to completing education.

Newly hired licensed nurses, including agency staff, will be educated on accessing medications from the emergency dispensing system per facility policy and procedure, accordingly in orientation by Human Resources Director beginning 12/21/23.

The nurse or medication aide administering medications will receive education beginning 12/21/23 from the DON and pharmacy consultant on reordering medications observed to have less than a week supply available via the EMAR system.

The DON obtained charge nurse access from the pharmacy to the emergency medication system on 12/20/23. The charge nurse access allows the DON to grant access to nurses working at the facility.

The pharmacy will provide additional monthly in-service education beginning 12/21/23 for the nurses and medication

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F 755	Continued From page 41 surgically placed into the stomach). A physician order for Resident #3 dated 9/25/23 indicated valproic acid (anticonvulsant) oral solution give 10 milliliters (ml) via G-tube three times a day related to epilepsy. A physician order for Resident #3 dated 10/15/23 indicated Vimpat oral solution 10/milligrams (mg)/ml give 25 ml via G-tube two times a day for seizures. Give 250 mg/25ml two times a day. Review of the significant change Minimum Data Set dated 10/15/23 identified the resident as having moderately impaired cognition. The MDS coded the resident as having seizure disorder/epilepsy and for gastrostomy (G-tube) status. Resident #3's physician order summary for November 2023 indicated the orders for valproic acid and Vimpat remained as active orders. The Medication Administration Record (MAR) and progress notes revealed the following information for Resident #3: - 11/25/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #6 revealed Vimpat was on order. - 11/26/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #6 revealed Vimpat was on order. - 11/27/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #1 revealed Vimpat was out of stock and a prescription had been signed by the	F 755	aides regarding medication administration, ordering, accessing emergency supply and all other services available. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur. The Director of Nursing/Designee will audit 5 residents meds daily for availability 5 days a week for 12 weeks. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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provider.
- 11/28/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Waiting on pharmacy."
- 11/29/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Coming from pharmacy."
- 11/30/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #8 revealed the medication was not available.
- 12/1/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #3 indicated the medication was not available.
- 12/2/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available.
- 12/3/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available.
- 12/4/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "On order."
- 12/5/23: The MAR indicated the morning dose of Vimpat was not administered and a nurse's note written by Nurse #1 stated, "Out of stock. [Director of Nursing] and provider notified."

An interview was conducted on 12/20/23 at 10:12 am with staff Nurse #4 who stated she gave Resident #3 his last dose of Vimpat on 3rd shift 11/24/23. She stated she did not call the physician as the hard prescription had been faxed

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to the physician before the medication ran out.

On 12/19/23 at 1:21 pm the DON stated she had copies of the Vimpat prescriptions that were sent to the pharmacy. As of the survey exit date on 12/28/23 the information had not been provided.

A telephone interview was conducted on 12/20/23 at 4:47 pm with agency Nurse #6. She stated that Resident #3 ran out of his prescription on 11/25/23, she called and faxed the physician to request a reorder on Resident #3's Vimpat. She revealed 11/26/23 was the last day she worked, and she was not aware Resident #3's Vimpat was not available. When asked what the process was for ordering refills of medication Nurse #6 reported for a controlled substance such as Vimpat, the nurse on the medication cart, would call or fax the physician before the medication ran out to sign a prescription reorder and he sent it to the pharmacy.

An interview was conducted on 12/19/23 at 2:30 pm with agency Nurse #2 who had not administered the medication on 11/28/23, 11/29/23, and 12/4/23. Nurse #2 indicated Vimpat was a controlled substance, and they would need a signed prescription to reorder. She stated when the medication was not available, she called the pharmacy and was told the medication was coming on 11/29/23. She indicated when she called the pharmacy 11/29/23, she was told the medication was on its way. Agency Nurse #2 stated when the seizure medication had not arrived on 12/04/23 when she returned to work she notified the current DON and gave her a

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prescription to fax to the physician. When asked about the process for ordering refills of medication Nurse #2 revealed when in the building the doctor would sign the prescription and staff faxed it to the pharmacy. When the physician was not in the building the nurse needed a refill of a medication that was a controlled substance, the nurse would fax a refill prescription to the physician to sign and he faxed it to the pharmacy.

An interview was conducted on 12/20/23 at 2:42 pm with agency Nurse #3 who on 12/01/23 documented the Vimpat as not available. Nurse #3 stated if they needed a signed prescription their procedure was to call the physician for a prescription refill and he sent the order to the pharmacy. She indicated she could not remember if she had called the pharmacy to see where the Vimpat was.

A telephone interview was conducted on 12/20/23 at 2:35 pm with agency Nurse #5. Nurse #5 stated she called and left a message for the physician on 12/3/23 to order the seizure medication. She indicated she was not aware if the physician responded to her message. Nurse #5 indicated she did not remember if she contacted the pharmacy to find the Vimpat. Nurse #5 spoke about the process for obtaining medication refills and she indicated the nurse on the medication cart, would call or fax the physician for a signed prescription, and he would send it to the pharmacy.

A nurse's note written by Nurse #2 dated 12/04/23 at 2:30 pm revealed that Resident #3 was seen this morning having seizure activity by staff during this shift. Nurse #2 indicated when

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she arrived at his room the resident was not showing seizure activity but wasn't answering questions like he would normally do. The note stated Nurse #2 and staff stayed by his side until resident was completely alert and responding like normal. Resident #3 was in stable condition and hadn't shown anymore seizure activity as of yet.

An interview was conducted with Nurse #2 on 12/19/23 at 11:33 am who worked with Resident #3 on 12/04/23. She stated staff reported Resident #3 was having seizure activity and when she arrived to his room, she did not observe seizure activity. Nurse #2 stated she stayed with Resident #3 and continued to monitor him, to make sure he was alert and at his baseline on 12/04/23.

A nurses' notes written by Nurse #1 dated 12/05/23 at 10:14 am revealed an aide bathed and shaved Resident #3 at approximately 8:18 am and the resident displayed seizure like activity for approximately 2 minutes or less in duration. The note indicated seizure activity was displayed again at 10:10 am while working with therapy.

An interview was conducted with Rehabilitation Aide #1 on 12/19/23 at 10:09 am. Rehabilitation Aide #1 revealed that while bathing Resident #3 on 12/05/23 his arms drew tight up against his body for 10 seconds then ended. She indicated she reported the incident to the nurse (Nurse #1) who was agency staff.

A nurse's note written by Nurse #1 dated 12/5/23 at 3:50 pm revealed resident sent out to hospital due to seizure activity. The note indicated Resident #3 had 3 episodes of seizure activity with the last event at 1:47 pm.

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An interview was conducted on 12/19/23 at 12:02 PM with Nurse #1. Nurse #1 stated on Friday 11/27/23 she texted Resident #3's physician a prescription requesting the Vimpat, for the physician to sign and fax over to the pharmacy for refill. Nurse #1 stated when she returned to work on Tuesday 12/05/23, the Vimpat was not on the medication cart. She reported the physician had been in earlier doing rounds and was aware Resident #3 had previous seizure activity that day and told staff to administer the Vimpat or Ativan. Nurse #1 indicated the DON began to search and found no Vimpat was in the facility. She indicated the emergency medication supply was stored in a secure medication dispensing machine and none of the staff, including the DON, had access to pull the Ativan. She stated on 12/05/23 at 1:47 PM, she observed Resident #3's contracted arm became stiff, he got still, for a minute and then he said he was okay. Nurse #1 stated as there was no Vimpat available, staff could not access the emergency medication supply for Ativan, she called EMS and the physician said to send the resident out to the ER.

A physician note completed by the Medical Director dated 12/05/23 revealed Resident #3 had recurrent seizure activity on 12/05/23 with known history of seizure disorder. The resident was noted to recover in between the seizure episodes. He was at high risk for status epilepticus (a recurrent seizure activity without recovery between seizures) impending. He was currently on valproic acid plus Vimpat. The Medical Director indicated due to clinical condition he made the decision to transfer Resident #3 to the local emergency department for further definitive work up secondary to recurrent seizures

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since this morning.

The Medical Director was interviewed on 12/19/23 at 1:58 PM and 2:16 PM. He indicated he could not recall the exact date, but he was told by staff that Resident #3 had seizure activity. He stated that due to the seizure activity he wanted to give the resident IM Ativan. He stated the facility staff could not get ahold of the Ativan so he sent Resident #3 out to the ER for evaluation. He stated he could not comment on the availability of Resident #3's Vimpat.

The EMS Report dated 12/05/23 indicated dispatch received the call at 2:50 PM and they arrived at the facility at 2:57 PM. The nurse informed EMS Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). When asked about the resident having seizures the nurse indicated Resident #3 had 3 seizures on this date (12/5/23) at these times: 8:18 AM, 10:10 AM and 1:47 PM. EMS departed the facility at 3:25 PM and arrived at the hospital at 3:56 PM. No seizure activity was noted during transport. While giving report to the hospital nurse Resident #3 was noted to start having a seizure.

The hospital record dated 12/05/23 revealed Resident #3 presented on 12/05/23 for prior history of seizures, had three seizures on this date and had been out of Vimpat since Friday (11/24/23). He was noted as alert, verbally responsive but confused. The hospital report indicated he was treated with Vimpat 200 mg in sodium chloride 0.9 percent 50 mL via IV (intravenous), and no further seizure activity was

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noted. The record stated, "Spoke with facility, reports medication has not been picked up from the pharmacy emphasized importance of [Resident #3] getting his medications as prescribed ..." Resident #3's diagnoses were listed as seizures, seizure disorder, and noncompliance with medication regimen.

A nurse's note dated 12/05/23 at 9:52 pm revealed the resident returned from ER with no new orders.

A nurse's note dated 12/6/23 at 7:48 am written by Nurse #1 indicated Vimpat was not administered for the morning dose due to it being out of stock.

An interview was conducted on 12/20/23 at 10:16 AM with the facility's current DON who took the position on 11/27/23. The DON reported she was first made aware on 12/04/23 by Nurse #2 that Resident #3's Vimpat had not been available for administration and called the pharmacy that day. She revealed the pharmacy told her the medication was in the facility. When the medication was not found in the facility, she called the pharmacy back on 12/05/23 and was told it was found bagged up at the pharmacy. She stated the medication was delivered by the pharmacy the following day and the resident received his first dose as ordered on 12/06/23 in the evening. The DON could not explain why staff had not gone to the pharmacy to pick up Resident #3's Vimpat. The DON stated Resident #3 would have had his medication on 12/01/23 if the delivery driver had not hit a deer, the second driver could not find the facility and returned the medication to the pharmacy and they were never notified the medication was returned to the

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pharmacy. She stated when the physician ordered IM Ativan on 12/05/23, no staff in the facility had access to the emergency medication supply and could not access the Ativan. The DON revealed the facility had changed their pharmacy in October, gotten an emergency medication supply system from the pharmacy and staff had not received training on its use or had access. The DON indicated Resident #3's medical record revealed prior to the evening dose of Vimpat administered at the facility on 12/06/23, he had last received the medication at the facility on 11/24/23.

A phone interview was conducted on 12/28/23 at 1:20 pm with the facility Pharmacist #1. She indicated Resident #3's MAR documented the Vimpat ran out on 11/25/23 and on 12/05/23 he was sent to the ER for seizure activity. The Pharmacist stated that abruptly stopping the Vimpat for 10 days Resident #3 would have the potential for seizures. She stated the first attempted delivery the pharmacy driver hit a deer and could not deliver the Vimpat, the second attempt to deliver the driver could not find the facility and returned the Vimpat to the pharmacy.

An interview was conducted on 12/20/23 at 12:55 pm with the Administrator. He stated at the time of the issue with the availability of Resident #3's Vimpat they were in transition with a new pharmacy, the DON was new, and staff called the pharmacy, and were told the Vimpat was coming. The Administrator reported that nurses should notify the facility pharmacist when they were out of medication and notify the physician so he could sign the prescription in a timely manner. He stated he was not aware Resident #3 was out of his medication, most of the staff were from

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agencies and these agency staff failed to notify management the medication was not available. The Administrator indicated if medication did not arrive, staff should call the pharmacy to find out the status of the medication or call their back up pharmacy. The Administrator indicated he did not know why the medication would run out or why no one went to the pharmacy for the Vimpat.

An interview was conducted on 12/20/23 4:33 pm with the DON who indicated staff should always call the physician when any resident was observed with seizure activity and notify the physician when any residents medications were not available.

The Administrator was notified of immediate jeopardy on 12/20/23 at 1:40 PM.

The facility provided the following immediate jeopardy removal plan:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #3 was identified as being affected by the noncompliance.

Resident #3 had 4 incidents of seizure activity on the following approximate dates and times 12/4/23 at 2:30 PM, 12/5/23 at 8:18 AM, 12/5/23 at 10:10 AM, and 12/5/23 at 1:47 PM. The resident's Vimpat was not available within the facility and the nurses did not have access to remove medication from the emergency supply system.
The physician indicated when he was first notified

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of the seizure activity on 12/5/23 he assessed the resident and wanted Ativan to be administered. He indicated there was no Ativan accessible for the resident, so he sent the resident to the ER.

" Resident #3's Vimpat was ordered on 12/4/23 and received from pharmacy 12/6/23. All other medication orders were reviewed, and medications were confirmed to be available on 12/4/23 by the DON.
" All other residents' medication orders were reviewed on 12/21/23 to ensure all medications were available. Any residents who had a medication with less than a week's supply available were reordered. This action was completed by the DON and MDS nurse.

2. 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.
" All licensed nurses, including agency staff, were educated by the DON on accessing medication from the emergency dispensing system per facility policy and procedure on 12/21/23 no nurse will be permitted to work the medication cart prior to completing education. The Administrator, DON and Staffing Coordinator will ensure compliance.
" Newly hired licensed nurses, including agency staff, will be educated on accessing medications from the emergency dispensing system per facility policy and procedure, accordingly in orientation by Human Resources Director beginning 12/21/23. The Human Resources Director was notified of the change by the Administrator.
" The nurse or medication aide administering medications will receive education beginning

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F 755	Continued From page 52 12/21/23 from the DON and pharmacy consultant on reordering medications observed to have less than a week supply available via the EMAR system. " The DON obtained charge nurse access from the pharmacy to the emergency medication system on 12/20/23. The charge nurse access allows the DON to grant access to nurses working at the facility. " The DON is actively granting access to the nurses for the emergency medication system. The DON will be available as needed to obtain emergency medications until there is at least one nurse per shift with access to the emergency medication system. " The Chief Operating Officer conducted a conference call on 12/21/23 to discuss medication refill and emergency medication availability and access with the pharmacy director. The pharmacy will ensure that the emergency medication supply system is available and stocked. Replacement medications are automatically ordered through the inventory control system when removed and will be received on the next service day after being removed from the cabinet. New and refill orders are sent within 24 hours of receiving order unless order is written for stat dispensing. " Pharmacy will provide additional monthly in-service education beginning 12/21/23 for the nurses and medication aides regarding medication administration, ordering, accessing emergency supply and all other services available. Alleged date of immediate jeopardy removal: 12/22/23	F 755		

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F 755	Continued From page 53 Onsite validation of the immediate jeopardy removal plan was conducted on 12/28/23. The audit of medication orders was verified as completed and any medications with less than a week's supply were reordered. Inservice records and interviews confirmed educated was completed as indicated. The education included: accessing medication from the emergency dispensing system per facility policy and procedure and reordering medications observed to have less than a week supply available. The DON received access from the pharmacy to the emergency medication system, was in the process of granting access to facility nurses and the DON was available as needed to obtain emergency medications until there was at least one nurse per shift with access to the emergency medication system. The Chief Operating Officer conference call with the pharmacy was confirmed to be completed. The HR Director confirmed she is responsible for ensuring all new staff are educated in orientation on accessing medications from the emergency dispensing system per facility policy and procedure. It was verified that the pharmacy is to provide additional monthly in-service education for the nurses and medication aides regarding medication administration, ordering, accessing emergency supply and all other services available. The immediate jeopardy removal date of 12/22/23 was verified.	F 755		
F 760 SS=K	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	F 760		1/26/24

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F 760	Continued From page 54 by: Based on record review and interviews with staff, Emergency Medical Services (EMS) personnel, pharmacist, and physician interviews, the facility failed to administer an anticonvulsant medication to a resident for a period of 10 and half consecutive days and doses (11/25/23 through 12/5/23). Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. EMS was contacted on 12/5/23 and the resident was transported to the Emergency Room (ER) where Vimpat was administered. The resident had no further seizure activity after receiving Vimpat in the ER and was discharged back to the facility the same day. Upon return to the facility the resident was not administered one dose of the anticonvulsant on 12/6/23 for a total of 22 missed doses. This occurred for 1 of 3 residents (Resident #3) whose medications were reviewed. Immediate Jeopardy began on 11/25/23, when the facility failed to administer Resident #3's antiseizure medication. The immediate jeopardy was removed on 12/22/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of a E (a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective. The findings included: Resident #3 was admitted to the facility on 3/2/23 and readmitted to the facility on 11/13/23 with diagnoses which included traumatic subdural hemorrhage, seizure disorder/epilepsy, traumatic	F 760	F 760 1. How corrective action will be accomplished for resident(s) found to have been affected. Resident # 3 was sent to the ER on 12/05/23 and received his medication Vimpat. The medication was reordered and received at the facility on 12/06/23. All other medication orders were reviewed, and medications were available on 12/04/23 by the Director of Nursing. 2. Identify other residents who have the potential to be affected All other residents' medication orders were reviewed on 12/21/23 to ensure all medications were available and being administered as ordered. Any residents who had a medication with less than a week's supply available were reordered. This action was completed by the DON and MDS nurse. 3. What measures will be put in place to ensure the identified issue does not occur in the future? All full-time, part-time, prn, and agency licensed nurses and medication aides were educated by the DON on preventing medication errors included missed medications, the significant risks to residents and the consequences for not notifying the physician and DON of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure beginning 12/21/23. No licensed nurse or medication aide will work until education has been completed. Nurses are to contact the DON and	

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F 760	Continued From page 55 brain injury, gastrostomy status (a tube surgically placed into the stomach). Review of the significant change Minimum Data Set dated 10/15/23 identified the resident as having moderately impaired cognition. The MDS coded the resident as having seizure disorder/epilepsy and for gastrostomy (G-tube) status. Resident #3's physician orders for November 2023 indicated an order initiated on 10/15/23 for Vimpat oral solution 10/milligrams (mg)/milliliters (ml) - give 25 ml via G-tube two times a day for seizures. Give 250 mg/25ml two times a day. A physician order dated 9/25/23 revealed an order for Valproic Acid oral solution give 10 ml via G-tube three times a day related to epilepsy. Resident #3's November 2023 electronic Medication Administration Record EMAR indicated the resident's last dose of Vimpat was administered on 11/24/23 at 8:00 pm. The EMAR also documented no doses of Vimpat were administered to Resident #3 from 11/25/23 through 11/30/23. Resident #3's December EMAR documented no doses of Vimpat were administered to Resident #3 from 12/01/23 through 12/06/23 with the first dose administered during 3rd shift on 12/06/23 at 8:00 pm. The Medication Administration Record (MAR) and progress notes revealed the following information for Resident #3: - 11/25/23: The MAR indicated no doses of Vimpat were administered and a nurse's note	F 760	physician via phone immediately when resident medication errors occur or are anticipated to occur for further instructions. All newly hired and agency staff (licensed nurses and medication aides) will be educated on preventing medication errors including missed medications, the significant risks to residents and the consequences for not notifying the physician of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure, accordingly in orientation prior to working the floor. The DON and Human resources will ensure education is complete prior to allowing staff to work the medication cart. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur. The Director of Nursing/designee will observe med pass three times a week for twelve weeks. The Director of Nursing/Designee will audit 5 residents meds daily for availability 5 days a week for 12 weeks. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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written by Nurse #6 revealed Vimpat was on order.
- 11/26/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #6 revealed Vimpat was on order.
- 11/27/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #1 revealed Vimpat was out of stock and a prescription had been signed by the provider.
- 11/28/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Waiting on pharmacy."
- 11/29/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "Coming from pharmacy."
- 11/30/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #8 revealed the medication was not available.
- 12/1/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #3 indicated the medication was not available.
- 12/2/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available.
- 12/3/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #5 indicated the medication was not available.
- 12/4/23: The MAR indicated no doses of Vimpat were administered and a nurse's note written by Nurse #2 stated, "On order."
- 12/5/23: The MAR indicated the morning dose

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of Vimpat was not administered and a nurse's note written by Nurse #1 stated, "Out of stock. [Director of Nursing] and provider notified."

An interview was conducted on 12/20/23 at 10:12 am with staff Nurse #4 who stated she gave Resident #3 his last dose of Vimpat on 3rd shift 11/24/23. She stated she did not call the physician as the hard prescription had been faxed to the physician before the medication ran out.

A telephone interview was conducted on 12/20/23 at 4:47 pm with agency Nurse #6. She stated that Resident #3 ran out of his prescription on 11/25/23, she called and faxed the physician to request a reorder on Resident #3's Vimpat. She revealed 11/26/23 was the last day she worked, and she was not aware Resident #3's Vimpat was not available.

A nurse's note written by agency Nurse #2 dated 12/04/23 at 2:30 pm revealed that Resident #3 was seen this morning having seizure activity by staff during this shift. Nurse #2 indicated when she arrived at his room the resident was not showing seizure activity but wasn't answering questions like he would normally do. The note stated Nurse #2 and staff stayed by his side until resident was completely alert and responding like normal. Resident #3 was in stable condition and no further seizure activity was observed.

An interview was conducted on 12/19/23 at 2:30 pm with agency Nurse #2 who had not administered the medication on 11/28/23, 11/29/23, and 12/4/23. Nurse #2 indicated Vimpat was a controlled substance, and they would need a signed prescription to reorder. She stated when the medication was not available, she called the

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pharmacy and was told the medication was coming on 11/29/23. She indicated when she called the pharmacy 11/29/23, she was told the medication was on its way. Agency Nurse #2 stated when the seizure medication had not arrived on 12/04/23 when she returned to work she notified the current Director of Nursing (DON) and gave her a prescription to fax to the physician.

A nurse's note written by Nurse #1 on 12/05/23 at 10:14 am revealed resident resting in bed no signs or symptoms of pain, distress, or discomfort. Alert to person. Rehabilitation Aide #3 bathed and shaved resident at approximately 8:18 am. Resident displayed seizure like activity approximately 2 minutes or less in duration. And again at 10:10 am while working with therapy. DON notified. Will notify provider and family contact.

An interview was conducted on 12/20/23 at 10:16 AM with the facility's current DON who took the position on 11/27/23. The DON reported she was first made aware on 12/04/23 by Nurse #2 that Resident #3's Vimpat had not been available for administration and called the pharmacy that day. She revealed the pharmacy told her the medication was in the facility. When the medication was not found in the facility, she called the pharmacy back on 12/05/23 and was told it was found bagged up at the pharmacy. She stated the medication was delivered by the pharmacy the following day and the resident received his first dose as ordered on 12/06/23 in the evening. The DON could not explain why staff had not gone to the pharmacy to pick up Resident #3's Vimpat. The DON indicated Resident #3's medical record revealed prior to the evening dose

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of Vimpat administered at the facility on 12/06/23, he had last received the medication at the facility on 11/24/23.

An interview was conducted on 12/20/23 at 12:55 pm with the Administrator. He stated at the time of the issue with the availability of Resident #3's Vimpat they were in transition with a new pharmacy, the DON was new, and staff called the pharmacy, and were told the Vimpat was coming. The Administrator reported that nurses should notify the facility pharmacist when they were out of medication and notify the physician so he could sign the prescription in a timely manner. He stated he was not aware Resident #3 was out of his medication, most of the staff were from agencies and these agency staff failed to notify management the medication was not available. The Administrator indicated if medication did not arrive, staff should call the pharmacy to find out the status of the medication or call their back up pharmacy. The Administrator indicated he did not know why the medication would run out or why no one went to the pharmacy for the Vimpat.

The Medical Director was interviewed on 12/19/23 at 1:58 PM and 2:16 PM. He indicated he could not recall the exact date, but he was told by staff that Resident #3 had seizure activity. He stated he could not comment on the availability of Resident #3's Vimpat.

The EMS Report dated 12/05/23 indicated dispatch received the call at 2:50 pm for a resident with seizures and the EMS crew arrived at the facility at 2:57 pm and advised of Resident #3's room number. Resident #3 was found sitting up in bed and there was no nurse or medical staff available to give a report. The EMS crew had to

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request nursing staff to give them a report. The nurse informed EMS Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). When asked about the resident having seizures the nurse indicated Resident #3 had 3 seizures on this date (12/5/23) at these times: 8:18 am, 10:10 am and 1:47 pm. EMS departed the facility at 3:25 pm and arrived at the hospital at 3:56 pm. No seizure activity was noted during transport. While giving a report to the hospital nurse, Resident #3 was noted to start having a seizure.

A telephone interview was conducted on 12/19/23 at 12:48 pm with EMS #1. He indicated when he arrived to the resident's room there were no staff available to give report and he had to request nursing staff to give them a report. EMS #1 reported that Resident #3 was being sent out to the hospital per physician request due to the facility not having the resident's medication (Vimpat). EMS #1 stated he asked the nurse why Resident #3 went 4-5 days without his Vimpat and she could not answer, just said they did not have his Vimpat.

The hospital record dated 12/05/23 revealed Resident #3 presented on 12/05/23 for prior history of seizures, had three seizures on this date and had been out of Vimpat since Friday (11/24/23). He was noted as alert, verbally responsive but confused. The hospital report indicated he was treated with Vimpat 200 mg via IV (intravenous), and no further seizure activity was noted. The record stated, "Spoke with facility, reports medication has not been picked up from the pharmacy emphasized importance of [Resident #3] getting his medications as

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prescribed ..." Resident #3's diagnoses were listed as seizures, and seizure disorder.

A phone interview was conducted on 12/28/23 at 1:20 pm with the facility Pharmacist #1. She indicated Resident #3's MAR documented the Vimpat ran out on 11/25/23 and on 12/05/23 he was sent to the ER for seizure activity. Pharmacist #1 stated that abruptly stopping the Vimpat for 10 days Resident #3 would have the potential for seizures. She stated the first attempted delivery the pharmacy driver hit a deer and could not deliver the Vimpat, the second attempt to deliver the driver could not find the facility and returned the Vimpat to the pharmacy.

The Administrator was notified of immediate jeopardy on 12/20/23 at 1:40 PM.

The facility provided the following immediate jeopardy removal plan:

1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance;

Resident #3 was identified as being affected by the noncompliance.
The facility failed to provide anti-seizure medication (Vimpat) ordered twice daily to Resident #3 from 11/25/23 through 12/5/23 resulting in 19 missed doses of the medication. Resident #3 experienced seizure activity on 12/4/23 and again on 12/5/23 the resident was transferred to the hospital and administered Vimpat in the ER on 12/5/23 and no further seizure activity was noted. Upon return to facility, he did not receive his morning dose and was not administered Vimpat again until 12/6/23 in the

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evening.

Resident #3's Vimpat was reordered on 12/4/23 and received on 12/6/23. All other medication orders were reviewed, and medications were available on 12/04/23 by the DON.

All other residents' medication orders were reviewed on 12/21/23 to ensure all medications were available and being administered as ordered. Any residents who had a medication with less than a week's supply available were reordered. This action was completed by the DON and MDS nurse.

2. 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.

" All full-time, part-time, prn, and agency licensed nurses and medication aides were educated by the DON on preventing medication errors included missed medications, the significant risks to residents and the consequences for not notifying the physician and DON of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure beginning 12/21/23. No licensed nurse or medication aide will work until education has been completed. Nurses are to contact the DON and physician via phone immediately when resident medication errors occur or are anticipated to occur for further instructions.

" All newly hired and agency staff (licensed nurses and medication aides) will be educated on preventing medication errors including missed

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medications, the significant risks to residents and the consequences for not notifying the physician of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure, accordingly in orientation prior to working the floor. The DON and Human resources will ensure education is complete prior to allowing staff to work the medication cart.
The regional nurse will conduct weekly meetings with the DON and Administrator to provide general oversight and monitoring of corrective actions.

Alleged date of immediate jeopardy removal: 12/22/23

Onsite validation of the immediate jeopardy removal plan was conducted on 12/28/23. The audit of medication orders and medication administration was verified as completed and any medications with less than a week's supply were reordered. Inservice records and interviews confirmed educated was completed as indicated and covered preventing medication errors included missed medications, the significant risks to residents and the consequences for not notifying the physician and DON of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure. The DON and the Human Resources Director verified this education is now included in orientation and they are responsible for ensuring the education is completed prior to working on the floor. The DON and Administrator are participating in weekly meetings with the regional nurse for general oversight and monitoring. The immediate jeopardy removal date of 12/22/23 was verified.

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F 835 SS=K	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, pharmacist and physician, the facility failed to provide effective leadership and oversight to ensure systems and processes were in place as evidenced by numerous deficient practices in multiple regulatory groupings resulting in immediate jeopardy and substandard quality of care. These high severity deficiencies were in the areas of physician notification, management of change in condition, safe transportation of residents, competent nursing staff, routine and emergency medication availability, accessibility and administration. Residents #1 and #2 were not transported in the van safely using transport chairs and fastening seat belts. Resident #3 did not receive his seizure medication as ordered and experienced seizure activity. These incidents had the high likelihood of serious harm, injury, or death. These deficient practices affected three of 46 residents residing in the facility and had a high likelihood of affecting other facility residents. Immediate jeopardy began on 11/1/23 when a lack of leadership and oversight in the area of safe transportation of Resident #1 resulted in the resident falling out of the chair during transport. The immediate jeopardy was removed on	F 835	F 835 1. How corrective action will be accomplished for resident(s) found to have been affected. Residents #1, #2, and #3 were identified as affected by the deficient practice. 2. All residents have the potential to be affected. 3. On 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator on oversight of facility transportation including educating and monitoring drivers, safety procedures, and following manufacturers recommendation for transporting residents. On 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator and Director of Nursing (DON) on oversight of nursing staff administering medications, pharmacy processes for reordering and accessing emergency medications, identifying resident's emergency needs, reporting events through chain of command, and notifying physicians. On 12/21/23 The Chief Director of Operations reviewed policies and educated the Administrator on the requirements of F835. This education	1/26/24

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F 835	Continued From page 65 12/23/23 when the facility provided an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity of E (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: This tag is cross-referenced to: a) F580: Based on record review and interviews with staff and physician, the facility failed to notify the physician of a medical emergency when Resident # 3 had seizure activity. Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. Emergency Medical Services (EMS) was contacted and the resident was transported to the Emergency Room (ER) where Vimpat (anti-seizure medication) was administered. The resident had no further seizure activity after receiving Vimpat and was discharged back to the facility the same day. This occurred for 1 of 3 residents (Resident #3) reviewed for notification of change. b) F684: Based on record review and interviews with staff, Emergency Medical Services (EMS) personnel, pharmacist, and physician, the facility failed to identify the seriousness of seizure activity on 12/4/23 and the need for medical intervention for a resident with a history of seizures who had not been provided with his anti-seizure medication (Vimpat) since 11/25/23. Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. Following the fourth seizure (12/5/23) the physician ordered Ativan (an antianxiety medication commonly used	F 835	included the expectations of oversight and completion of all education and staff monitoring. This education also includes the Administrator's responsibility to maintain safe transportation and provide quality care based on the facility's quality of care policy and daily monitoring to ensure adherence to required supervision. On 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator and DON regarding reviewing the 24- hour report daily and discussing issues that need addressed through proper morning meeting communication. Ensuring all members of the facility administration team are following through with their job duties in reference to resident care and safety. 4. Indicate how the facility plans to monitor its performance to make sure that the deficient practice does not reoccur. The Chief Operations Officer/Regional Nurse will conduct daily calls as well as weekly on-site meetings with the facility Administrator and DON to ensure compliance with all practice standards discussed and that plan of correction is being followed. The Administrator will discuss the audit results with the IDT during the monthly Quality Assurance Performance Improvement meeting for three months. The audits will be reviewed to ensure compliance is ongoing and will determine whether there is a need for further audits, re-education, or modification.	

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as a rescue medication for seizures) via intramuscular (IM) injection and the facility staff were unable to access the emergency Ativan medication supply to treat the resident in the facility. Emergency Medical Services (EMS) was contacted, and the resident was transported to the Emergency Room (ER) and Resident #3 experienced a fifth seizure upon arrival in the emergency room (ER). Intravenous (IV) Vimpat was administered in the ER and the resident had no further seizure activity and was discharged back to the facility the same day. This occurred for 1 of 2 residents whose condition required Emergency Medical Services.

c) F 689: Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, the facility failed to provide safe transportation in the facility's transportation van and to ensure wheelchairs were utilized during transportation in accordance with manufacturer's instructions for 2 of 4 residents reviewed for accidents (Resident #1 and Resident #2). On 11/1/23 Transportation Assistant #1 utilized a geriatric wheelchair (a reclining chair with wheels) to transport Resident #1 and during transportation the resident slid out of the chair onto the floor of the van. Resident #1 was not injured. On 11/27/23 Transportation Assistant #1 did not buckle Resident #2's seatbelt and during transportation the resident fell out of the wheelchair and onto the floor of the van. Resident #2 reported pain in her right shoulder the following day. These incidents had the high likelihood of serious harm, injury or death.

d) F 726: Based on observation, record reviews and interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, the

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facility failed to ensure Transportation Assistant #1, who was also a facility Nurse Aide, was trained by staff who was aware of the facility's transportation van's manufacturer's instructions for safe securement when Nurse Aide #1 provided her with training. Nurse Aide #1 was not aware that transporting a resident in a geriatric chair (a padded chair with a wheeled based) was not in accordance with the transportation van's manufacturer's instructions. In addition, the facility failed to verify Transportation Assistant #1's competency to ensure resident safety during transportation for 1 of 1 staff who transported residents in the facility's transportation van. On 11/1/23 Transportation Assistant #1 utilized a geriatric wheelchair (geri chair) to transport Resident #1 and during transportation the resident slid out of the chair onto the floor of the van. Resident #1 was not injured. On 11/27/23 Transportation Assistant #1 did not buckle Resident #2's seatbelt and during transportation the resident fell out of the wheelchair and onto the floor of the van. Resident #2 reported pain in her right shoulder the following day. This deficient practice had a high likelihood of resulting in serious harm, injury, or death to residents who were transported in the facility's transportation van.

e) F755: Based on record review and interviews with staff, pharmacist, and physician, the facility failed to obtain an anti-seizure medication for a resident with a history of seizures resulting in 22 missed doses of the medication and to have staff capable of accessing the emergency medication supply to treat a medical emergency. Resident #3 was ordered Vimpat two times a day for seizures and from 11/25/23 through 12/5/23 the resident did not receive the medication as it was not

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obtained from the pharmacy. Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. Following the fourth seizure (12/5/23) the physician ordered Ativan (an antianxiety medication commonly used as a rescue medication for seizures) via intramuscular (IM) injection and the facility staff were unable to access the emergency medication supply. EMS was contacted and the resident was transported to the Emergency Room (ER) where Vimpat was administered. The resident had no further seizure activity after receiving Vimpat and was discharged back to the facility the same day. Upon return from the ER the resident was not administered Vimpat until the evening dose on 12/6/23 as the medication had still not been obtained from the pharmacy. This deficient practice was for 1 of 1 resident reviewed for pharmaceutical services.

f) F760: Based on record review and interviews with staff, Emergency Medical Services (EMS) personnel, pharmacist, and physician interviews, the facility failed to administer an anticonvulsant medication to a resident for a period of 10 and half consecutive days and doses (11/25/23 through 12/5/23). Resident #3 had four incidents of seizure activity between 12/4/23 and 12/5/23. EMS was contacted on 12/5/23 and the resident was transported to the Emergency Room (ER) where Vimpat was administered. The resident had no further seizure activity after receiving Vimpat and was discharged back to the facility the same day. Upon return to the facility the resident missed one additional dose of the anticonvulsant on 12/6/23 for a total of 22 missed doses. This occurred for 1 of 1 resident (Resident #3) whose medications were reviewed.

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An interview was conducted on 12/20/23 at 12:55 pm with the Administrator. The Administrator reported that nurses should notify the facility pharmacist when they were out of medication and notify the physician so he could sign the prescription in a timely manner. The Administrator stated he was unaware that geri chairs were not to be used in facility transportation vans. He stated the Maintenance Director did not train Transportation Aide #1. He stated at the time of the issue with the availability of Resident #3's Vimpat they were in transition with a new pharmacy and the Director of Nursing (DON) was new. He stated most of the staff were from agencies and these agency staff failed to notify management the medication was not available. He indicated they had inconsistent communication with agency nurses.

An interview was conducted with the Chief Operations Officer (COO) on 12/28/23 at 1:00 PM. She stated she was working with the Administrator and DON to ensure effective systems are put in place. The COO stated she was working with the pharmacy to correct the procedure to ensure medications were delivered on time.

The Administrator was notified of immediate jeopardy on 12/20/23 at 1:40 PM.

The facility provided the following immediate jeopardy removal plan with a removal date of 12/23/23.

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

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The facility failed to provide effective leadership and oversight to ensure effective systems and processes were in place to manage change in condition, physician notification, to ensure routine and emergency medications were available, accessible, and administered as ordered, and ensure safe transportation of residents.
Residents #1 and #2 were not properly secured while being transported in the van causing them to slide from their chairs onto the floor. Resident #3 did not receive his seizure medication as ordered and facility failed to immediately notify the physician or seek emergency care for the resident when he had seizure activity.

Residents #1, #2, and #3 were identified as affected by the deficient practice.

All residents have the potential to be affected by the deficient practice.

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 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator on oversight of facility transportation including educating and monitoring drivers, safety procedures, and following manufacturers recommendation for transporting residents.

On 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator and Director of Nursing (DON) on oversight of nursing staff administering medications, pharmacy processes for reordering and accessing emergency medications, identifying resident's emergency needs, reporting events

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through chain of command, and notifying physicians.

On 12/21/23 The Chief Director of Operations reviewed policies and educated the Administrator on the requirements of F835. This education included the expectations of oversight and completion of all education and staff monitoring. This education also includes the Administrator's responsibility to maintain safe transportation and provide quality care based on the facility's quality of care policy and daily monitoring to ensure adherence to required supervision.

On 12/21/23 The Chief Operations Officer reviewed policies and educated the Administrator and DON regarding reviewing the 24- hour report daily and discussing issues that need addressed through proper morning meeting communication. Ensuring all members of the facility administration team are following through with their job duties in reference to resident care and safety.

The Chief Operations Officer will conduct daily calls as well as weekly on-site meetings with the facility Administrator and DON to ensure compliance with all practice standards discussed and that plan of correction is being followed.

Alleged date of immediate jeopardy removal: 12/23/23

Onsite validation of the immediate jeopardy removal plan was conducted on 12/28/23. Inservice records and interviews confirmed education was completed as indicated and covered preventing medication errors including missed medications, the significant risks to residents and the consequences for not notifying

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F 835	Continued From page 72 the physician and DON of medications not administered so further instructions can be given to reduce the risk to residents' health per facility policy and procedure. An observation was conducted of Transportation Assistant #2 securing a resident in the facility's transportation van according to manufacturer's recommendations. The DON and Administrator were participating in weekly meetings and daily calls with the Chief Operations Office for general oversight and monitoring to ensure the plan of correction is being followed. The immediate jeopardy removal date of 12/23/23 was verified.	F 835		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §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	F 867		1/26/24

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F 867	Continued From page 73	F 867		

will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

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

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

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

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 867	Continued From page 74 §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §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	F 867		

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F 867	Continued From page 75 program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility's Quality Assessment and Assurance 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 1/11/22. The deficiency is in the area of providing oversight and leadership to ensure and maintain effective systems and processes (F835). The continued failure during two federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assurance Program. Findings included: This tag is cross referenced to: F835: Based on observation, record review, interviews with residents, staff, dialysis center nurse, and Emergency Medical Services staff, pharmacist and physician, the facility failed to provide effective leadership and oversight to ensure systems and processes were in place as evidenced by numerous deficient practices in multiple regulatory groupings resulting in immediate jeopardy and substandard quality of care. These high severity deficiencies were in the areas of physician notification, management	F 867	F 867 The Administrator has been reeducated by the Regional Director of Clinical Services concerning the Quality Assurance and Performance Improvement(QAPI) Program. This was completed on 01/23/2024. The facility will hold monthly meeting, utilizing the company□s standard QAPI format to review plans for areas identified in state surveys, mock surveys, facility audits, regional team visits, grievances, and any other feedback given to the facility. The committee will evaluate the effectiveness of each plan based on the monitoring feedback and decide if there needs to be a continuation, change, or resolution of the plans. This will include incidents or accidents, change in conditions, pharmacy services and medication errors. The meeting minutes will be reviewed by the Regional Director of Clinical Services monthly X 3 months and will update or make changes as needed. The Administrator is responsible for this plan of correction.	

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of change in condition, safe transportation of residents, competent nursing staff, routine and emergency medication availability, accessibility and administration. Residents #1 and #2 were not transported in the van safely using transport chairs and fastening seat belts. Resident #3 did not receive his seizure medication as ordered and experienced seizure activity. These incidents had the high likelihood of serious harm, injury, or death. These deficient practices affected three of 46 residents residing in the facility and had a high likelihood of affecting other facility residents.

During the recertification and complaint investigation survey of 1/11/22 the facility was cited at F835 for failing to provide oversight and leadership to ensure the facility was free from abuse and to prevent and protect residents from physical abuse from another resident.

An interview with the Administrator was conducted on 12/28/23 at 1:37 PM. He reported the facility attempted to correct any on-going issues that were identified. The Administrator further stated the facility had some turnover in administrative staff which may have contributed to the repeat citation. He reported he came to the facility in May 2023. He further stated there had been turnover in the Director of Nursing position and the new Director of Nursing started 11/27/23. He added the facility was utilizing agency staff which may have also led to repeat citation. The Administrator reported that the facility's Quality Assessment and Assurance committee met monthly and they looked at trends to identify issues. He further stated employees were encouraged to discuss issues of concern.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345356	A. BUILDING: _____ B. WING _____	12/28/2023

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted

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

The above isolated deficiencies pose no actual harm to the residents

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 842	Continued From Page 1

by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to maintain a complete and accurate medical record that included a fall in the facility's transportation van for 1 of 4 residents (Resident #2) reviewed for accidents.

The findings included:

Resident #2 was admitted to the facility on 11/20/23.

A facility concern/comment report for Resident #2 dated 11/27/23 revealed a family member expressed a concern about an incident in the facility's transportation van. This form was not part of the medical record.

Review of Resident #2's medical record did not reveal any evidence of an incident that occurred in the facility's transportation van on 11/27/23.

During a phone interview with Transportation Assistant #1 on 12/19/23 at 12:30 PM she reported she was transporting Resident #2 and Resident #4 on 11/27/23 in the facility's transportation van. She reported someone pulled out in front of her and she came to an abrupt stop and Resident #2 slid forward out of her wheelchair onto the floor of the van onto her buttocks. She indicated she may have not buckled Resident #2's seatbelt.

An investigation report with an initiated date of 11/27/23 and completion date of 12/3/23 revealed Transportation Assistant #1 failed to properly secure the resident. The investigation was completed by the Administrator. The investigation report was not part of the medical record. The investigation report was maintained in the Administrator's office.

An interview was conducted with the Administrator on 12/19/23 at 12:22 PM who stated he was made aware of Resident #2 fell from her wheelchair in the facility's transportation van when the concern came in from Resident #2's family member on 11/27/23. He stated the incident was investigated and Transportation Assistant #1 was terminated from employment for not reporting the incident and failing to properly secure the resident. The Administrator indicated the incident should have been documented in the medical record.