STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345477	A. BUILDING _____ B. WING _____	C 01/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE OAKS AT SWEETEN CREEK	3864 SWEETEN CREEK ROAD ARDEN, NC 28704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted from 01/08/24 through 01/12/24. The survey team returned to the facility on 01/16/24 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 01/16/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event # E4QB11.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted from 01/08/24 through 01/12/24. The survey team returned to the facility on 01/16/24 to validate the credible allegation of IJ removal. Therefore, the exit date was changed to 1/16/24. Event ID # E4QB11. The following intakes were investigated: NC00204842, NC00208025, NC00208070, NC00208728, NC00208973, NC00211418, NC 00211610, NC00211627, NC 00211683, NC00211943, and NC00211982. 7 of the 39 allegations resulted in deficiencies. Immediate Jeopardy was identified at: CFR 483.12 at tag 607 at a scope and severity of K. CFR 483.25 at tag 689 at a scope and severity of K. CFR 483.70 at tag 835 at a scope and severity of K. The tags F607 and F689 constituted Substandard Quality of Care. Immediate Jeopardy for F689 and F835 began on 10/05/23 and was removed on 01/12/24.	F 000		

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

Electronically Signed | 02/06/2024

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F 000	Continued From page 1 Immediate Jeopardy for F607 began on 12/28/23 and was removed on 01/12/24. An extended survey was conducted.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		2/14/24

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F 578	Continued From page 2 with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with staff, Nurse Practitioner and Medical Director, the facility failed to have accurate advanced directive information documented throughout the medical record for 1 of 5 residents reviewed for code status (Resident #81). The findings included: A yellow Do Not Resuscitate (DNR) form dated 12/13/23 was noted in Resident #81's electronic health record. Resident #81 was admitted to the facility on 12/15/23. A pink Medical Orders for Scope of Treatment (MOST) form dated 12/17/23 was in Resident #81's electronic health record and in the MOST forms book at the nurses' station. This form indicated to attempt resuscitation when Resident #81 had no pulse and was not breathing. The form was signed by the Nurse Practitioner on 12/17/23 and by Resident #81 on 12/17/23. The Medical Director's History and Physical written on 12/21/23 indicated Resident #81's code status was Do Not Attempt Resuscitation (DNR/no Cardiopulmonary Resuscitation). The Medical Director wrote that Resident #81 had	F 578	F 578 Advanced Directives On 01/10/2024 resident #81 had a clarification order written for Do Not Resuscitate. On 01/10/2024 the Medical Order for Scope of Treatment and was placed in the medical record. Resident #81 discharged on 01/14/2024. On 1/15/2024 the Regional Minimum Data Set Nurse performed A Quality Improvement Monitoring of current resident□s code statuses. No issues identified. On 01/16/2024 through 02/14/2024 current Licensed Nurses were re-educated by the Director of Nursing and/or designee on obtaining code status orders and goldenrod with Medical Order for Scope of Treatment and to be placed in the medical record. Newly hired staff will be educated upon hire. Starting on 02/12/2024 the Social Services Director and/or designee to perform Quality Improvement Monitoring on code status 10 random residents three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months. The	

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F 578	Continued From page 3 confirmed Do not Resuscitate (DNR) and Do Not Intubate (DNI) status. The admission Minimum Data Set assessment dated 12/22/23 indicated Resident #81 was severely cognitively impaired. During an interview on 1/10/24 at 9:22 AM, Nurse #6 stated that if he found Resident #81 without pulse and respiration, he would send someone to check the resident's code status in the MOST form book located in the nurses' station. Since Resident #81's MOST form indicated to attempt to resuscitate, Nurse #6 stated he would call out a code and set up a code situation. The nurse would start chest compression and artificial respiration while another staff called for emergency services. Nurse #6 acknowledged the presence of the yellow DNR form dated 12/13/23 in Resident #81's electronic health record. He stated that he would follow the resuscitation orders on the MOST form dated 12/17/23 since the date was most recent. During an interview on 1/10/24 at 10:05 AM, the Nurse Practitioner (NP) reviewed Resident #81's code status in his electronic health record. She remembered talking to Resident #81 and completing the MOST form with him on 12/17/23. Resident #81 told the Nurse Practitioner he wanted to be resuscitated. The NP said she knew Resident #81 was a DNR when he first came in from the hospital. The NP reviewed the yellow DNR form dated 12/13/23, the MOST form she signed on 12/17/23, and the resident's History and Physical on 12/21/23 written by the Medical Director. She acknowledged the inconsistencies in the resident's advance directive and those documents. The NP stated she did not know	F 578	Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 02/12/2024. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Alleged Compliance is 02/14/2024	

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F 578	Continued From page 4	F 578		

where the miscommunication occurred, but she would talk to Resident #81 again and confirm his advance directive.

During an interview on 1/11/24 at 8:42 AM, the Medical Director stated Resident #81 had a yellow DNR form from the hospital and had a MOST form that indicated to attempt resuscitation in his electronic record. He stated he discussed and clarified with Resident #81 on 12/21/23 that he wanted DNR/DNI status. The Medical Director did not recall writing an order for a DNR for the nurse to carry out. He stated he talked to the nursing staff about the resident's DNR status. He could not recall who he talked to. He stated the nursing staff usually prepared the forms but then the resident already had the yellow DNR form in place.

During an interview on 1/11/24 at 12:30 PM, the Unit Manager stated if she received a DNR or full code order, she would take the MOST form and take it to the resident to sign. If the provider communicated to her that the resident had a change in their advance directive, the Unit Manager prepared the form and would have the resident or representative sign. The Unit Manager stated she could not recall if the Medical Director notified her of Resident #81's DNR status on 12/21/23.

During an interview on 1/11/24 at 10:35 AM, the Director of Nursing (DON) stated that the nursing staff determined the advance directive of new admissions by looking at the medical records sent from the hospital and by talking to the resident or their representative when they come in. The nurses called the providers and obtained orders for new admission's code status. The

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F 578	Continued From page 5 nurses transcribed the order and prepared or changed MOST forms. The nurses filled out the MOST form and/or the yellow DNR form and had the resident sign after their discussion. The nurses gave the form to the providers and the providers reviewed the form. She was not sure why the nurse did not change the MOST form on 12/21/23. The DON stated the advance directives were supposed to match in the residents' electronic health record, but nobody was checking on these forms. The DON stated they needed to do audits on the advance directives to prevent discrepancies. She acknowledged that if something happened to Resident #81 the staff would attempt resuscitation on this resident who opted for a DNR status. During an interview on 1/12/24 at 2:25 PM, the Administrator stated that he agreed that the documentation regarding residents' advance directive should be clear and consistent.	F 578		
F 607 SS=K	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the	F 607		2/14/24

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F 607	Continued From page 6 QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident and staff, the facility failed to follow their abuse policy for protection after Resident #52 reported on 12/28/23 that Nurse Aide (NA) #1 had been providing her with methamphetamine and syringes. The facility failed to suspend NA #1 and allowed her to work her scheduled shift on 12/28/23 from 7:00 PM to 7:00 AM on 12/29/23. This deficient practice had the high likelihood of serious adverse outcome for 10 residents with history of substance abuse which included Resident #52. Immediate jeopardy started on 12/28/23 when the facility failed to follow their abuse policy and protect all residents with a history of substance abuse including Resident #52 by not suspending NA #1 after Resident #52 alleged that NA #1 had been supplying her with methamphetamine and syringes at the facility. Immediate jeopardy was removed on 1/12/24 when the facility implemented an acceptable credible allegation on	F 607	F607 Develop/Implement Abuse/Neglect Policies The deficient practice involving Resident #52 was addressed during the IJ corrective process and the CNA in question was suspended on 12/29/2024 and employment terminated on 1/5/2024 due to noncompliance with the investigation. Current Residents with the potential to be affected will be interviewed by the Social Services Director/Designee, regarding all facets of the Abuse, Neglect, Exploitation and Misappropriation policy. Positive findings will be reported to the Executive Director or Director of Nursing to begin the reporting/investigation) allegedly involved will be suspended immediately pending the investigation.	

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F 607	Continued From page 7 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 is completed and monitoring systems put in place are effective. The findings included: Review of the facility's "Abuse, Neglect, Exploitation & Misappropriation Policies and Procedures" revised on 11/16/22 indicated under Protection: Any suspect(s), who is an employee or contract service provider, once he/she has (have) been identified, will be suspended pending the investigation. A review of the Facility-Reported Incident dated 12/28/23 indicated an original allegation regarding a staff member allegedly brought syringes and/or drugs to Resident #52 sometime on or before 12/28/23. An interview with Resident #52 on 1/8/23 at 10:09 AM revealed while she received a shower on 12/28/23, they went through her bags and found the methamphetamine and the syringes. She told NA #4 on 12/28/23 after she received her shower that NA #1 had been bringing her methamphetamine and syringes whenever she worked. Review of NA #1's time sheet for 12/28/23 indicated NA #1 clocked in at 7:26 PM on 12/28/23 and clocked out at 7:23 AM on 12/29/23. Multiple attempts were made to contact NA #1 during the investigation, but they were all	F 607	The Vice President of Clinical Operations provided education regarding policies for Abuse, Neglect, Exploitation and Misappropriation to the Executive Director, Director of Nursing and Nurse Managers on 01/11/2024. Included in the training on 01/11/2024 were the reporting and investigation rules pertaining to any abuse allegation. In addition, staff members have been educated on the abuse policy to ensure accurate and timely reporting. Education completed on 1/15/2024. All reported allegations of abuse, neglect, exploitation, and misappropriation will be reviewed by the Executive Director, DON and Social Services Director 3X per week for one month and then one time per week for two months. The Mock Survey team will interview 10 random residents each week to determine any possibility of the need for a reportable investigation for 12 weeks. Any interviews found to trigger reporting, will immediately be presented to the Executive Director, DON and Social Services Director for investigations/suspension/reporting. Any Reportable incidents will be reviewed by the QAPI team monthly both for content and accurate reporting time frame. In addition, the Quality monitors performed by the Mock Survey Team will be reviewed each month. The Executive Director is responsible for introducing the plan of corrections to the QAPI committee on 2/12/2024. The QAPI team will make recommendations based on the monitors.	

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F 607	Continued From page 8 unsuccessful. An interview with NA #4 on 1/11/24 at 9:01 AM revealed on 12/28/23, Resident #52 told her while she was getting her dressed that she had some needles, syringes and a vape in the pouch. Resident #52 later told her around 5:00 PM that she also had some methamphetamine in the pouch which were brought in to her by NA #1. NA #4 stated she reported this information to the Unit Manager. A written signed statement dated 12/29/23 by the Unit Manager (UM) revealed: Another nurse aide came to the DON's office and stated that Resident #52 told her, while getting her shower, that NA #1, the night shift nurse aide, had been supplying needles and methamphetamine to her when she was working. During an interview with the Unit Manager (UM) on 1/11/24 at 12:15 PM, she stated that Resident #52 told NA #4 after she gave her a shower on 12/28/23 that NA #1 had been bringing her methamphetamine. The UM indicated she learned about this information from Nurse #6. Nurse #6 told the UM that NA #4 did not want to report it directly to the UM because she was scared that she would get in trouble with Resident #52 if she learned that NA #4 was the one who reported it. After hearing about this information, the UM talked to NA #4 in the DON's office on 12/28/23 and confirmed this story from NA #4. Attempts were made to contact Nurse #6 but they were unsuccessful. An interview with the Director of Nursing (DON) on 1/12/24 at 1:13 PM revealed that she was	F 607	The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver. Date of alleged compliance: 2/14/2024	

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aware of Resident #52's allegation about NA #1 bringing her drugs on 12/28/23 but their only evidence at that time were the syringes with clear and red liquids. She stated that NA #1 should not have worked on the night of 12/28/23 and they should have suspended her that night. The DON remembered calling NA #1 on 12/29/23 to let her know that she was going to be suspended due to Resident #52's allegations.

An interview with the Administrator on 1/10/24 at 3:05 PM revealed that he believed the nurses and the nurse aides discovered the syringes in a bag when it fell over while she was getting a shower on 12/28/23. He and the DON talked to Resident #52, and she admitted to them that NA #1 gave her the syringes and the methamphetamine.

Review of a credible allegation of immediate jeopardy removal plan dated 1/11/24 revealed there were currently 10 residents with a history of substance abuse including Resident #52.

During a follow-up interview with the Administrator on 1/12/24 at 2:14 PM, he stated that NA #1 should not have worked on the night of 12/28/23 and they should have suspended her immediately when they became aware of Resident #52's allegation on 12/28/23.

The Administrator was notified of immediate jeopardy (IJ) on 1/10/24 at 4:16 PM.

The facility provided the following credible allegation of IJ removal.

* 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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Resident #52 has a history of drug abuse. On 12/28/23 a bag with approximately 10-20 insulin syringes, some with clear liquid and some with red liquid, was found in the Resident #52's room. Items were removed and placed in the Director of Nursing office. Resident #52 reported Nurse Aide #1 had been providing her with methamphetamine and syringes. The center failed to suspend Nursing Assistant #1 until 12/29/23 and Nursing Assistant #1 worked 7p-7a on 12/28/23. The center failed to provide protection to Resident #52 by not suspending Nurse Aide #1 on 12/28/23.

Current residents in the facility 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 1/11/24 the Vice President of Clinical Services provided education to the Executive Director, Director of Nursing and Nurse Manger about Abuse, Neglect, Exploitation and Misappropriation. Education included implementing effective systems or processes to protect residents with a history of substance abuse. The Vice President of Clinical Services also educated the Executive Director, Director of Nursing and Nurse Manger on the importance of immediate suspension of any suspect in an abuse allegation to ensure the protection of all residents until the investigation is completed.

Starting on 1/11/24 all current staff, including contract employees, will be educated by the

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F 607	Continued From page 11	F 607		

Director of Nursing, Assistant Director of Nursing and/or the Unit Managers on Abuse Policy including the immediate suspension of any suspect until the investigation is completed. Staff members not educated on 1/11/2024 will not work their next shift until their education has been provided.

On 1/11/24 the Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will track who has received and not received education daily by using the facility employee roster. The Director of Nursing, Assistant Director of Nursing and the Unit Managers have been notified of this responsibility.

On 1/12/24, the Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will continue to provide abuse education to all current employees including contract employees. Education will include the following: the immediate suspension of any suspect until the investigation is completed. Education will continue throughout the night shifts and weekend by Director of Nursing, Assistant Director of Nursing and/or the Unit Managers until current staff have been completed. This will include calling staff who are not on the schedule and are not scheduled to work. The Director of Nursing, Assistant Director of Nursing and the Unit Managers were notified of this responsibility on 1/11/2024.

Newly Hired staff will be educated during the Orientation process by the Director of Nursing going forward. The Director of Nursing was notified of this responsibility on 1/11/24.

The alleged date of IJ removal is 1/12/24.

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F 607	Continued From page 12 On 1/16/24, the facility's credible allegation of immediate jeopardy removal was validated by review of documentation regarding staff training on the systems and interventions to protect residents from abuse and the importance of immediate suspension of any suspect in an abuse allegation. Staff interviews revealed receipt of training regarding abuse including immediate suspension of any suspect until the investigation is completed. The facility's date of immediate jeopardy removal of 1/12/24 was validated.	F 607		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 656		2/14/24

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F 656	Continued From page 13 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record reviews, and staff interviews, the facility failed to develop and implement an individualized person-centered care plan that addressed substance use disorder for 1 of 3 sampled residents with a known history of substance abuse (Resident #52). The findings included: Resident #52 was admitted to the facility on 6/7/23 with diagnoses that included bipolar disorder, cervical intraspinal abscess due to history of intravenous drug use, and opioid dependence with other opioid-induced disorder.	F 656	F 656- Comprehensive Care Plans Resident #52 Care Plan was updated by the Regional Minimum Data Set Nurse on 1/11/2024 to accurately reflect resident's history of substance abuse. A quality review was conducted by the Regional Minimum Data Set nurse of current residents to ensure care plans accurately reflect a history of substance abuse on 1/15/2024 with corrections made as needed. 2/5/2024 to 2/9/2024, the Regional	

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F 656	Continued From page 14 The quarterly Minimum Data Set (MDS) assessment dated 12/15/23 indicated Resident #52 was cognitively intact and had no behaviors. The MDS further indicated Resident #52 received antipsychotic, antianxiety, antidepressant, opioid and antiplatelet medications. Resident #52's care plan last reviewed on 12/20/23 indicated Resident #52 had an ADL self-care performance deficit, hypotension (low blood pressure), was at risk for falls, had anemia, was on antipsychotic therapy, used anti-anxiety medications, used antidepressant, had nutritional problem or potential nutritional problem, was admitted with pressure ulcer to sacrum, had chronic pain, and had indwelling urinary catheter. Resident #52 also had a mood problem related to Resident #52 was young and far from her family. Interventions included to administer medications as ordered, monitor/document for side effects and effectiveness, and monitor/record/report to the doctor any acute episodes or feelings of sadness. Resident #52 did not have a care plan to address her history of substance use disorder. An interview with the MDS Nurse on 1/11/24 at 12:58 PM revealed Resident #52's care plan was last reviewed on 12/20/23 after she completed a quarterly MDS assessment for Resident #52. The MDS Nurse stated substance use disorder was not usually addressed in care plans unless there was an issue. The MDS Nurse stated she remembered the incident regarding Resident #52 back in October 2023 being brought up at the morning meeting, but she was the treatment nurse back then and not the MDS Nurse. She stated that Resident #52's care plan should have been revised and updated then to include	F 656	Minimum Data Set nurse provided re-education to the MDS Coordinator and Interdisciplinary Team to include Director of Nursing, Unit Manager and Social Worker, on developing and implementing an individualized care plan for any resident with a history of substance use disorder. Starting on 2/12/2024 the Director of Nursing and/or designee will conduct random Quality Reviews to ensure residents with a history of substance use disorder have an individualized care plan in place on 5 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Minimum Data Set Coordinator will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. AOC Date: 2/14/2024	

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F 656	Continued From page 15 interventions to address the issue regarding substance abuse. The MDS Nurse stated she had heard about staff finding syringes in Resident #52's room in December 2023 and she should have updated Resident #52's care plan. An interview with the Director of Nursing (DON) on 1/12/24 at 1:13 PM revealed Resident #52's care plan was focused more on her medical issues such as her sacral wound and her history of infection. The DON stated they did not normally address issues related to opioid dependence in the care plans, but these should have been addressed in Resident #52's care plan. The DON stated she was not aware of Resident #52 being found with syringes while she was at the hospital in September but when she was sent to the hospital due to possible drug use in October, her care plan should have been addressed when she came back and after she was found with drug paraphernalia in December.	F 656		
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: Based on record review, observations, and interviews with resident, staff, Nurse Practitioner, Medical Director and Police Officer, the facility failed to discuss with Resident #52 the presence	F 689	F 689 Accidents and Hazards The deficient practice involving Resident #52 was addressed during the IJ	2/14/24

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F 689	Continued From page 16 of many needles found in her possession at the hospital, monitor for illegal substances in her room and supervise Resident #52 for triggers of illegal substance abuse for a resident with a known history of substance abuse. Resident #52 was found with many needles in her room while in the hospital on 9/22/23. On 10/5/23, Resident #52 was sent to the hospital after a sudden onset of lethargy, low oxygen saturation and increased heart rate. Hospital staff documented suspicion of illicit drug use. Staff observed drug paraphernalia in her room including vape pens (a handheld device consisting of a battery attached to a cartridge filled with a concentrate), syringes (some used with old blood in the syringe and some with medication residual), medicine cups with medication residual, and flushes. The facility failed to notify law enforcement and obtain Resident #52's consent to search her room to remove any additional illegal drugs or drug paraphernalia. On 12/28/23, a bag with approximately 10-20 insulin syringes with clear and red liquid and another bag with lighters and a vape pen were found in Resident #52's room. Upon investigation on 12/29/23, a folded-up piece of paper with crystals was discovered in one of the bags. Police were notified and identified the crystals as methamphetamine. The facility failed to obtain consent to search Resident #52's room for any additional illegal drugs or drug paraphernalia. This was for 1 of 3 residents reviewed for supervision to prevent accidents. Immediate jeopardy started on 10/5/23 when Resident #52 had a change of condition and staff found drug paraphernalia in her room. Immediate jeopardy was removed on 1/12/24 when the facility implemented an acceptable credible allegation on immediate jeopardy removal. The	F 689	corrective process. Drug paraphernalia and suspicious substances have been removed from the resident's room. Resident #52 has consented to having the Social Worker/Designee present for opening packages and mail. Current and new admissions with identified drug abuse history will be asked to allow a room search periodically as well as upon suspicion and or visual observation of illicit substance or paraphernalia. Law Enforcement will be contacted for Residents who refuse the voluntary search. Any positive findings will be reported to the Executive Director or Director of Nursing. The Vice President of Clinical Operations provided education regarding maintaining an environment free of accidents, hazards, and supervision, to the Executive Director, Director of Nursing and Nurse Managers on 01/11/2024. Additionally noted in the training on 01/11/2024 included the Resident Rights for consented room search, as well as reporting noncompliance to Law Enforcement. In addition, staff members have been educated on 01/11/2024 by the DON/Designee on reporting observation of illicit substances/paraphernalia to the Executive Director/Designee to further provide a safe environment. New staff will be in-serviced during orientation by the DON/Designee. Any reported observations and/or suspicions will be investigated by the	

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F 689	Continued From page 17 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 is completed and monitoring systems put in place are effective. The findings included: Resident #52 was admitted to the facility on 6/7/23 with diagnoses that included quadriplegia (form of paralysis that affects all four limbs and torso), C1-C4 incomplete, respiratory failure with hypoxia (absence of enough oxygen in the tissues to sustain bodily functions), chronic osteomyelitis (bone infection), bipolar disorder, intraspinal abscess, anxiety disorder, chronic pain, opioid dependence with other opioid-induced disorder, obstructive hepatitis, and neuromuscular dysfunction of bladder. Resident #52's care plan initiated on 8/22/23 indicated Resident #52 had chronic pain. Interventions included to administer analgesia as per orders and to give a half hour before treatments or care, evaluate the effectiveness of pain interventions, monitor/document for side effects of pain medication and notify physician if interventions were unsuccessful or if current complaint was a significant change from resident's past experience of pain. Resident #52 did not have a care plan to address her history of substance use disorder. The hospital records for Resident #52's hospital stay from 9/15/23 through 9/28/23 indicated Resident #52 who had a history of intravenous drug abuse-related cervical spine infection was	F 689	Executive Director or Designee. The mock survey team are to observe resident rooms for illicit substances/paraphernalia during rounds 3X per week for one month and then one time per week for two months. Any questionable observations are to be considered an unsafe/hazardous environment and will immediately be presented to the Executive Director/Designee for investigation. Reportable incidents will be reviewed by the QAPI team monthly and the Safety Team quarterly. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The QAPI team will make recommendations based on the monitors. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver. Date of alleged compliance 2/14/2024.	

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transferred from the facility to the hospital on 9/15/23 due to worsening of a known pressure ulcer. She was noted to have purulent (containing or consisting of pus) drainage. She was on Hydromorphone for chronic pain due to her sacral wounds. The History & Physical dated 9/16/23 indicated she reported to the Emergency Department (ED) doctor that she had used alcohol and methamphetamine in the past with her last use approximately a year ago. A hospital physician note dated 9/22/23 indicated many needles and contraband were found in her room last night. Urine drug screen was not helpful as she had been getting opioids at the hospital although she tested positive for cannabis. She told the doctor that her last intravenous drug use was several months ago in her facility. The urine drug screen done on 9/22/23 indicated Resident #52 was positive for benzodiazepine, cannabinoid, opiate and tricyclic antidepressant. PICC (peripherally inserted central catheter) line was placed on 9/26/23 for intravenous antibiotics. Resident #52 was discharged back to the facility on 9/28/23 with an order for intravenous antibiotics every 6 hours.

The Nurse Practitioner's progress note dated 9/29/23 indicated under history of present illness: The hospital discharge summary reports contraband was found in Resident #52's room on the night of 9/22/23 but she stated that her last intravenous drug abuse was prior to coming to the facility. Left upper extremity had an occlusive superficial vein thrombosis (inflammation of the superficial vein) in the basilic and cephalic veins but no deep vein thrombosis. Plan included to continue (antibiotic medication) via PICC line every 6 hours scheduled until 11/2/23 and current pain regimen included Hydromorphone (opioid

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medication used to treat moderate to severe pain), Oxycodone (opioid medication used to treat moderate to severe pain), Pregabalin (nerve pain medication), Acetaminophen (analgesic used to treat mild to moderate pain) and Tizanidine (muscle relaxant).

An interview with the Nurse Practitioner (NP) on 1/12/24 at 9:02 AM revealed she did not remember asking Resident #52 about the contraband that was found while she was in the hospital in September. The NP stated she might have reviewed the hospital discharge summary after she had already seen Resident #52 and was doing her documentation at the end of the day. The NP stated she did not call the hospital to get more information regarding this incident about Resident #52. She also did not remember if she had talked to the nursing staff about Resident #52 having been found with contraband in the hospital.

An interview with the Director of Nursing (DON) on 1/12/24 at 9:42 AM revealed she did not know anything about Resident #52 having been found with contraband and testing positive for cannabinoid while she was at the hospital in September. The DON stated she started working as the DON in the middle of August 2023 but had to take a medical leave for two weeks and then worked a few hours from home and then a few hours at the facility afterwards in September 2023. The DON stated they had an interim Administrator at that time, but she did not find any investigation regarding this incident with Resident #52.

A review of Resident #52's Medication Administration Record for September 2023

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indicated she received the following medications:
* Hydromorphone 8 milligrams (mg) oral tablet 1 tablet by mouth every 8 hours scheduled for chronic pain
* Alprazolam 0.5 mg oral tablet 1 tablet by mouth every 8 hours as needed for anxiety
* Pregabalin 200 mg oral capsule 1 capsule by mouth three times a day for nerve pain
* Oxycodone 10 mg oral tablet 1 tablet by mouth every 6 hours as needed for pain
* Tizanidine 6 mg oral capsule 1 capsule by mouth three times a day and 2 mg 1 tablet by mouth every 8 hours as needed for muscle spasms

The quarterly Minimum Data Set (MDS) assessment dated 10/4/23 indicated Resident #52 was cognitively intact, had no behaviors and had range of motion impairment on both sides of the upper and lower extremities. She required set-up or clean-up assistance with eating and oral hygiene but was totally dependent on staff assistance with other activities of daily living. The MDS further indicated Resident #52 received scheduled and as needed pain medication regimen and complained of frequent pain at a level of 6 (moderately stronger pain). Frequent pain rarely or not at all affected Resident #52's sleep at night and rarely or not at all interfered with her day-to-day activities. Resident #52 had one stage 4 pressure ulcer present upon admission. She received antipsychotic, antianxiety, antidepressant, antibiotic, opioid and hypoglycemic medications. She also received intravenous medications and had an intravenous access while a resident at the facility.

The Nurse Practitioner's progress note dated 10/5/23 indicated Resident #52 was seen for

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concerns of hypovolemia. Recurrent fever of 102.0 (normal body temperature is around 98.6 degrees). The NP ordered intravenous fluids and laboratory studies this morning. Nursing reported Resident #52 had been non-compliant with the intravenous antibiotics and had skipped two doses. Upon initial assessment, she was awake and appropriate. Color pale but last hemoglobin was 8.5 (normal hemoglobin level for females is 12 to 16). Lips dry and urine dark. At that point, the NP was going to continue intravenous fluids and obtain blood cultures. Approximately two hours later, nursing requested reassessment. She was very pale, oxygen saturation 40s (normal level of oxygen is usually 95% or higher), lethargic, with heart rate 120-130s (normal resting heart rate for adults ranges from 60 to 100 beats per minute) and systolic blood pressure 80 (normal blood pressure for most adults is systolic pressure of less than 120 and a diastolic pressure of less than 80). She appeared to be intoxicated. 911 was called for transfer to the emergency room (ER). She was placed on non-rebreather with oxygen saturation up to the 90s. She was more alert and talking. She did receive Hydromorphone scheduled, Oxycodone for breakthrough, and Alprazolam 0.5 mg every 8 hours as needed. She had been given one (dose of Alprazolam) around 12 PM which was two hours prior. Found paraphernalia in her room including vape pens, cigarettes, syringes (some used with old blood in the syringe and some with medication residual), medicine cups with medication residual, and flushes. When questioned she denied using any of the supplies found in her room. She became very tearful. The NP called and discussed with her (family member). Plan included due to fever, tachycardia (fast heart rate) and hypoxia to send to ER for

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evaluation and treatment. Concerned for possible endocarditis (inflammation of the heart valve).

The hospital records for Resident #52's hospital stay from 10/5/23 through 10/25/23 indicated Resident #52 was sent to the ER on 10/5/23 for decreased responsiveness and hypoxia. Resident #52 appeared to be poor historian and was in severe distress with pain and crying during the encounter. She reported that the staff at the facility was not able to wake her up and she was very low on oxygen and was transferred to the hospital. Per ED report, Resident #52's oxygen saturation dropped down to 50% and she was put on 15 liters with a non-rebreather when (her oxygen saturation came up to) around 90%. The urine drug screen dated 10/5/23 indicated Resident #52 was positive for benzodiazepine, cannabinoid, opiate, oxycodone and tricyclic antidepressant. ED note also mentioned concern that Resident #52 might have been crushing up her pain medications and injecting them into her PICC line and possibly also having benzodiazepines snuck into the facility. Toxicology screen on admission was positive for benzodiazepines, cannabinoids, opiates, and tricyclics (although she was prescribed many of these medications chronically). The Infectious Disease (ID) Consultation note dated 10/6/23 indicated the ID doctor recorded that he thought Resident #52 was illicitly injecting/using drugs and this was likely what caused her hypoxia/unresponsiveness/current presentation/readmission rather than a new infection, although they had not ruled this out yet. (She could have a PICC-related bacteremia [presence of bacteria in the bloodstream] or fungemia [presence of fungi or yeasts in the

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blood] especially if she was using the line illicitly). The ID doctor was also concerned about the possibility of endocarditis given evidence suggesting pulmonary and splenic emboli (sudden blocking of an artery) and recent bacteremia with enterococcus and Klebsiella, but she had been on Ampicillin/Sulbactam covering both of these organisms so he doubted even if she had endocarditis that it would explain this readmission. She was nearly ready to discharge back to the facility on 10/16/23 when she had recurrent fever to 102.0 and she reported chills, so they requested ID to re-evaluate her to see if any changes were needed. At this point, she had completed four weeks of Ampicillin/Sulbactam and it seemed unlikely that (antibiotic) failure was the cause of her fevers, so ID stopped antibiotics in favor of monitoring fever curve/vitals. Resident #52 had a PICC line that was removed on 10/16/23 and a right-sided internal jugular central venous line was placed. She was transitioned to oral medications and was determined to be stable for discharge on 10/25/23.

An interview with Resident #52 on 1/10/24 at 1:08 PM revealed the syringes including the vape pens that were found in her room in October 2023 originally came in with her when she was first admitted to the facility. Resident #52 stated she did not feel comfortable answering more questions because she was trying to transfer to another facility which was closer to her family. She said that if she divulged more information, she felt that this might jeopardize her chances of moving to another facility.

An interview with Nurse #2 on 1/10/24 at 9:09 AM revealed she usually took care of Resident #52, but she did not work with Resident #52 on

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10/5/23 when she was found non-responsive. Nurse #2 stated that she heard Resident #52 was just checked by the Nurse Practitioner (NP), and she was fine initially. She also heard that they observed paraphernalia in her room including vape pens, cigarettes, syringes, medicine cups with medication residual, and flushes. She heard there was a box of insulin syringes. Nurse #2 stated she had asked Resident #52 later on whether she had used the syringes and she denied having used them. She also asked Resident #52 where she obtained the box of insulin syringes and she stated to her that she had brought them from home before she was admitted to the facility. Nurse #2 stated Resident #52 had no visitors because her family lived six hours away and she had no friends. Nurse #2 stated she could have only gotten the vape pens from staff. Nurse #2 further stated that she remembered Resident #52 having a dresser in her room that she kept locked up so that might have been where she was hiding the paraphernalia found in her room. Nurse #2 also shared that when Resident #52 came back to the facility from her hospitalization in October 2023, they started crushing her medications and putting them in applesauce to make sure that she swallowed her pills. Nurse #2 stated that they thought she might have been cheeking (pretending to swallow medications but actually hiding the pills in the part of the mouth between the gum and the cheek) her pills, crushing them later and then injecting them directly into her PICC line.

An interview with the Unit Manager (UM) on 1/8/24 at 3:27 PM revealed she was aware of Resident #52's history of drug use and remembered sometime in October 2023 when

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she was sick and was receiving intravenous antibiotics through a PICC line. The UM stated all of a sudden she became very lethargic and was not responding. The UM stated they found a box of insulin syringes in her room and then Resident #52 was sent to the hospital. While at the hospital, they ran a drug panel which showed positive for a bunch of substances but then she also received a lot of medications. They kept her at the hospital for a long time before she came back to the facility. Back in October 2023, Resident #52 denied having used any intravenous medications, but the staff speculated that she might have been crushing her oral pills and injecting them directly into her PICC line. The UM stated she remembered one of the ports in Resident #52's PICC line being clogged all the time. When Resident #52 came back to the facility, they started crushing all of her medications and placing them in applesauce to make sure she swallowed her pills.

During a follow-up interview with the UM on 1/11/24 at 12:15 PM, she stated that she remembered Resident #52 being non-responsive on 10/5/23 and she reported this to the NP and the Director of Nursing. The UM stated she remembered seeing at least three vape pens in addition to the box of insulin syringes at Resident #52's bedside. The UM stated they suspected Resident #52 of cheeking her oral pills, crushing them and then injecting them directly into her PICC line. After they removed everything they found at Resident #52's bedside, they discarded everything. She remembered trying to find out what kind of vape pens they were, but they thought one was for sure a weed pen. The police were not notified, and they did not come to the facility that day.

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An interview with the Nurse Practitioner (NP) on 1/10/24 at 9:24 AM revealed she had assessed Resident #52 on 10/5/23 and she was fine but two hours later, she was unresponsive. When she went into her room, they found all kinds of drug paraphernalia including vape pens, syringes, and medicine cups with medication residual. The NP stated there was blood in some of the syringes, so she suspected Resident #52 of not swallowing her pills, crushing them later and then injecting them directly into her skin and into her vein. The NP stated she did not see any marks on Resident #52's skin that day and when she asked her about the syringes in her room, she just cried and denied everything. The NP stated that she told Resident #52 on 10/5/23 that injecting drugs to herself could kill her. The NP also stated that she called Resident #52's family member that day but all she told her was that this was her history and that she had done this before. The NP stated she discussed with Resident #52's family member what actions to take but there was nothing they could do when there were no facilities that would take her. The NP stated that Resident #52 required a facility that offered drug rehabilitation as well as skilled nursing services and this facility was not ideal for her. She shared that when Resident #52 came back to the facility from the hospital in October 2023, she was switched to oral antibiotics, and they decided to crush all her medications. She also shared that Resident #52 was manipulative and tried to trick some of the nurses, so she gave them an order to crush all of her medications. While discussing the drug tests at the hospital, the NP stated that Resident #52 tested positive for cannabinoid which was probably from the vape pens which were found in her room. Her

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Oxycodone was changed to Hydromorphone while she was at the hospital because it was the medication that was controlling her pain the best. The NP shared she was also hesitant about prescribing Hydromorphone because it was ten times more potent than Oxycodone and was also not ideal with her history of drug abuse. The NP stated Resident #52 was ordering the syringes online.

An interview with the Social Worker (SW) on 1/10/24 at 8:74 AM revealed after Resident #52 was re-admitted to the facility from the hospital in October 2023, she knew that the nurses had started crushing up her medications whenever they gave them, and she was instructed to open any package together with Resident #52. The SW stated she had been doing this for the last few months and she made sure that there were no suspicious materials or drug paraphernalia such syringes or illegal drugs.

An interview with the Director of Nursing (DON) on 1/9/24 at 2:31 PM revealed Resident #52 always had make-up size bags and one fell out into the floor in October 2023. There were insulin syringes and saline flushes with no needles attached with white residue inside. Resident #52 never admitted to doing anything in October 2023, but they thought she had figured out a way to cheat with her medications. The DON stated they thought she was self-injecting her oral pain medications into her PICC line so when she came back to the facility, they started crushing all her medications. The DON also shared that Resident #52 had two different stories regarding how she obtained the insulin syringes: one was that she ordered them online and one was that she had brought them in to the facility when she was first

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admitted.

During a follow-up interview with the DON on 1/11/24 at 11:06 AM, she stated that they were more concerned about sending Resident #52 out to the hospital after she was found unresponsive on 10/5/23 and when she left, she thought she was no longer in danger. The DON stated she didn't know why they didn't call the police to search her room, but they didn't think there were drugs in the vape pens. She stated she thought the vapes were cigarette pens.

An interview with the Administrator on 1/10/24 at 3:05 PM revealed he didn't know anything about the incident on 10/5/23 when Resident #52 was unresponsive and was observed with paraphernalia in her room. The Administrator stated there was an interim Administrator at that time, but he hadn't seen any investigation into the incident.

A review of the Facility-Reported Incident dated 12/28/23 indicated an original allegation regarding a staff member allegedly brought syringes and/or drugs to Resident #52 sometime on or before 12/28/23. The accused individual's employment was terminated on 1/4/24 and the termination was related to the allegation. Summary of Facility Investigation: Discovery was made by day shift nurse of several used needles in Resident #52's room in a bag near her bed. The Unit Manager verified the same, confiscated the items and kept until police picked them up. Interviews with Resident #52 by the Social Worker, the Administrator and the Director of Nursing verified that Nurse Aide (NA) #1 was supplying Resident #52 with methamphetamine and syringes/needles. Interviews conducted with alert

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and oriented residents turned up with no further evidence. Skin checks with those residents who were not alert and oriented were completed with no further evidence.

The quarterly Minimum Data Set (MDS) assessment dated 12/15/23 indicated Resident #52 was cognitively intact, had no behaviors and had range of motion impairment on both sides of the upper and lower extremities. She required set-up or clean-up assistance with eating and oral hygiene but was totally dependent on staff assistance with other activities of daily living. The MDS further indicated Resident #52 received scheduled and as needed pain medication regimen and was in almost constant pain at a level of 10 (most severe pain). Frequent pain made it hard for Resident #52 to sleep at night and occasionally limited her day-to-day activities. Resident #52 had one stage 4 pressure ulcer present upon admission. She received antipsychotic, antianxiety, antidepressant, opioid and antiplatelet medications.

Resident #52's care plan last reviewed on 12/20/23 indicated Resident #52 had chronic pain. Interventions included to administer analgesia as per orders and to give a half hour before treatments or care, evaluate the effectiveness of pain interventions, monitor/document for side effects of pain medication and notify physician if interventions were unsuccessful or if current complaint was a significant change from resident's past experience of pain.

An interview with Resident #52 on 1/8/24 at 10:09 AM revealed she had been completely paralyzed but she was now able to move both arms and

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could lift her left leg a little. She stated she couldn't sit up on her own. Resident #52 stated NA #1 had been bringing her drugs whenever she worked on the night shift. She shared that this got started after she talked to NA #1 about how she ended up with her medical issues which was from doing intravenous drugs. Resident #52 stated that NA #1 mentioned to her that she did them as well, so they started talking about it and NA #1 offered to bring her some drugs. Resident #52 stated she was still in the beginning of her recovery phase of her drug addiction, and this was not something she should have been exposed to, but it was hard for her to say no. Resident #52 stated NA #1 was bringing methamphetamine to her for free but that this didn't help with her goal of trying to get closer to her family. Resident #52 shared that she didn't have a family member close by and they lived six hours away. The interview further revealed that Resident #52 received the methamphetamine in crystal form, dissolved it with water and "shoot" it with a syringe. Resident #52 stated she had been doing this for about two months a couple of times a day. Resident #52 denied having experienced any withdrawal symptoms after her drugs were removed from her room. She shared that the methamphetamine gave her more energy and that she was not using it often enough to make her experience withdrawal symptoms. Resident #52 explained that when she went to take a shower, the staff went through her bags and found the drugs, but nobody said anything to her right away. Resident #52 stated nobody talked to her for five days except for Nurse #2 who told her that she could get in trouble for it, and she could get arrested. They called her family member and told her that they were worried because the drugs came from an

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employee. Resident #52 denied having gone through any drug test or talking to the police about the drugs. Resident #52 explained that some of the liquid in the syringes were red due to blood, but the clear liquid was diluted methamphetamine in water.

A follow-up interview with Resident #52 on 1/10/24 at 1:08 PM revealed she didn't remember any of the nurses doing full head-to-toe skin assessments on her. Resident #52 stated that she was re-using the syringes that were discovered and that NA #1 was also supplying her those. Resident #52 shared that she injected the methamphetamine straight into whatever vein she could find on her hands and arms. They sometimes left a bump on her skin but no bruising. During the interview, Resident #52 was wearing long sleeves and kept both hands under her bed sheet. When she occasionally pulled out her hands from under her sheet, no marks were observed on her hands. Resident #52 added that she didn't really time the two doses of methamphetamine injection and she just did them whenever she wanted to. Resident #52 stated that her privacy screen was always pulled up around her bed because staff wanted her door open all the time. She reiterated that she never paid for the methamphetamine and that she didn't have enough money to pay for them. She also shared that the vape that was discovered recently was a vape that she kept with her when she went to the hospital back in October 2023 and she didn't need to refill the cartridge because she didn't use it that often.

Multiple attempts were made to contact NA #1 during the investigation, but they were all unsuccessful.

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A written signed statement dated 12/29/23 by Nurse #2 revealed: On 12/28/23, Resident #52 got up for her shower. Nurse #2 went to wipe Resident #52's bed down with bleach wipes, moved her red and black blanket and her cheetah print bag fell over on the bed. In the bag were needles (several), tissue with blood on them, vapes. Nurse #2 took bag to DON. Resident #52 was upset and crying. Nurse #2 informed Resident #52 that her bag was with the DON.

An interview with Nurse #2 on 1/8/24 at 11:59 AM revealed she was wiping Resident #52's bed and sanitizing it while she was getting a shower in the shower room on 12/28/23 when her bag fell over after she moved her blanket. The contents of the bag spilled onto Resident #52's bed and revealed some bloody tissues in the bag, and several insulin syringes. Nurse #2 stated she was not sure whether all the insulin syringes were used but some of them had red liquid, and some had a clear substance. Nurse #2 stated she didn't look at all the contents of the bag because Resident #52 had a bloodborne illness, and she didn't want to touch the used syringes without gloves. Nurse #2 stated they later discovered that there was a folded piece of paper in a perfect square and inside was crystal methamphetamine after the police officer identified it the next day. Nurse #2 stated she did not ask Resident #52 about the contents of her bag because she was already upset and crying. She later found out that Resident #52 said that NA #1 had been bringing the drugs to her for free, but she stated that she did not believe that she was getting them for free. Nurse #2 stated she brought Resident #52's bag to the DON's office and they kept it.

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A follow-up interview with Nurse #2 on 1/10/24 at 9:09 AM revealed she had been doing skin assessments on Resident #52 and did not notice any marks on Resident #52's arms and hands. Nurse #2 stated Resident #52's arms had always looked gray, and she did not notice anything unusual with her skin or her behavior.

An interview with NA #3 on 1/9/24 at 12:41 PM revealed she got Resident #52 up out of the bed because she was scheduled to receive a shower. NA #4 along with another nurse aide were assigned to do showers on 12/28/23. NA #3 helped Nurse #2 wipe Resident #52's bed when her cheetah print bag fell over on her bed and some of the needles/syringes fell out of the bed. NA #3 stated she didn't look much inside the bag but the syringes she saw had caps and she was unsure if they had been used. Nurse #2 took the bag to the DON's office. NA #3 stated that while Resident #52 was receiving a shower in the shower room, she must have known that they were going to discover her bag because she sent NA #4 to retrieve her bag, but they had already given it to the DON. When they put Resident #52 back into bed, she must have realized that her bag was gone because she started screaming and yelling about the bag. She kept crying and told them that she had some needles and vape in there. Resident #52 told her that "the nurse gave her the vape" but she didn't think that was right and she thought that Resident #52 was just making up that statement. Resident #52 also told her that she had brought in the syringes from when she was admitted to the facility.

An interview with NA #4 on 1/11/24 at 9:01 AM revealed while assisting Resident #52 with her shower on 12/28/23, she sent her back into her

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room to get her pouch from her bed. When she went into Resident #52's room, staff had already gotten her bag, so she went back to tell Resident #52 that she didn't see it. NA #4 stated after she put Resident #52 back into bed, she was crying and said that she was mad about the pouch being gone. Resident #52 told her while she was getting her dressed that she had some needles, syringes and a vape in the pouch. Resident #52 later told her around 5:00 PM that she also had some methamphetamine in the pouch which was brought in to her by NA #1. NA #4 stated she reported this information to the Unit Manager.

A written signed statement dated 12/29/23 by the Unit Manager (UM) revealed: On 12/28/23, NA #3 brought her two bags and stated while Resident #52 was getting a shower she was making up her bed and cleaning her room up when she noted these two bags on her bedside table. One bag was green and blue, and the other was leopard print. NA #3 told the UM to look in the bags. Upon observation, the UM noted several needles both used and full of clear or red substances. This was in the green and blue bag. In the leopard print bag, there were lighters and a "weed vape." The DON, the Administrator and the Social Worker were informed. Another nurse aide came to the DON's office and stated that Resident #52 told her, while getting her shower, that NA #1, the night shift nurse aide, had been supplying needles and methamphetamine to her when she was working.

An interview with the Unit Manager on 1/8/24 at 3:27 PM revealed NA #3 brought to her the two bags that were in Resident #52's room while she was in the shower room. The UM stated she remembered because NA #3 had asked for some

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bleach wipes to sanitize Resident #52's bed while she was in the shower. The UM looked inside the green and blue bag and saw some needles and syringes which some had clear liquid, and some had red liquid. In the leopard print bag were a vape and lighters. Both bags were placed in a plastic bag and locked up in the DON's office. The next day, a police officer came, and she went through the contents of the bags with the police officer. The police officer opened up a card case that was stuck on a pocket on one of the bags and inside was a folded piece of paper with crystals that looked like glass. The UM stated that the police officer identified the crystals as crystal methamphetamine. The UM stated the crystals looked like ice. The police officer confiscated the crystals and instructed them to dispose of the rest. The UM stated the police officer told them that it was up to the facility to do an internal investigation and to press charges if they wanted to and that he didn't ask for any other information. The UM stated she did not talk to Resident #52 about what was discovered inside her bags. The UM stated she later found out that Resident #52 reported to the Director of Nursing and the Administrator that NA #1 had been bringing her methamphetamine when she worked. The UM stated she didn't know whether Resident #52 paid for the drugs or not.

During a follow-up interview with the UM on 1/11/24 at 12:15 PM, she stated that Resident #52 told NA #4 after she gave her a shower that NA #1 had been bringing her methamphetamine. The UM learned about this information from another nurse to whom NA #4 had reported to. The nurse told the UM that NA #4 did not want to report it directly to the UM because she was scared that she would get in trouble with Resident

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#52 if she learned that NA #4 was the one who reported it. After hearing about this information, she talked to NA #4 in the DON's office on 12/28/23 and confirmed this story from NA #4. The UM remembered talking to the DON about this on 12/28/23. The UM shared that she took a picture on her phone of the piece of paper with crystals that were found inside and showed it. In the picture, there were at least 3 pieces of crystals which were approximately half-inches long and cloudy while the rest were small particles. The UM stated the Administrator asked her to take this picture which he sent to the police officer before he came to the facility.

A phone interview with NA #5 on 1/10/24 at 4:56 AM revealed she had taken care of Resident #52 on the day and evening shifts and had noticed a change in her alertness level. NA #5 stated Resident #52 was more back to her baseline lately wherein she would talk a lot and request for things. NA #5 stated about a couple of months ago, Resident #52 would sleep for days like three to four days in a row. She refused to be repositioned and did not want to be moved. She often missed her meals. She stayed wrapped up in bed, always complained of pain and often told her to leave her alone and not touch her. NA #5 stated she did not report this to anyone, and she did not know that she was supposed to report it.

A phone interview with NA #6 on 1/10/24 at 4:50 AM revealed Resident #52 slept most of the time on the night shift. NA #6 stated Resident #52 normally went to sleep between 11:00 PM and 12:00 AM and would sometimes ring her call light if she needed to be repositioned or if she needed something to drink, snacks or medications. NA #6 stated she did not notice anything different

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with Resident #52's behaviors.

A phone interview with NA #7 on 1/10/24 at 5:06 AM revealed Resident #52 slept all the time and didn't call much for help during the night shift. NA #7 stated he didn't notice any changes in Resident #52's behavior because she was always asleep at night.

A phone interview with NA #8 on 1/10/24 at 5:18 AM revealed she had taken care of Resident #52 as a medication aide and remembered her asking for her Hydromorphone a lot. She often asked for whatever medications she could get. NA #8 stated she had no idea that NA #1 was bringing in drugs to Resident #52, but she did notice NA #1 disappeared quite often whenever she worked with her. NA #8 stated this happened all the time.

An interview with Nurse #3 on 1/9/24 at 5:40 PM revealed she took care of Resident #52 on the night shift, and she slept 99% of the time and hardly asked for anything in the middle of the night. Nurse #3 stated she was shocked to hear that Resident #52 received drugs from NA #1 and had thought that she had quit doing drugs while she was at the facility. Nurse #3 stated she did not remember seeing any signs of any this going on in her shift.

An interview with the Nurse Practitioner (NP) on 1/10/24 at 9:24 AM revealed she was informed about the drug paraphernalia that was found in Resident #52's room on 12/28/23. The NP stated she saw Resident #52 on 12/29/23 for coughing and congestion but she did not ask her about the drugs because she would only "start squalling (crying)," but she probably should have questioned her. The NP stated she didn't indicate

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any of this in her note for 12/29/23 because she didn't know what to put in her note. The NP stated she talked to the Medical Director about this, and she should have ordered a drug test in hindsight but at that time, she assumed that it would just be positive. The NP stated she looked at Resident #52's visible skin during the visit on 12/29/23 and she did not recall seeing any marks on her skin. The NP stated Resident #52 could have died from overdose of everything she was getting including her own medications and the drugs that she was injecting into herself.

A typed-up statement dated 1/2/24 by the Social Worker (SW) indicated: The SW met with Resident #52 to talk about her wishes to transfer to a facility closer to (another) area. Resident #52 asked the SW if she was aware of what happened. The SW told her that she was aware of the situation. Resident #52 told the SW that it was her fault and that she just should have told NA #1 no. Resident #52 told the SW that she and NA #1 just started talking casually about how Resident #52 got into the situation that she was today regarding her health. Resident #52 shared that she was an addict and they talked more about her time using drugs. NA #1 offered to get her methamphetamine and Resident #52 agreed even though it was not her drug of choice. Resident #52 reported that she would get cash and then pay NA #1 for the drugs. NA #1 also provided her with the needles to inject the drugs.

An interview with the Social Worker (SW) on 1/10/24 at 8:47 AM revealed she talked to Resident #52 on 1/2/24 after she was told by the Administrator, the DON and the UM about what happened on 12/28/23. Resident #52 told her that she and NA #1 started talking about their

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history of drug abuse and NA #1 offered to get her drugs. Resident #52 told the SW that it wasn't her drug of choice, but she took it anyway. Resident #52 said to her multiple times that it was her fault, but the SW told her that she shouldn't have been placed in that position. Th SW stated Resident #52 didn't tell her how long she had been taking the drugs and she didn't ask her that question. She shared that Resident #52 wanted to move closer to her family and they had tried multiple times, but she kept getting denied from multiple facilities. The SW stated that it was unfortunate, but she had three things working against her: her history, her age, and her medical history. She further stated that Resident #52 indicated to her that she was somehow going to get cash, and this gave her the impression that she was paying NA #1 for the drugs and that they were not given to her for free. The SW stated that Resident #52 said to her that she was trying to figure out how to get cash.

During a follow-up interview with the SW on 1/10/24 at 10:58 AM, she stated that she went back to clarify with Resident #52, and she told her that NA #1 gave her the drugs for free. The SW further stated that Resident #52 told her she did not remember saying to her that she paid for the drugs. Resident #52 also told her that she obtained the insulin syringes from NA #1.

An interview with the Director of Nursing (DON) on 1/9/24 at 2:31 PM revealed the nurses brought Resident #52's open bag with insulin syringes to her when they gave her a shower on 12/28/23. The DON stated she should have counted them, but she estimated there were 10-20 syringes with needles attached. A couple of them had clear liquid and at least one had red liquid. Many

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syringes were empty and looked like they had been used. They didn't dig further into the bag until the next day on 12/29/23 when the Administrator found a piece of notebook paper stuck in a pocket in the bag and inside were substances that looked like rocks. Resident #52 confided to the SW on 1/2/24 that NA #1 had given her the drug and the syringes after they started talking as fellow addicts. She and the Administrator talked to her on 1/3/24 and Resident #52 said it was all her fault. The DON tried to get ahold of NA #1, but NA #1 texted her that she was out of town. NA #1 called her back and said she didn't do anything and that she was not coming to the facility for a drug test. The DON said she called NA #1 again so she could give them her statement and come in for a drug test and NA #1 told her that she couldn't because she had COVID-19. The DON further stated that they ended up terminating her for not participating in the investigation. The DON shared that Resident #52 had a history of medical issues which were brought on by drug abuse and she needed to be safe from that while she was at the facility. Resident #52 kept on telling her that she felt bad about the incident and that she should have just said no to NA #1. Resident #52 didn't tell her how long she had been taking the drugs. The DON shared that Resident #52 slept a lot, but this would not have triggered her to suspect drug abuse because she had a lot of medical issues. She also stated that the needles on the insulin syringes were tiny to leave a mark on Resident #52's skin. The DON explained that even though Resident #52 used the insulin syringes that were found in her bag to inject drugs directly into her skin, they would not always leave a mark because the needles were tiny.

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A typed-up and signed statement dated 1/3/24 by the Administrator indicated: The Administrator and the DON visited Resident #52 today about 11:20 AM and asked whether NA #1 had delivered the articles to her room (methamphetamine and needles/syringes). She stated yes. This verified what the SW had determined after interviewing Resident #52 on 1/2/24. They explained to Resident #52 that she needed to be on her best behavior in order for them to find her a new home closer to (another area). She was told not to indulge in any other illicit activity. She agreed to do this.

An interview with the Administrator on 1/10/24 at 3:05 PM revealed that he started collecting information on the evening of 12/28/23. The next day on 12/29/23, he discovered a rolled up piece of paper with what looked like methamphetamine. When police came, he looked at it and said he thought it was methamphetamine. The police officer took the substance that looked like methamphetamine. The Administrator stated he believed the nurses and the nurse aides discovered the syringes in a bag when it fell over while she was getting a shower on 12/28/23. He and the DON talked to Resident #52, and she admitted to them that NA #1 gave her the syringes and the methamphetamine. Resident #52 didn't seem to be altered in any way. NA #1 refused to cooperate with the investigation when they called her to come in for a drug test and this was grounds for termination, so they decided to go ahead and terminate her.

A phone interview with the Medical Director (MD) on 1/10/24 at 10:41 AM revealed he did not recall the incident related to Resident #52 being found with drug paraphernalia. He stated he must have

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been off during that time, but the NP must have told him about it. The MD stated he would have ordered a drug test on Resident #52 only if she was acting differently or experiencing unusual symptoms. The MD stated the methamphetamine in her system would make her blood pressure go up, and give her tachycardia. He said it would not make her sleepy unless she was coming off from it. Withdrawal from methamphetamine would cause tiredness. The MD stated he saw her last on 1/4/24 to check on her sacral pressure ulcer which was currently stable. Resident #52 didn't ask for more medications like she normally did. The MD explained that Resident #52's Oxycodone was switched to Hydromorphone because it was becoming more ineffective in controlling her pain.

During a follow-up phone interview on 1/10/24 at 11:12 AM, the MD stated that the adverse reactions were more severe if Resident #52 was shooting the methamphetamine directly into her veins. He stated that aside from the injection sites being infected, death could be possible from ventricular tachycardia or cardia arrhythmia (irregular heartbeat) brought on by the increase in heart rate and blood pressure.

A phone interview with the Police Officer on 1/12/24 at 10:43 PM revealed evidence was taken from the scene after they were notified of illegal drugs at the facility. The Police Officer stated they seized a small amount of methamphetamine, but they didn't need to test it. He stated they didn't need to do further investigation because it was a small amount. They closed the case, and no one was charged.

The Administrator was notified of immediate

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jeopardy (IJ) on 1/12/24 at 11:30 AM.

The facility provided the following IJ Removal Plan with the correction date of 1/12/24.

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

Resident #52 went to the hospital on 9/15/23. During the hospital stay illegal substances were removed from Resident #52. Upon returning to the facility on 9/28/23, the facility failed to implement effective interventions to prevent further illegal substance abuse. The facility failed to notify the police. The facility failed to search the resident room. On 10/5/23 Resident #52 was sent to hospital after a sudden onset of lethargy, low oxygen saturation and increased heart rate. Staff observed and removed insulin syringes, vape pens, and old medicine cups. Resident #52 returned to facility on 10/25/23. After Resident #52 returned to the center she gave the center Social Worker permission to open her mail together to ensure there were no syringes. The facility failed to search Resident #52's room to remove any additional illegal drugs or drug paraphernalia and notify law enforcement. The facility failed to identify any additional illegal drugs or drug paraphernalia. Facility failed to investigate and put protective and preventative measures into place. On 12/28/23 a bag with approximately 10-20 insulin syringes, some with clear liquid and some with red liquid, was found in the Resident's room. Items were removed and placed in the Director of Nursing office. On 12/29/23 upon investigation of the bag of items there was also a folded-up piece of paper with crystals in the bag. The police were notified, and the police stated the

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crystals appeared to be methamphetamine. It was removed from the center on 12/29/23 by the police but the police didn't interview or search the room. The facility failed to search the room for any additional illegal drugs or drug paraphernalia.

On 1/10/24 the Director of Nursing completed a review of current residents with a history of drug abuse. The audit revealed 10 residents with a history of drug abuse. The 10 residents in the facility have a potential to be affected by the deficient practice.
o 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

Starting on 1/02/24 mock survey room rounds were conducted on current residents while residents are present by the department managers to include observing residents' room for illegal substances and/or drug paraphernalia. These rounds are completed 3 days a week.

On 1/10/24 the Regional Director of Nursing and the Executive Director searched Resident #52's room with the resident present and with her permission for illegal drugs, medications not prescribed to her, and any other drug paraphernalia not allowed to be kept in her room.

On 1/10/24 the Director of Nursing completed a review of current residents with a history of drug abuse. The audit revealed 10 residents with a history of drug abuse. On 1/10/24 the Director of Nursing compiled a list of current residents residing in the facility with drug abuse. A review of the identified residents' plan of care was completed on 1/11/24 and updated to reflect their

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history of drug abuse. Interventions included the resident will avoid the use of illegal substances and the identified resident were notified of the care plan updates at this time.

On 1/10/24 the Vice President of Clinical Services provided education to the Executive Director and the Director of Nursing to notify law enforcement if the resident presented with illegal drugs, drug paraphernalia. If the resident has signs of being under the influence of any substance the Executive Director and/or the Director of Nursing will ask for permission to look in the room with the resident present and if illegal substances and/or drug paraphernalia are found, they are to notify law enforcement. If the resident refuses to the room search, then law enforcement will need to be notified.

Starting on 1/11/24 all current staff including contract employees will be educated by the Director of Nursing, Assistant Director of Nursing and/or the Unit Managers that residents are not to have illegal substances or any other drug paraphernalia. Staff are to notify the Executive Director and/or the Director of Nursing immediately. The contact information for the Executive Director and the Director of Nursing is placed at the nursing station. Staff members not educated on 1/11/24 will not work their next shift until their education has been provided.

On 1/11/24 the Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will track who has received and not received education daily by using the facility employee roster. The Director of Nursing, Assistant Director of Nursing and the Unit Managers have been notified of this responsibility.

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The Director of Nursing, Assistant Director of Nursing and/or the Unit Managers will continue to provide education to all current employees including contract employees that residents are not to have illegal substances to include drug paraphernalia. Staff are to notify the Executive Director and/or the Director of Nursing immediately. Contact information for the Executive Director and the Director of nursing is placed at the nursing station. Education will continue throughout the night shifts and weekend by Director of Nursing, Assistant Director of Nursing and/or the Unit Managers until current staff have been completed. This will include calling staff who are not on the schedule and are not scheduled to work. The Director of Nursing, Assistant Director of Nursing and the Unit Managers were notified of this responsibility 1/11/24.

Starting on 1/11/24 room rounds will be conducted by the department managers to include observing all residents' room for illegal substances and/or drug paraphernalia 3 times a week. If any illegal substances and/or drug paraphernalia are found the department manager will notify the Executive Director and/or the Director of Nursing immediately. The Executive Director and the Director of Nursing would notify law enforcement if the resident presented with illegal drugs or drug paraphernalia. If the resident has signs of being under the influence of any substance the Executive Director and/or the Director of Nursing will ask for permission to look in the room with the resident present and if illegal substances and/or drug paraphernalia are found, they are to notify law enforcement. If the resident refuses to the room search, then law enforcement

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F 689	Continued From page 47 will need to be notified. Newly Hired staff will be educated during the Orientation process by the Director of Nursing going forward. The Director of Nursing was notified of this responsibility 1/11/24. The alleged date of IJ removal is 1/12/24. On 1/16/24, the facility's credible allegation of immediate jeopardy removal was validated by review of documentation regarding staff training on the systems and interventions to prevent residents from having illegal substances or any other drug paraphernalia, and reporting to the Administrator and/or Director of Nursing immediately. Staff interviews revealed receipt of training related to observing for illegal substances and/or drug paraphernalia in resident rooms and watching for signs of being under the influence. The daily rounds conducted by the department managers to observe all residents' rooms for illegal substances were also reviewed and verified. The facility's date of immediate jeopardy removal of 1/12/24 was validated.	F 689		
F 740 SS=E	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and	F 740		2/14/24

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F 740	Continued From page 48	F 740		

mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.
This REQUIREMENT is not met as evidenced by:
Based on record review and interviews with staff, Nurse Practitioners and the Medical Director, the facility failed to have systems in place to prevent a delay in obtaining mental health services for 1 of 3 residents reviewed for behavioral and emotional status (Resident #19).

The findings included:

Resident #19's medical record contained a Preadmission Screening Resident Review (PASRR) Level II dated 8/23/23. The notification indicated that the resident's placement in a nursing facility was appropriate with a recommendation for resident to attend individual or group psychotherapy.

The hospital discharge summary dated 9/12/23 revealed Resident #19 was admitted to the hospital for suicidal ideation and urinary tract infection. She received antibiotics and was referred to a psychiatric provider. Psychiatry determined that Resident #19's suicidal thoughts/comments were due to grief about being lonely and not having anyone to care for her. Resident #19 also had diagnoses of bipolar disorder, depression, and anxiety with psychosis which were stable/controlled upon discharge to the facility. There were no recommendations for psychiatric services in the discharge summary.

Resident #19 was admitted to the facility on 9/12/23 with diagnoses of major depressive disorder, schizophrenia, anxiety disorder,

F 740 Behavior Health Services
On 01/8/2024 resident #19 had psychotherapy services provided.

On 2/5/2024-2/9/2024 the Social Services Director and Admissions Director performed A Quality Improvement Monitoring of current resident's Preadmission ¿Screening and Resident Review (PASRR) that require psychotherapy services. No issues identified. Residents assessed by the physician needing psychiatric services will be referred for psychiatric evaluation.

On 02/5/2024 the Admissions Director and Social Services Director were re-educated by the Regional Director of Nursing on referring residents to psych services if psychotherapy was indicated on the Preadmission ¿Screening and Resident Review (PASRR). From 2/5/2024 to 2/12/2024 current licensed nursing staff will be educated regarding referring residents with a psychiatric diagnosis and/or behaviors to receive a psychiatric evaluation.

Starting on 2/12/2024 the Executive Director and/or designee to perform Quality Improvement Monitoring on PASRR and residents with behaviors and/or psychiatric diagnosis for 10 random residents, three times a week for

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F 740	Continued From page 49 attention-deficit hyperactivity disorder, and psychosis. Admission orders dated 9/12/23 for Resident #19 included a standing order for psychiatric consult as needed. Resident #19's History and Physical on 9/14/23 written by the Medical Director revealed the resident was concerned about her amphetamine/dextroamphetamine medication. The Medical Director wrote that the resident needed psychiatric consultation. Further review of Resident #19's medical record revealed there was no physician order written separate order for a psychiatric consultation. Resident #19's quarterly Minimum Data Set (MDS) assessment on 12/20/23 revealed she was cognitively intact and had verbal behavioral symptoms directed towards others for 1 to 3 days during the assessment period. Resident #19 received antipsychotic, antianxiety and antidepressant medications. A review of Resident #19's medical record from 9/12/23 through 1/7/24 revealed no evidence of a psychiatric consult. Review of nursing progress notes from 9/12/23 through 1/7/24 revealed Resident #19 frequently exhibited behaviors such as yelling, making angry statements, repeatedly ringing for help, and demanding medications that were not due for administration. A Psychiatric Initial Evaluation dated 1/8/24 for Resident #19 indicated she was seen by the Psychiatric Nurse Practitioner for management of	F 740	four weeks, then two times a week for four weeks, and then one time monthly for three months. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Alleged Compliance is 2/14/2024	

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schizophrenia. She had a known history of schizophrenia, anxiety and depression. Resident #19 reported a long history of psychotic symptoms starting in early adulthood. She routinely experienced auditory disturbances that varied significantly in content/theme. Sometimes these were benign, but sometimes they instructed her to harm herself, or tell her cruel things. She also reported a lifelong inability to sit still, fidgeting, difficulty focusing on tasks requiring sustained mental effort, starting tasks before completing previous ones, trouble following conversation or lectures, and impulsivity. She had extrapyramidal symptoms (drug-induced movement disorders) readily observable in her jaw movements, essentially opening and closing often without lateral movement. She also had a waxing and waning tremor. Recommend to monitor for changes in mood or behaviors and continue the following medications: Fluoxetine, Diazepam, Amphetamine/Dextroamphetamine, and Olanzapine. Benztropine and Lamotrigine were started.

During an interview on 1/10/24 at 11:15 AM, the Admissions Coordinator stated she was the Social Worker when Resident #19 was admitted to the facility on 9/12/23. She stated Resident #19 should have been referred to the psychiatric provider because of her admitting diagnoses and the behaviors she displayed. She stated the nurses usually reviewed the orders and informed the psychiatric provider of any referrals. She did not know why the resident was not evaluated by the psychiatric provider.

During an interview on 1/10/24 at 11:30 AM, the Scheduler stated she was the Admissions Coordinator when Resident #19 was admitted to

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the facility. She stated that if the resident came in with a Level II PASRR, she would usually inform nursing and the Minimum Data Set (MDS) nurses during the morning meetings. She stated she could not recall if she notified them about Resident #19's psychiatric consult but was sure the resident's behaviors were discussed during the meeting. She stated there would be notes from the psychiatric provider if she was referred. During the interview, the Scheduler did not have access to Resident #19's electronic medical record and was unable to look up if there were any psychiatric notes.

During an interview on 1/11/24 at 12:30 PM, the Unit Manager stated if there were psychiatric consult orders, she would put them in the psychiatric provider book at the nurses' station. She stated the psychiatric Nurse Practitioner (NP) came to the facility once a week between 5:00 PM to 8:00 PM to check on residents and check the book for new orders. The Unit Manager stated she could not recall if Resident #19's psychiatric consult referral was put in that book. The Unit Manager stated the NP took the copies of the orders/referrals from the book, and she was unable to look them up. She could not recall if she received any verbal instruction from the medical providers to refer Resident #19 to the psychiatric Nurse Practitioner.

During an interview on 1/10/24 at 12:55 PM, Medical Nurse Practitioner (NP) #1 stated she made a psychiatric referral and Resident #19 had a standing order for psychology consult on 9/12/23 but believed there was no current psychotherapist who came to the facility. She stated that the psychiatric providers were currently in transition. During the interview,

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Medical NP #1 called psychiatric NP #2 to clarify. Psychiatric NP #2 told her that Resident #19 was on their list and had been seen by the new psychiatric provider on 1/8/24.

During a telephone interview on 1/10/24 at 12:57 PM, Psychiatric NP #2 stated she did not receive Resident #19's psychiatric referral until last week from the Director of Nursing during their meeting. Psychiatric NP #2 stated she did not evaluate the resident but believed she was evaluated by the new Psychiatric NP on 1/8/23. Psychiatric NP #2 stated she did not evaluate Resident #19 because they were currently transitioning to new psychiatric providers.

During a follow-up telephone interview on 1/12/24 at 10:32 AM, Psychiatric NP #2 revealed she tried to go to the facility once a week. She checked the psychiatric book in the nurses' station and checked with the Social Worker or the Director of Nursing if they needed her to check on a resident. NP #2 stated the medical providers would also reach out and inform her of any residents she needed to evaluate. She stated the psychiatric consult order for new admissions were written "as needed." She stated it was good to have that order in place in case a resident exhibited behavioral problems but could get confusing for staff. She stated she did not evaluate all residents who were admitted unless she was notified to check on a specific resident. She stated she could not recall seeing any referral for Resident # 19 in the book. She could not recall if she received any notification from the medical providers for Resident #19 to be evaluated. She was surprised Resident #19's psychiatric referral was missed. She stated Resident #19 needed the psychiatric evaluation because she had behaviors

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and was receiving psychiatric medications.

During a telephone interview on 1/12/24 at 1:37 PM, the Medical Director (MD) stated he determined after he saw her on 9/14/23 that Resident #19 needed psychiatric consultation because of her behaviors, medications and admitting diagnoses. He stated he usually contacted the psychiatric provider or wrote a referral if a resident needed a psychiatric evaluation. He stated he could not recall if he wrote a referral or if there was a conversation with nursing or the psychiatric provider regarding Resident #19. The MD stated he didn't think there was any negative outcome for Resident #19 due to the delay.

During an interview on 1/11/24 at 10:43 AM, the Director of Nursing (DON) stated she met with the new Psychiatric NP and Psychiatric NP #2 last week. They discussed the list of residents with psychiatric issues when they all became aware that Resident #19 was never evaluated by the previous psychiatric Nurse Practitioner. She stated Resident #19 was stable but needed psychiatric evaluation because of her diagnoses. The DON indicated Resident #19 should have been seen as soon as the psychiatric provider was available. She stated for some reason she thought Resident #19 had already been seen by the psychiatric provider and she said she was not sure why Psychiatric NP #2 missed it. The DON shared that when they had new admissions, they had batch orders which included a standing order for psychology consult as needed. The psychiatric providers had access to their electronic medical record and could see any newly admitted resident. She stated the nurses put any psychiatric referrals or concerns in the

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F 740	Continued From page 54 psychiatric book in the nurses' station. The DON stated the psychiatric providers should review all newly admitted residents whether they need to be seen because psychology consult was a standing order for all new admissions. The DON stated Resident #19 should have been seen by psychiatry especially because she had a PASRR level II, and this was part of the recommendations. During an interview on 1/12/24 at 2:25 PM, the Administrator stated the staff needed to ensure psychiatric consultations were completed, especially if residents needed it.	F 740		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 756		2/14/24

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F 756	Continued From page 55 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, Consultant Pharmacist, and Medical Director (MD), the Consultant Pharmacist failed to identify drug irregularities related to the use of as needed (PRN) psychotropic drug (drug that affects mental state) and provide recommendations for 1 of 5 residents reviewed for unnecessary medications (Residents #61). The findings included: Resident #61 was admitted to the facility on 08/30/23 with diagnoses including anxiety disorder. A physician's order dated 11/15/23 indicated 1 tablet of Ativan 0.5 milligram (mg) by mouth once every 8 hours as needed for agitation was ordered for Resident #61. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found	F 756	F756 Drug Regimen Review, Report and Act on Irregularities PRN Lorazepam order clarified to include 14 day stop date on 1/18/2024 for Resident #61 by Unit Manager. Starting on 1/18/2024 the Director of Nursing and/or nursing designee reviewed current resident PRN orders with emphasis on identifying PRN orders without a stop date. All issues corrected. This will be completed by 1/22/2024. On 1/18/2024 the Regional Director of Nursing re-educated the Director of Nursing and the Unit Managers on PRN psychotropic medications and ensuring stop dates are in place. On 2/5/2024, the	

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F 756	Continued From page 56 in Resident #61's medical records. A review of the medication administration record (MAR) revealed Resident #61 had received 4 doses of PRN Ativan in November, 8 doses in December 2023, and 1 dose in January 2024. A review of medical records revealed the Consultant Pharmacist had conducted medication regimen review (MRR) for Resident #61 on 11/16/23 and 12/12/23. He did not identify any drug irregularities or provide recommendations for the PRN Ativan order without a stop date. The quarterly Minimum Data Set (MDS) dated 12/06/23 assessed Resident #61 with severely impaired cognition and indicated she had received antianxiety in the 7-day assessment periods. During an interview conducted on 01/11/24 at 8:50 AM, the MD expected the prescribers to limit PRN psychotropic order to 14 days. If the order had to be extended, he expected the prescribers to document the rationale in the medication record and indicate the duration of therapy. It was his expectation for the Consultant Pharmacist to identify the drug irregularities and report the findings to the facility in a timely manner when performing the monthly MRR. During a phone interview conducted on 01/12/24 at 11:08 AM, the Consultant Pharmacist confirmed he had completed MRRs for Resident #61 on 11/16/23 and 12/12/23. He did not notice the drug irregularities related to the PRN Ativan order without a stop date and attributed the error to his oversight.	F 756	Director of Nursing and Unit Manager began educating the current licensed nursing staff, including those nurses on leave or vacation, and facility providers on PRN psychotropic medications and ensuring a stop date is in place. Education to be completed by 2/12/2024. Newly hired licensed nurses will receive this education upon hire or prior to their first assigned shift. On 2/5/24, the Executive Director and the Director of Nursing will educate the pharmacist on identifying and recommending changes to the physician with emphasis on stop dates for PRN psychotropic medications. Pharmacy consultant will review newly ordered PRN psychotropic medication monthly. The pharmacist will document the recommendations in the electronic record. Starting on 2/12/24 the Director of Nursing and/or nursing designee will complete a random audit on 10 resident orders 3 times a week for 4 weeks, then 1 time a week for 8 weeks to review PRN psychotropic orders and ensure a stop date is in place to avoid use of unnecessary psychotropic drugs. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/24. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services,	

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F 756	Continued From page 57 An interview was conducted with the Director of Nursing (DON) on 01/12/24 at 1:15 PM. She expected the Consultant Pharmacist to identify the drug irregularities and report the findings to the facility and provider in a timely manner. During an interview conducted on 01/12/24 at 2:05 PM, the Administrator stated it was his expectation for the Consultant Pharmacist to identify the drug irregularities and report it in a timely manner.	F 756	Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. AOC: 2/14/2024 Alleged compliance date is 2/14/2024	
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and	F 758		2/14/24

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F 758	Continued From page 58 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to ensure physician's orders for as needed (PRN) psychotropic drug (drug that affects mental state) was time limited in duration and provided rationales for therapy exceeding 14 days for 1 of 5 sampled residents reviewed for unnecessary medications (Residents #61). The findings included: Resident #61 was admitted to the facility on	F 758	F758 Drug Regimen is Free From unnecessary psychotropic Drugs PRN Lorazepam order clarified to include 14 day stop date on 1/18/2024 for Resident #61 by Unit Manager. Starting on 1/18/2024 the Director of Nursing and/or nursing designee reviewed current resident PRN orders with emphasis on identifying PRN orders	

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F 758	Continued From page 59 08/30/23 with diagnoses including anxiety disorder. A physician's order dated 11/15/23 indicated Resident #61 had an order to receive 1 tablet of Ativan 0.5 milligram (mg) by mouth once every 8 hours as needed for agitation. This active order did not have a stop date and the rationales for extended therapy beyond 14 days were not found in Resident #61's medical records. A review of the medication administration record (MAR) revealed Resident #61 had received 4 doses of PRN Ativan in November, 8 doses in December 2023, and 1 dose in January 2024 on the following dates: 11/15/23 - 1 dose 11/19/23 - 1 dose 11/24/23 - 2 doses 12/01/23 - 1 dose 12/02/23 - 2 doses 12/14/23 - 1 dose 12/25/23 - 1 dose 12/26/23 - 1 dose 12/29/23 - 1 dose 12/30/23 - 1 dose 01/08/24 - 1 dose The quarterly Minimum Data Set (MDS) dated 12/06/23 assessed Resident #61 with severely impaired cognition and indicated she had received antianxiety in the 7-day assessment periods. A review of Resident #61's psychotropic drug use care plan that was last revised on 12/13/23 revealed she was on antipsychotic therapy related to restlessness and agitation. The goal	F 758	without a stop date. All issues corrected. This will be completed by 1/22/2024. On 1/18/2024 the Regional Director of Nursing re-educated the Director of Nursing and the Unit Manager on PRN psychotropic medications and ensuring stop dates are in place. On 2/5/2024, the Director of Nursing and Unit Managers began educating the current licensed nursing staff, including those on leave or vacation, and facility providers on PRN psychotropic medications and ensuring a stop date is in place. Education to be completed by 2/12/2024. Newly hired licensed nurses will receive this education upon hire or prior to their first assigned shift. Starting on 2/12/24 the Director of Nursing and/or nursing designee will complete a random audit on 10 resident orders 3 times a week times 4 weeks, then 1 time a week times 8 weeks to review PRN psychotropic orders and ensure stop date is in place to avoid use of unnecessary psychotropic drugs. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/24. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director,	

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	345477	A. BUILDING _____ B. WING _____	C 01/16/2024

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F 758	Continued From page 60 was to remain free of antipsychotic drug related complications. Intervention included administering medications as ordered by the physician. On 01/08/24 at 12:26 PM an attempt to interview Resident #61 was unsuccessful. She was unable to engage in the interview. During an interview conducted on 01/11/24 at 8:50 AM, the MD expected the prescribers to limit PRN psychotropic order to 14 days. If the order had to be extended, he expected the prescribers to document the rationale in the medication record and indicate the duration of therapy. On 01/12/24 at 9:13 AM an interview was conducted with Medication Aide (MA) #1 who confirmed she had administered the PRN Ativan to Resident #61 on 11/24/23, 12/29/23, 12/30/23, and 01/08/24 due to combative behavior when receiving care. During a phone interview conducted on 01/12/24 at 11:08 AM, the Consultant Pharmacist stated PRN psychotropic medication was limited to 14 days unless the prescriber provided a justification in the medical records to extend the order beyond 14 days. An interview was conducted with the Director of Nursing (DON) on 01/12/24 at 1:15 PM. She expected all the prescribers in the facility to follow the Centers for Medicare & Medicaid Services (CMS) PRN psychotropic medication regulations. During an interview conducted on 01/12/24 at 2:05 PM, the Administrator stated it was his expectation for the all the providers to follow CMS PRN psychotropic medication regulations.	F 758	Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. The alleged date of compliance is 2/14/2024 AOC: 2/14/2024	

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F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the resident, staff, Consultant Pharmacist, and Medical Director (MD), the facility failed to prevent a significant medication error when nursing staff failed to follow physician's parameter as ordered during insulin and blood pressure medication administration. As a result, Resident #61 had received 6 doses of unnecessary Novolin insulin and 4 doses of blood pressure medication within 24 days. This affected 1 of 5 residents reviewed for unnecessary medications (Resident #61). The findings included: Resident #61 was admitted to the facility on 08/30/23 with diagnoses including diabetes mellitus (DM) and high blood pressure. A physician's order dated 11/11/23 indicated Resident #61 had an order to receive 1 tablet of metoprolol (blood pressure drug) 25 milligrams (mg) via percutaneous endoscopic gastrostomy (G tubes) 2 times daily for high blood pressure. The order set a parameter to hold the metoprolol if systolic blood pressure was less than 100 or pulse less than 60. On 12/18/23, Resident #61 received an order to start 8 units of Novolin insulin subcutaneously once every 6 hours for DM. The order set a parameter to hold the insulin when blood glucose level was less than 120 mg per deciliter (dl).	F 760	F760- Free of Significant Med Errors Resident #61 orders were reviewed on 1/12/2024 by the provider. New order to discontinue Novolin R noted on 1/12/2024 for resident #61. Additional directions regarding parameters adjusted for metoprolol order on 2/5/2024. Starting on 2/5/2024, the Director of Nursing and Unit Manager reviewed current resident orders for Insulin and Blood pressure medication with parameters to verify physician order is being followed. Any issues identified were corrected. This will be completed by 2/12/2024. Starting on 2/5/2024 to 2/12/2024, the Director of Nursing and Unit Manager began educating the licensed nursing staff , including the nurses on leave or vacation, on following physician orders to include parameters set by the physicians. Newly hired licensed nurses will receive this education upon hire. Education to be completed by 2/12/2024. Starting on 2/12/24, the Director of Nursing and/or Nursing Designee will complete a random audit on 10 residents 3 times a week times 4 weeks, then 1	2/14/24

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F 760	Continued From page 62 Review of Resident #61's blood pressure and blood sugar levels since November 2023 revealed they remained at the baseline and within the normal limits. The quarterly Minimum Data Set (MDS) dated 12/06/23 assessed Resident #61 with severely impaired cognition and indicated she had received insulin in the 7-day assessment periods. A review of Resident #61's care plan for DM initiated on 12/13/23 revealed she was diagnosed with DM with the goal to remain free of complications related to diabetes through the review date. Intervention included administering diabetic medications as ordered by the physician. A review of the medication administration records (MARs) revealed Resident #61 had received 4 doses of metoprolol since 12/16/23 and 6 doses of Novolin since 12/19/23 outside of the parameters on the following dates: Metoprolol: - 12/16/23 9:00 AM when blood pressure = 96/62 millimeters of mercury (mm Hg). - 01/03/24 9:00 AM when blood pressure = 96/60 mm Hg. - 01/03/24 5:00 PM when blood pressure = 99/64 mm Hg. - 01/09/24 5:00 PM when blood pressure = 93/50 mm Hg. Novolin insulin: - 12/19/23 12:00 noon when the blood sugar level was 94 mg/dl. - 12/23/23 6:00 PM when the blood sugar level was 115 mg/dl. - 12/24/23 6:00 PM when the blood sugar level	F 760	time a week times 8 weeks to ensure licensed nursing staff are following physician orders with parameters set by the physician order. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/24. The Executive Director is responsible for implementing this plan with any recommendations and/or changes reviewed in QAPI. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. AOC: 2/14/2024	

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F 760	Continued From page 63	F 760		

was 112 mg/dl.
- 12/31/23 12:00 midnight when the blood sugar level was 98 mg/dl.
- 01/02/24 12:00 noon when the blood sugar level was 115 mg/dl.
- 01/04/24 6:00 PM when the blood sugar level was 100 mg/dl.

On 01/08/24 at 12:26 PM an attempt to interview Resident #61 was unsuccessful. She was unable to engage in the interview.

During an interview conducted on 01/10/24 at 3:39 PM, the Unit Manager (UM) confirmed she worked on 12/23/23 and had administered 8 units of Novolin to Resident #61 that day. She did not know why she had failed to follow the parameter set forth for the Novolin order that day and acknowledged that it was an error.

An interview was conducted with the Director of Nursing (DON) on 01/10/24 at 4:10 PM. She stated she was covering a medication aide (MA) on 12/19/23 and had administered the Novolin outside of the parameter. She could not recall how the incident occurred but stated it was an oversight.

During an interview conducted on 01/10/24 at 5:38 PM, Nurse #3 confirmed she worked on 01/03/24 and had administered metoprolol to Resident #61 outside of the parameter. She explained the MA who measured the vital signs had forgotten to give her the blood pressure and pulse reports before the metoprolol administration, and she had forgotten to ask for it. She acknowledged that it was an error due to her oversight.

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F 760	Continued From page 64	F 760		

An interview was conducted with the MD on 01/11/24 at 8:50 AM. He expected nurses to follow the parameter with the orders all the time. He stated continuous failure of nursing staff to follow the parameters set forth for metoprolol and Novolin insulin could increase the risk of low blood pressure and/or low blood sugar.

During an interview conducted on 01/11/24 at 9:20 AM, Nurse #1 confirmed she had administered metoprolol to Resident #61 on 01/09/24 when the blood pressure was 93/50 mm Hg and the pulse was 93. She explained she had misinterpreted the parameters as she thought both the systolic blood pressure and pulse had to be below 100 mm Hg and 60 to hold the metoprolol. She confirmed she had administered Novolin to Resident #61 when her blood sugar levels were below 120 mg/dl on 12/24/23, 01/02/24, and 01/04/24. She could not recall how it happened and explained it could be caused by distractions during medication pass.

During a phone interview conducted on 01/12/24 at 11:08 AM, the Consultant Pharmacist confirmed he had completed MRRs for Resident #61 on 11/16/23 and 12/12/23. He was not aware of the above drug irregularities as all the above incidents occurred after the last MRR on 12/12/23.

An interview was conducted with DON on 01/12/24 at 1:15 PM. She expected nursing staff to follow the parameters set forth by the provider when administering medication.

During an interview conducted on 01/12/24 at 2:05 PM, the Administrator stated it was his expectation for nursing staff to follow physician's

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F 760	Continued From page 65 parameters when administering medication. He added failure to do so could result in adverse events or therapy failures.	F 760		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and record reviews, the facility failed to secure an opened tube of antifungal cream for 1 of 1 Resident (Resident #61) reviewed for medication storage, failed to record opening date for 3	F 761	F 761- Label/Storage of Drugs and Biologicals Antifungal cream removed from resident #61 room on 1/8/2024. Expired medication removed from medication	2/14/24

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F 761	Continued From page 66 opened insulin pens in 1 of 4 medication carts (500 Hall medication cart), and failed to remove expired over the counter (OTC) medications in accordance with the manufacturer's expiration date for 1 of 4 medication carts (500 Hall medication cart) and 1 of 1 medication room observed during medication storage checks (Main medication room). The findings included: a. During an observation conducted on 01/08/24 at 12:17 PM, an opened tube of antifungal cream containing approximately 100 grams of 2% miconazole nitrate was found left unattended on top of the over-bed table next to Resident #61's bed. Resident #61 was not in the room during the observation. An interview was conducted with Nurse #5 on 01/08/24 at 12:21 PM. She stated she had not been to Resident #61's room in the morning as she had administered her morning medications in the hallway. She denied leaving any medications unattended in Resident #61's room and did not know who had done it. During an interview attempted on 01/08/24 at 12:26 PM, Resident #61 was unable to provide any pertinent information related to the antifungal cream found in her room. An interview was conducted with the Wound Care Nurse on 01/08/24 at 12:28 PM. She stated she had not been to Resident #61's room this morning and denied she had left the antifungal cream unattended. She added the antifungal cream should be kept in the medication cart.	F 761	room on 1/11/2024. Unlabeled insulin and expired over-the-counter medication removed from 100/500 cart on 1/10/2024. A quality review was completed by the Director of Nursing and/or designee to ensure all medication in medication carts is labeled and dated, with emphasis on insulin and over-the-counter medication, and any expired medications removed on 2/5/2024. A quality review was completed by the Director of Nursing and/or designee to ensure medication room is free from expired medication on 2/5/2024. On 2/5/24 to 2/9/2024, the Director of Nursing and Unit Manager audited all resident rooms to identify any medication and/or creams at bedside. All abnormalities were corrected. On 2/5/2024, The Director of Nursing and/or Designee re-educated all Licensed Nursing Staff and Medication Aides, including those licensed nurses and medication aides on leave or vacation, on labeling and dating all medication in medication carts and all expired and/or unlabeled medication in medication carts and in medication room must be removed. Education will also include not leaving creams and/or medication in a resident room. Education to be completed by 2/12/2024. Starting on 2/12/2024 the Director of Nursing and/or designee will conduct random Quality Reviews on all medication carts and medication room for expired and/or un-labeled medications 3 times a	

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F 761	Continued From page 67 Review of Resident #61's medication administration records and treatment administration records revealed she did not have an order to receive the antifungal cream. b. A medication storage audit was conducted on 01/10/24 at 11:07 AM in the presence of Nurse #6. The following medications were found in 500 Hall medication cart and ready to be used: 1. 1 opened bottle of Vitamin E 10 milligrams (mg) containing 75 soft gels expired on 11/30/23. 2. 1 opened pen of insulin Lantus 100 unit per milliliter (ml) without an opening date. 3. 1 opened pen of insulin Glargine 100 unit/ml without an opening date. 4. 1 opened pen of insulin Lispro 100 unit/ml without an opening date. During an interview conducted on 01/20/24 at 11:09 AM, Nurse #6 explained the Vitamin E were rarely used by any resident recently. He confirmed the 3 undated insulin pens had been used and one of the pens was for a discharged resident. He did not use any of the 3 insulin pens in the morning and did not know how they had been left undated in the medication cart. c. A medication storage audit was conducted on 01/11/24 at 12:28 PM for the Main medication room in the presence of the Unit Manager (UM). The following expired medications were found and ready to be used: 1. 5 unopened bottles of Vitamin E 180 mg with 2 bottles expired on 09/20/23 and 3 bottles expired on 11/30/23. Each bottle contained 100 soft gels. 2. 4 unopened bottles of Vitamin B-1 100 mg	F 761	week for 8 weeks then weekly for 4 weeks. Executive Director and/or designee will conduct quality reviews on 10 Random resident rooms 3 times a week for 8 weeks then weekly for 4 weeks to ensure medication and/or creams are not stored at bedside. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Alleged Compliance Date is 2/14/2024 AOC Date: 2/14/2024	

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F 761	Continued From page 68 expired on 12/31/23. Each bottle contained 100 tablets. During an interview conducted on 01/11/24 at 12:36 PM, the UM acknowledged that the above medications had expired and needed to return to the pharmacy. She did not know any designated staff had been assigned to check the medication storage room for expired medication on a regular basis. An interview was conducted with the Director of Nursing (DON) on 01/12/24 at 1:15 PM. She stated nurses working on Sunday night were assigned to check the entire medication cart for expired medication and proper storage once a week. In addition, the Consultant Pharmacist would pick and check a few medication carts randomly during the monthly visit. All nursing staff were ordered to check the expiration date before administering medication. It was her expectation for nursing staff to date all the insulin pens when they were opened, and keep the facility free of expired and unattended medications. During an interview conducted on 01/12/24 at 2:05 PM, the Administrator expected nurses to date the insulin pen once it was opened and assign a designated person to check the medication storage room on a regular basis. It was his expectation for the facility to remain free of expired and unattended medications.	F 761		
F 791 SS=G	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care.	F 791		2/14/24

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F 791	Continued From page 69 §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.	F 791		

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F 791	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews the facility failed to obtain dental services when ordered by the medical provider for 1 of 1 resident reviewed for dental services (Resident #52). The findings included: Resident #52 was admitted on 6/8/23. with diagnosis that included quadriplegia. Resident #52's quarterly Minimal Data Set (MDS) dated 12/19/23 coded Resident #52 as cognitively intact and with no dental concerns. A review of a Nurse Practitioner (NP) progress note dated 7/14/23 read in part Resident #52 was seen for reports of dental pain and possible infected gum. The NP additionally wrote the resident had a cavity in the left lower molar and a referral to the inhouse dentist was made. The NP's plan of treatment included using a numbing gel to help numb the pain and clindamycin (antibiotic) 150 mg capsules 2 times daily for 5 days. A review of Resident #52's physician orders revealed an order dated 7/14/23. The order read to set up in-house dental referral for dental abscess/pain/cavities for 7 days. The 7/14/23 order was signed completed on 7/21/23. The previous Social Worker (SW) for the facility stated on 1/12/24 at 12:55 PM a referral to the in-house dentist was submitted for Resident #52 on 7/14/23. The SW recalled and confirmed the order on 7/14/23 and the Resident's insurance	F 791	F 791- Dental Services Resident #52 was seen by Aria Care Partners Dental Services on 12/20/2023. Follow up visit for resident #52 scheduled for 2/8/2024. The Director of Nursing, Minimum Data Set Nurse, and the Social Services director completed a quality review of current residents to ensure dental services provided for any identified dental issues on 1/16/2024 to 2/8/2024. The Regional Director of Nursing provided re-education to the Director of Nursing and Social Services Director on ensuring Dental Services provided for residents with identified dental issues in a timely manner on 1/18/2024. Policy PS-117 reviewed with Director of Nursing and Social Services Director. Director of Nursing and/or Designee will re-educate current licensed nursing staff, including those on leave or vacation, on ensuring that residents with identified dental issues are referred to the physician for dental services in a timely manner. Education to be completed by 2/12/2024. Starting on 2/12/2024 the Director of Nursing and/or designee will conduct random Quality Reviews on current residents to ensure residents with identified dental issues receive dental services in a timely manner on 10 random residents 3 times a week for 8 weeks then weekly for 4 weeks. The Director of	

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F 791	Continued From page 71 status. Resident #52's was on short term Medicaid at that time, and it did not cover an in-house dental visit. Resident #52's long term Medicaid insurance was approved on 10/1/23. The SW stated Resident #52's first in-house dental visit was on 12/20/23 and she was scheduled to have an extraction 1/22/24. The SW said Resident #52 should have been sent out to a dentist when the referral was made but was overlooked. A review of dental visits to the facility revealed the dentist was at the facility on 10/16/23, and 12/20/23. The dental hygienist visited the facility on 10/2/23, 11/9/23, and 11/20/23. Resident #52 was not seen by the dentist or dental hygienist until 12/20/23. Additional NP progress notes revealed Resident #52 was seen on 11/20/23 for reported tooth pain and for a follow up visit on 11/22/23 for reported tooth pain. The NP's assessment revealed the gum around the left bottom back molar was inflamed and edematous and the resident had trouble chewing. Resident # 2 was started on amoxicillin (antibiotic) 500 mg 3 times daily for 3 days and vicious lidocaine (numbing liquid) 2 times daily for 3 days (11/20/23). On 11/20/23 an order read to begin Amoxicillin 500 mg give 1 capsule by mouth 3 times a day for 3 days and viscous lidocaine 2% swish 10 mL 2 times daily for 3 days for dental abscess. The facility's current SW stated on 1/12/24 at 10:00 AM she started working at the facility in October 2023. The SW said she relied on the staff and the residents to let her know who needed to see the dentist. The SW was not	F 791	Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Managers, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months for review and recommendations to plan. Alleged date of compliance is 2/14/2024. AOC Date: 2/14/2024	

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aware Resident #52 needed to see the dentist until the referral made on 11/20/23 and Resident #52 was placed on the list to be seen when dental came back to the facility on 12/20/23. The SW stated Resident #52 was scheduled to have a tooth extracted on 1/22/24 by the in-house dentist.

A review of Resident #52's dental progress noted dated 12/20/23 revealed the resident was seen for a comprehensive oral exam. The Dentist note included the resident needed an extraction of a molar.

On 1/8/24 at 10:19 AM Resident #52 stated she had been waiting a couple months to get her tooth pulled. The resident stated she thought she was seen by a dentist a couple weeks ago and was supposed to come back and extract her tooth that had been bothering her. The resident did not report any difficulty or pain with eating or swallowing and the medicine she had taken for her tooth had helped, and she did not have pain.

The Nurse Practitioner (NP) stated on 1/12/24 at 9:38 AM a referral was made for Resident #52 to see the in-house dentist on 7/14/23. The NP said Resident #52 had pain in her tooth and gum from a cavity and it was treated with an antibiotic and numbing gel. The NP stated Resident #52 did not see a dentist after the referral on 7/14/23 and was not sure why the resident didn't see a dentist. The NP stated the Resident did not complain of any tooth pain after she was treated on 7/14/23 until she saw the resident 11/20/23 for complaints of tooth pain. Resident #52 had pain in the same tooth and was treated with antibiotics and numbing gel. Resident #52 was referred to see a dentist on 11/20/23 and was seen the following

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F 791	Continued From page 73 month by a dentist on 12/20/23. Resident #52 was scheduled for a tooth extraction on 1/22/24. The Director of Nursing (DON) stated on 1/12/24 at 1:16 PM she was unaware of the referral written on 7/14/23 to see a dentist for tooth pain. Resident #52 should have been sent out to a dentist when the referral was made, and all dental referrals needed to be reviewed and discussed. The Administrator stated on 1/12/24 at 2:07 PM the resident should have been sent out to see a dentist after the referral was made on 7/14/23.	F 791		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by:	F 809		2/14/24

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F 809	Continued From page 74 Based on observation, and resident and staff interviews, the facility failed to provide snacks for 7 out of 7 residents that requested bedtime snacks (Resident #67, #34, #65, #5, #10, #60, #74). The findings included: During a resident council meeting on 1/10/24 at 2:08 PM, the residents in attendance (Resident #67, #34, #65, #5, #10, #60, #74) all complained about not always receiving snacks at bedtime or whenever they requested some. Resident #60 stated she could ask for a snack whenever she needed them, but the dietary staff did not always remember to refill the snack room and there were not a lot of choices or variety in the snacks that they had. Resident #60 stated this concerned her especially at bedtime when she needed to eat a snack because she was a diabetic and they didn't have any snacks available in the nourishment room. Resident #34 voiced agreement and stated that this happened all the time. He added that the snack drawer was empty from the night before and the staff didn't have any snacks to give out to the residents. An observation on 1/10/24 at 2:30 PM with Nurse Aide (NA) #7 revealed the nourishment room on the 400 hall had 10 individual containers of yogurt, approximately 10 small cartons of milk and 20 cans of soda. In the drawer were 10 cookies, 10 peanut butter crackers and 5 graham crackers. An interview with NA #7 on 1/10/24 at 5:15 PM revealed that the nourishment room was full now, but it was empty yesterday (1/09/2024). NA #7 stated the staff ran out of snacks at least 1 day	F 809	F 809 On 01/10/2024 residents nourishment room was stocked with snacks. On 1/11/2024 the Dietary Manager performed a quality review of current resident□s snack preferences. Identified snack preferences will be provided in the residents nourishment room. On 01/12/2024 through 01/16/2024 current dietary aides were re-educated by the Dietary Manager on providing preferred snacks in the residents□ nourishment room. Newly hired staff will be educated upon hire. Starting on 02/1/2024 the Executive Director and/or designee to perform Quality Improvement Monitoring on snacks in the residents□ nourishment room three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months. The Executive Director introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 01/18/2024. The Executive Director is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one	

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F 809	Continued From page 75 every week. NA #7 stated she was unable to provide any snacks to the residents from the evening before. An interview with NA #3 on 1/10/24 at 5:13 PM revealed that the snacks in the nourishment room ran low every week. NA #3 stated that the staff could go to the kitchen to get a snack if they ran out, however once the kitchen staff left for the day no snacks were available. An interview was conducted at 10:46 AM with the Dietary District Manager, who was overseeing the kitchen, revealed that the nourishment room was stocked twice a day once in the morning and then in the evening around 7-8 PM before the kitchen staff left for the day. Some of the snacks they stocked for diabetic residents included diet soda, graham crackers and animal crackers. If the staff ran out of snacks in the evening there was a master key that they could use to get into the kitchen. The District Manager did not know where the key was kept. She said she just knew that the nurses had the key. The Dietary Manager was not aware the residents were running out of snacks. An interview with the Director of Nursing (DON) on 1/12/24 at 1:34 PM disclosed that the nourishment room should have snacks. The DON stated that the 300 hall medication cart had a key so staff could get into the kitchen to get snacks if they ran out after hours. The DON stated that she did not realize that some staff were not aware of the master key kept on the 300 hall medication cart. An interview with the Administrator on 1/12/24 at 2:24 PM revealed that he was aware that at times	F 809	direct care giver. The Executive Director will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. DATE OF ALLEGED COMPLIANCE IS 02/14/2024 Date of Alleged Compliance is 02/14/2024	

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F 809	Continued From page 76 the nourishment room ran out of snacks, and he had been working with the contracted company running the kitchen to ensure snacks were supplied to the nourishment room.	F 809		
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 record review, observation, and interviews with resident, staff, Nurse Practitioner, Medical Director and Police Officer, the facility failed to provide effective leadership and implement effective systems to manage and supervise a resident with a history of substance abuse after syringes were found in Resident #52's room and protect all residents after Resident #52 reported Nurse Aide #1 was providing her with methamphetamine and syringes. This failure had a high likelihood of affecting other facility residents. Immediate jeopardy started on 10/5/23 when after observing drug paraphernalia in Resident #52's room the facility's administrative team failed to identify the seriousness of the situation and put effective systems in place. Immediate jeopardy was removed on 1/12/24 when the facility implemented an acceptable credible allegation on 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	F 835	F 835 The deficient practice involving Resident #52 was addressed during the IJ plan of correction. The deficient practice involving other affected Residents was addressed in the IJ plan of correction. The Executive Director was provided education on 01/11/2024 from the Executive Vice President regarding the development of effective systems to protect Residents with a history of drug abuse; the need to contact law enforcement for suspicion or evidence of illegal substance use, as well as following the rules regarding timely abuse reporting, investigation and employee suspension as indicated. The Regional Director for Clinical Services educated the DON and Nurse Managers, and Market Leader on 01/11/2024 regarding the abuse policy	2/14/24

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F 835	Continued From page 77 minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective. The findings included: This tag is cross-referenced to: F607 - Based on record review and interviews with the resident and staff, the facility failed to follow their abuse policy for protection after Resident #52 reported on 12/28/23 that Nurse Aide (NA) #1 had been providing her with methamphetamine and syringes. The facility failed to suspend NA #1 and allowed her to work her scheduled shift on 12/28/23 from 7:00 PM to 7:00 AM on 12/29/23. There were a total of 10 residents with a history of substance abuse. This deficient practice affected 1 of 3 residents reviewed with a history of substance abuse. F689 - Based on record review, observations, and interviews with resident, staff, Nurse Practitioner, Medical Director and Police Officer, the facility failed to discuss with Resident #52 the presence of many needles found in her possession at the hospital, monitor for illegal substances in her room and supervise Resident #52 for triggers of illegal substance abuse for a resident with a known history of substance abuse. Resident #52 was found with many needles in her room while in the hospital on 9/22/23. On 10/5/23, Resident #52 was sent to the hospital after a sudden onset of lethargy, low oxygen saturation and increased heart rate. Hospital staff documented suspicion of illicit drug use. Staff observed drug paraphernalia in her room including vape pens (a handheld device consisting of a battery attached to a cartridge	F 835	requirement for timely reporting, investigation and employee suspension as indicated; education was also provided regarding protection of residents with history of substance abuse as well as contacting law enforcement for suspicion or evidence of illegal substance use. The education also included the Resident Right to consent/or not to a room search. In addition, staff members have been educated on 01/11/2024 by the DON/Designee on reporting observation of illicit substances/paraphernalia to the Executive Director/Designee to further provide a safe environment. New staff will be in-serviced during orientation by the DON/Designee. The Market Leader will review and provide oversight for the development of the effective systems weekly. The DON/Designee will provide the Market Leader and Executive Director with information regarding suspicious activity, abuse allegations as well as newly admitted Residents who have a history of substance abuse. The mock survey team are to observe resident rooms for illicit substances/paraphernalia during rounds 5X per week for one month and then one time per week for two months. In addition, the Mock Survey teams will inquire and report any abuse allegations immediately. Any questionable observations are to be considered an unsafe/hazardous environment and will immediately be	

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F 835	Continued From page 78 filled with a concentrate), syringes (some used with old blood in the syringe and some with medication residual), medicine cups with medication residual, and flushes. The facility failed to notify law enforcement and obtain Resident #52's consent to search her room to remove any additional illegal drugs or drug paraphernalia. On 12/28/23, a bag with approximately 10-20 insulin syringes with clear and red liquid and another bag with lighters and a vape pen were found in Resident #52's room. Upon investigation on 12/29/23, a folded-up piece of paper with crystals was discovered in one of the bags. Police were notified and identified the crystals as methamphetamine. The facility failed to obtain consent to search Resident #52's room for any additional illegal drugs or drug paraphernalia. This was for 1 of 3 residents reviewed for supervision to prevent accidents. An interview with the Administrator on 1/10/24 at 3:05 PM revealed when staff found the syringes in Resident #52's bag on 12/28/23, they did not know what were in the syringes and at that point, he did not suspect her of any drug abuse. He acknowledged that he waited another 12 hours before notifying the police, but this was after he discovered the folded-up piece of paper with crystals that was tucked in a pocket of the bag. The Administrator stated he wanted to be sure that there were illegal drugs before notifying the police. He stated that corporate staff advised him on the steps to take in reporting and monitoring regarding Resident #52 after she alleged that Nurse Aide (NA) #1 had been bringing her methamphetamine and syringes to the facility. He further stated that they instructed him on how to do a 4-point plan of correction. He added that once Nurse Aide #1 was terminated on 1/4/24 for	F 835	presented to the Executive Director/Designee for investigation. Reportable incidents will be reviewed by the QAPI team monthly and the Safety Team quarterly. The QAPI team will make recommendations based on the monitors. The Quality Assurance Performance Improvement Committee members consist of but not limited to Executive Director, Director of Nursing, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and one direct care giver. DATE OF ALLEGED COMPLIANCE IS 02/14/2024. Date of alleged compliance : 02/14/2024	

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not cooperating with the investigation, he didn't see anything else happening to Resident #52. He started talking about having done an ad hoc QAPI (Quality Assurance and Performance Improvement) meeting related to this incident but after he looked at his QAPI folder, he realized that there wasn't one done. The Administrator stated the administrative staff started monitoring Resident #52's room daily through rounds and looking for any obvious signs of illegal drugs in the room. The nurses also monitored Resident #52 for changes in behavior. They also did in-services to all staff regarding abuse and their abuse policy. The Administrator added that after he talked to Resident #52, she promised him that she would not engage in illicit drug use anymore while she was at the facility.

The Administrator was notified of immediate jeopardy (IJ) on 1/11/24 at 1:37 PM.

The facility provided the following credible allegation IJ Removal.

* 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 provide leadership and effective systems related to a resident with a history of drug abuse not being protected from illegal substances.
The facility failed to provide leadership and effective systems related to the protection of all residents after an abuse allegation was made.

* 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

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when the action will be complete.

The Regional Vice President of Operations (RVPO) educated the Executive Director (ED) on 1/11/24 in regard to implementing effective systems or processes to protect residents with a history of substance abuse. The RVPO also educated the ED on the importance of immediate suspension of any suspect in an abuse allegation to ensure the protection of all residents until the investigation is completed. The Regional Director of Clinical Services and the Vice President of Clinical Services provided education to the Director of Nursing and Nurse Mangers on the Abuse Policy including the immediate suspension of any suspect until the investigation is completed. The Nurse Managers educated the Department Heads of this process. The ED understands that law enforcement is to be notified at the time of the identification of any suspicion or evidence of any illegal substance abuse. During the facility stand up and stand down meeting residents' with a history of substance abuse will be discussed and reviewed for any signs of substance abuse. The Director of Nursing/Nurse Manager will report to the Executive Director daily during stand up/stand down meetings if any residents have exhibited signs of substance abuse. Upon any receipt of an allegation of abuse, the ED will notify both the RVPO and the Regional Director of Clinical Services (RDCS). Upon notification, the RVPO and/or RDCS will provide additional guidance as needed related to any investigation. The RDCS will provide additional oversight to the center leadership team on implementation of policies to ensure the center has effective systems. As stated in the Employee Handbook, possession of illegal drugs on company property is a Level 2 violation and is

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F 835	Continued From page 81 grounds for immediate termination. The alleged date of IJ removal is 1/12/24. On 1/12/24, the facility's credible allegation of immediate jeopardy removal was validated by an interview with the Administrator. He stated that he received education by the Regional Vice President of Operations regarding processes related to substance abuse which included immediately suspending any suspect and calling the police if they suspected any resident with drug abuse. As the abuse coordinator, he was responsible for conducting the investigation and doing interviews with residents and staff. The facility's date of immediate jeopardy removal of 1/12/24 was validated.	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.	F 867		2/14/24

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F 867	Continued From page 82 §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §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	F 867		

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safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, 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.

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F 867	Continued From page 84 §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the recertification survey conducted on 06/24/22 and the complaint investigation survey conducted on 05/03/23. This was for a repeat deficiency in the area of accident hazards/supervision/devices that was originally cited on 06/24/22 during the recertification survey, and subsequently recited during the complaint investigation survey completed on 05/03/23, and recertification survey completed on 01/16/24. The continued failure of the facility during three federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to:	F 867	F867 - QAPI/QAA Improvement Activities The Executive Director held a Quality Assurance Performance Improvement meeting on 1/15/2024 with the Interdisciplinary Team including the Director of Clinical Services, Social Services, Admissions Director, MDS Coordinator, Regional Director of Clinical Services, Medical Records Director, Human Resources Coordinator, and Director of Rehab focusing on the areas of F689 Accidents and Hazards related to failure to provide supervision to prevent accidents and hazards. The facility Quality Assurance Performance Improvement Committee reviewed the new plan of correction for maintaining compliance in this area. During the Quality Assurance Performance Improvement on 1/15/2024 the Regional Director of Clinical Services along with the Executive Director	

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F 867	Continued From page 85 F 689 - Based on record review, observations, and interviews with resident, staff, Nurse Practitioner, Medical Director and Police Officer, the facility failed to discuss with Resident #52 the presence of many needles found in her possession at the hospital, monitor for illegal substances in her room and supervise Resident #52 for triggers of illegal substance abuse for a resident with a known history of substance abuse. Resident #52 was found with many needles in her room while in the hospital on 09/22/23. On 10/05/23, Resident #52 was sent to the hospital after a sudden onset of lethargy, low oxygen saturation and increased heart rate. Hospital staff documented suspicion of illicit drug use. Staff observed drug paraphernalia in her room including vape pens (a handheld device consisting of a battery attached to a cartridge filled with a concentrate), syringes (some used with old blood in the syringe and some with medication residual), medicine cups with medication residual, and flushes. The facility failed to notify law enforcement and obtain Resident #52's consent to search her room to remove any additional illegal drugs or drug paraphernalia. On 12/28/23, a bag with approximately 10-20 insulin syringes with clear and red liquid and another bag with lighters and a vape pen were found in Resident #52's room. Upon investigation on 12/29/23, a folded-up piece of paper with crystals was discovered in one of the bags. Police were notified and identified the crystals as methamphetamine. The facility failed to obtain consent to search Resident #52's room for any additional illegal drugs or drug paraphernalia. This was for 1 of 3 residents reviewed for supervision to prevent accidents. During the recertification and complaint survey on	F 867	re-educated the attendees on the Quality Assurance process to include identifying, correcting, and monitoring of identified deficiencies to ensure compliance and quality are maintained. Beginning 2/12/2024, the Quality Assurance Performance Improvement Committee will continue to meet on at least a monthly basis identifying new concerns as well as reviewing past identified concerns with updated interventions as required. The Executive Director, Market Leader, and/or the Regional Director of Clinical Services will attend the Quality Assurance Performance Improvement meeting for 3 months for validation. Opportunities will be corrected as identified by the Executive Director. The results of these reviews will be submitted to the QAPI Committee by the Executive Director for review by IDT members each month for 6 months. The QAPI Committee will evaluate the effectiveness and amend as needed. Date of alleged compliance is 2/14/2024	

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06/24/22, the facility failed to prevent a fall during a transfer with a mechanical lift which resulted in the resident bumping his head and right hand on the floor for 1 of 4 residents reviewed for supervision to prevent accidents.

During the complaint survey on 05/03/23, the facility failed to safely transfer a resident from the bed to the wheelchair when one staff member used a mechanical lift resulting in the resident falling to the floor for 1 of 4 sampled residents reviewed for accidents. On 04/09/23, a Resident fell out of the sling attached to the mechanical lift landing on the floor on his back, hitting his head, sustaining an abrasion to the left elbow, and experiencing increased pain. Resident was transported to the hospital for evaluation, diagnosed with an age-indeterminate (unable to determine if new or old) right L2 (second lumbar spinal vertebrae) transverse process fracture (bony projection on either side of the bones that make up the spinal column) and returned to the facility on 04/10/23. As a result, Resident #1 voiced feeling "fearful" of falling whenever staff transferred him using a mechanical lift.

During an interview conducted with the Administrator on 01/12/24 at 3:01 PM, he stated the facility conducted QAA meeting at least once monthly to discuss area of previously and/or newly identified concerns in the facility. It also included deficiencies from the surveys. The areas of concern were tracked from month to month for progression toward the goals. The Administrator attributed the failure of facility during the recent federal surveys to extensive dependency of agency nursing staff and frequent turnover of both nursing and administrative staff in the recent months. He stated the facility was currently under

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F 867	Continued From page 87 a transitional and rebuilding phase that needed more cohesion among nursing and administrative staff to ensure success. He added he had been screening applicants personally during the hiring process to ensure the most qualified and dedicated candidates would be chosen.	F 867		
F 949 SS=E	Behavioral Health Training CFR(s): 483.95(i) §483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide behavioral health training that included the competencies and skills necessary to provide care for residents with substance use disorder for 9 of 9 nursing staff (Nurse Aide #3, Nurse Aide #6, Nurse Aide #5, Nurse Aide #7, Nurse Aide #9, Nurse Aide #10, Nurse Aide #8, Nurse #3 and Unit Manager) reviewed for education requirements. The findings included: Education records from 2/1/23 to 12/12/23 provided by the Administrator were reviewed for the following nursing staff: Nurse Aide (NA) #3: There was no behavioral health training recorded on the education records. NA #6: There was no behavioral health training recorded on the education records. NA #5: There was no behavioral health training recorded on the education records. NA #7: There was no behavioral health training	F 949	F 949 Behavioral Health On 2/5/2024 to 2/12/2024, Nurse Aide #3, Nurse Aide #5, Nurse Aide #6, Nurse Aide #7, Nurse Aide #8, Nurse Aide #9, Nurse Aide #10, Nurse #3, and Unit Manager received training on behavioral health to include approaches to care for residents with behavioral needs. Current residents have the ability to be affected. On 2/5/2024 through 2/12/2024, current staff were re-educated by the Director of Nursing and/or designee on behavioral health needs for the residents. Areas discussed include person-centered care and services, interpersonal communication, meaningful activities, environment and atmosphere, and non-pharmacological approaches to care. This also includes the needs of residents	2/14/24

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F 949	Continued From page 88 recorded on the education records. NA #9: There was no behavioral health training recorded on the education records. NA #10: There was no behavioral health training recorded on the education records. NA #8: There was no behavioral health training recorded on the education records. Nurse #3: There was no behavioral health training recorded on the education records. Unit Manager: There was no behavioral health training recorded on the education records. The Facility Assessment Tool dated 9/7/23 included an Education Calendar that indicated the topic "Screening and Assessing for Substance use disorder in Older Adults" was scheduled for June 2023 for nurses. An interview with Nurse Aide (NA) #3 on 1/9/24 at 12:41 PM revealed she had been working at the facility since 2018 and had not received any education on how to take care of residents with substance abuse disorder. A phone interview with NA #6 on 1/10/24 at 4:50 AM revealed she had been working at the facility for 5 years and did not remember receiving any training on how to take care of residents dealing with substance abuse. A phone interview with NA #5 on 1/10/24 at 4:56 AM revealed she started working at the facility in July 2023 and had not received any education or in-service related to how to take care of residents with substance abuse. A phone interview with NA #7 on 1/10/24 at 5:06 AM revealed he had been working at the facility for 3 years, but he did not recall ever receiving	F 949	diagnosed with a mental, psychosocial, or substance use disorder, a history of trauma, and/or post- traumatic stress disorder, or other behavioral health condition and the needs of residents living with dementia. Newly hired staff will be educated upon hire. Starting on 2/12/2024 the Director of Nursing and/or designee to perform Quality Improvement Monitoring on staff□s knowledge and approaches to care for residents with behavioral health needs three times a week for four weeks, then two times a week for four weeks, and then one time monthly for three months. The Director of Nursing introduced the plan of correction to the Quality Assurance Performance Improvement Committee on 2/12/2024. The Director of Nursing is responsible for implementing this plan. The Quality Assurance Performance Improvement Committee members consist of but not limited to Administrator, Director of Nursing, Staff Development Coordinator, Unit Manager, Social Services, Medical Director, Maintenance Director, Housekeeping Services, Dietary Manager, and Minimum Data Set Nurse and a minimum of one direct care giver. The Director of Nursing will report findings to the Quality Assurance Performance Improvement Committee monthly for three months. Date of Alleged Compliance is 2/14/2024	

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any training on how to deal with residents with substance abuse.

A phone interview with NA #9 on 1/10/24 at 5:11 AM revealed she started working at the facility 3 years ago, but she did not remember having been trained on how to take care of residents with substance abuse.

A phone interview with NA #10 on 1/10/24 at 5:14 AM revealed she had been working at the facility for five weeks, but she did not receive any type of specialized training regarding residents with substance abuse.

A phone interview with NA #8 on 1/10/24 at 5:18 AM revealed she had started working at the facility in October 2023 and she had not received any training on how to support residents dealing with substance abuse.

An interview with Nurse #3 on 1/10/24 at 5:42 PM revealed she did not get training on residents with substance abuse at the facility, but she already knew what signs to look for regarding potential drug abuse from working at the hospital before.

An interview with the Unit Manager (UM) on 1/11/24 at 12:49 PM revealed she had been in healthcare for 10 years and most of the things she knew she just learned over the years as she worked at the facility. The UM stated she had not received any education or in-service on how to support residents with substance abuse at the facility until today.

An interview with the Director of Nursing (DON) on 1/12/24 at 1:13 PM revealed she was responsible for staff training, but she had not

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gotten started on the education calendar. The DON stated they had completed in-services on any acute issues that came up, but she confirmed that they had not done any education on how to take care of residents dealing with substance abuse. The DON stated she was not sure why they hadn't done this and that she did not have an answer. She stated this was something the nurses picked up on, but it was not something the unlicensed staff would know how to deal with unless they received training on it.

An interview with the Administrator on 1/10/24 at 3:05 PM revealed staff had not received specific training related to residents dealing with substance abuse. The Administrator stated he was not sure how to go about doing this and he would need to contract specialty services to provide his staff with training on how to support residents with substance abuse.