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	345377	A. BUILDING _____ B. WING _____	C 04/05/2024

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F 000	INITIAL COMMENTS A complaint investigation was conducted onsite from 3/27/2024 to 3/28/2024 with additional information obtained remotely through 4/5/2024. Therefore, the exit date was 4/5/2024. Event ID # GR7311. The following intakes were investigated: NC00213710 and NC00214649. Two of the three allegations resulted in a deficiency.	F 000		
F 602 SS=D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, resident interviews, Medical Director interview, and Pharmacist interview the facility failed to protect residents right to be free from potential diversion of a total of seventeen narcotic tablets for two (Resident #7 and Resident #6) of three residents reviewed for diversion of narcotics. Findings included: Documentation on the facility abuse prevention program policies and procedures, dated as last reviewed on 3/6/2023, revealed the facility residents have the right to be free from verbal, sexual, physical, and mental abuse. The documentation further stated the following definition for misappropriation of property, "is the deliberate misplacement, exploitation, or	F 602	1. Nurse #5 is no longer employed by the facility. Nurse #5 employment was terminated on 4-8-2024. A report of possible misappropriation of resident property will be filled in and faxed into NCDHHS with a follow up 5 day report of the facility investigation into the possible misappropriation of resident property. The initial report will be faxed to NCDHHS on 4-26-2024. For resident #7 - she is no longer at our facility - family found a facility that was closer to their home and she was discharged on 4-15-2024. For resident #6 - the doctor reviewed the their medication regimen, including their controlled narcotics. The physician updated the controlled narcotic orders in	5/10/24

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

Electronically Signed | 04/19/2024

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F 602	Continued From page 1 wrongful, temporary, or permanent use of a patient's belongings or money without a patient's permission." 1. Resident #7 was admitted to the facility on 3/22/2024 with multiple diagnoses some of which included an ankle fracture, osteoarthritis, polyneuropathy, and fibromyalgia. Documentation on admission physician orders revealed an order for Dilaudid 2 milligram (mg) tablets to be administered as one tablet by mouth every 6 hours as needed for pain. Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #7 had the following information: Twenty pills of Hydromorphone (Dilaudid) 2 mg tablets were received by the facility on 3/22/2024. One tablet of Dilaudid 2 mg was signed out by Nurse #5 and "lost on the floor" on 3/22/2024 at 3:30 PM leaving 19 tablets remaining. One tablet of Dilaudid 2mg was signed out by Nurse #5 on 3/22/2024 at 3:30 PM leaving 18 tablets remaining. One tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 8:00 PM leaving 17 tablets remaining. One tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 10:40 PM leaving 16 tablets remaining. There was no documentation on the Medication Administration Record for the administration of the medication Dilaudid to Resident #7 on 3/22/2024. Documentation on a Basic Interview for Mental Status (BIMS) assessment dated 3/25/2024 revealed Resident #7 was assessed as	F 602	regards to time parameters and medications administration based on the resident's reported pain scale. 2. An initial audit will be completed on all the residents who are receiving controlled narcotics to check the documentation in the electronic medical record and the controlled narcotic sign out sheets to ensure that the documentation is correct and that the medications are being signed out based on the time parameters that are set by the resident□s physician. The audit will be performed by the Director of Nursing or their designee. This audit will be completed by 5-10-2024. 3. The facility nurses (RN□s and LPN□s) along with the medication aides will be inserviced on ensuring that all controlled narcotics are signed out in both the electronic medical record and the controlled narcotic count sheet and that any controlled narcotics are being signed out during proper time parameters that are determined by the physician order(s). The inservice will also talk about misappropriation of resident property and the steps that the facility takes when any misappropriation of resident property is noticed or reported. The inservice will be performed by the Director of Nursing or their designee. This inservice will be completed by 5-10-2024. 4. An audit will be performed to ensure that controlled narcotics are being signed out in both the electronic medical record and the controlled narcotic count sheets	

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F 602	Continued From page 2 cognitively intact with a score of 15 out of 15. Resident #7 was interviewed on 4/1/2024 at 4:56 PM. Resident #7 said she did remember Nurse #5. Resident #7 acknowledged that she would not be able to specifically say on what date and time she received medications from Nurse #5. Resident #7 stated that on one previous occasion at another facility she was given a Dilaudid tablet of 3 mg, and she was so sleepy her family was concerned she would not wake up. Resident #7 stated she knew that she was not supposed to take more than 2 mg of Dilaudid every 6 hours, and she would not have taken that much Dilaudid in such a short time if it was offered to her. Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #7. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Dilaudid for Resident #7, Nurse #5 stated he did not. An interview was conducted with the facility Pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to bring the medication delivery concerns to the physician for Resident #7 and investigate according to the facility protocol if drug diversion was suspected. The Pharmacist indicated it was very concerning if Resident #7 had been administered her Dilaudid in the amounts and times listed on the Controlled Drug Receipt/Record/Disposition Form. The facility Administrator was interviewed on	F 602	and that the controlled narcotics are being signed . The audit will also including ensuring that if any misappropriation of resident property is identified that an investigation is started and appropriate agencies are notified. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. This audit will begin during the week of 5-13-24. The audit will be performed by the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that controlled narcotics are being signed out in both the electronic medical record and the controlled narcotic count sheets. These audit will be discussed at this meeting for 6 months.	

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4/3/2024 at 12:55 PM. The Administrator stated had known Nurse #5 for years and known him to be competent and well liked. The Administrator stated Nurse #5 had worked in the facility for two years without any disciplinary action and he did not suspect drug diversion, or he would follow through with the facility protocol.

The facility Medical Director, who was also the physician for Resident #7, was interviewed on 4/4/2024 at 2:30 PM. The Medical Director stated she had seen Resident #7 on 4/3/2024 when she visited the facility. The Medical Director confirmed she thought Resident #7 was very much aware of her care and was a competent resident. The Medical Director stated that she thought Resident #7 would have been "knocked out" and "extremely sleepy" had she been administered the three doses of Dilaudid within a seven-hour and ten-minute time frame. The Medical Director stated the facility should be monitoring the Controlled Drug Receipt/Record/Disposition forms and the medication administration records so that the narcotic medication can be accounted for. The Medical Director revealed she did not know if narcotic medication was being diverted from the facility.

2. Resident #6 had multiple diagnoses some of which included benign neoplasm of the pituitary gland, history of cerebral infraction, and anxiety disorder.

Documentation on a Basic Interview for Mental Status assessment dated 1/22/2024 coded Resident #6 as a 9 out of 15 or having severely impaired cognition.

Documentation on the current March 2024 orders

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revealed Resident #6 had a physician's order initiated on 10/27/2023 for Oxycodone with Acetaminophen 5-325 milligrams (mg) tablets to be administered as 1 tablet by mouth every 4 hours as needed for severe pain at the 8 to 10 level not to exceed 3250 milligrams per day.

Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #6 had the following information.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 3:30 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 5:20 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 7:10 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 8:00 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 9:10 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 10:00 PM by Nurse #5.
One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 11:00 PM by Nurse #5.

There was no documentation on the Medication Administration record for the administration of Oxycodone with Acetaminophen 5-325 mg on 3/26/2024 from 3:00 PM to 11:00 PM.

An interview was conducted with Nurse #9 who was working on the 11:00 PM 3/26/2024 to 7:00

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AM 3/27/2024 shift for the medication cart for the hallway Resident #6 resided. Nurse #9 confirmed the number of tablets of Oxycodone with Acetaminophen for Resident #6 matched the Controlled Drug Receipt/Record/Disposition form for Resident #6 when she took over the medication cart from Nurse #5 on 3/26/2024. Nurse #9 stated she started working at the facility on 3/8/2024 and did not usually work on the hallway Resident #6 resided. Nurse #9 stated she did not recall any unusual behavior or concerns for Resident #6 that night and did not recall the nurse aides coming to her with any concerns for Resident #6. Nurse #9 stated she did not recall giving Oxycodone to Resident #6 on morning of 3/27/2024 but she knew he would have requested it if he needed it.

An interview was conducted with Nurse #6 on 4/1/2024 at 9:54 AM. Nurse #6 stated that on the morning of 3/27/2024 as she began her 7:00 to 3:00 PM shift, Resident #6 was requesting his pain medication Oxycodone. Nurse #6 stated when she looked at the Controlled Drug Receipt/Record/Disposition form, she noted eight doses of Oxycodone with Acetaminophen was removed from the medication cart for Resident #6 on the 3:00 PM to 11:00 PM shift on 3/26/2024. Nurse #6 stated this was concerning to her, so she called the Director of Nursing (DON) to alert her to the increased number of narcotics that were removed from the medication cart for Resident #6, but the DON did not respond to the phone call.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was

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removed for Resident #6 on 3/27/2024 at 3:15 PM by Nurse #5. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 5:10 PM by Nurse #5. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 6:20 PM by Nurse #5. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 8:20 PM by Nurse #5. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 10:30 PM by Nurse #5.

There was no documentation on the Medication Administration record for the administration of Oxycodone with Acetaminophen 5-325 mg on 3/27/2024 from 3:00 PM to 11:00 PM.

Medication Aide #2 (Med Aide #2) was interviewed on 4/2/2024 at 8:49 AM. Med Aide #2 confirmed she took over the medication cart from Nurse #5 at 11:00 PM on 3/27/2024. Med Aide #2 confirmed the number of tablets of Oxycodone with Acetaminophen for Resident #6 matched the Controlled Drug Receipt/Record/Disposition form for Resident #6 when she took over the medication cart from Nurse #5 on 3/27/2024. Med Aide #2 stated that Resident #6 immediately was requesting pain medication from her as soon as she started her shift at 11:00 PM. Med Aide #2 stated when she looked at the Controlled Drug Receipt/Record/Disposition form for Resident #6, she had to tell Resident #6 she was not able to give him any pain medication until 2:30 AM because he had last received the pain medication Oxycodone at 10:30 PM. Med Aide #2 said Resident #6 kept on requesting pain medication until 2:30 AM on 3/28/2024 and Resident #6 did

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not go to sleep or relent in his requests for pain medication. Med Aide #2 revealed she administered Oxycodone pain medication to Resident #6 at 2:30 AM and again at 6:00 AM on 3/28/2024 per his request. Med Aide #2 revealed she notified the DON on the morning of 3/28/2024 prior to leaving at the end of her shift at 7:00 AM, that she had a concern for the amount of Oxycodone removed for Resident #6 on the 3:00 PM to 11:00 PM shift on 3/27/2024.

The DON and ADON were interviewed on 3/28/2024 at 1:50 PM. The DON revealed Nurse #5 had been working at the facility for 2 years. The DON stated that despite being severely cognitively impaired, Resident #6 was very capable and knowledgeable of when his pain medication had been given to him. The DON stated it was her speculation that Resident #6 had been administered all of the doses of Oxycodone removed from the medication cart by Nurse #5 on 3/26/2024 and 3/27/2024. The DON did not think Resident #6 would suffer any ill effects of receiving eight doses of Oxycodone on the 3:00 PM to 11:00 shift on 3/26/0224 and 5 doses of Oxycodone on 3:00 PM to 11:00 PM shift on 3/27/2024. The DON and the ADON confirmed Med Aide #2 alerted them to documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #6 because it didn't look correct. Med Aide #2 had stated to the DON and the ADON the medication count of the Oxycodone left in the medication drawer on the medication cart matched the amount documented on the Controlled Drug Receipt/Record/Disposition form for Resident #6. The DON stated the nurses in the facility did not speculate about diversion if the narcotic medication was accounted for on the medication

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cart. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident. The DON stated that Nurse #6 should have alerted her to the unusual amount of Oxycodone removed for Resident #6 by Nurse #5 on 3/26/2024.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #6. Nurse #5 revealed Resident #6 was complaining on the 3:00 PM to 11:00 PM shift of terrible neck pain on 3/26/27 and again on 3/27/2024 so Nurse #5 gave him Oxycodone. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Oxycodone for Resident #6, Nurse #5 stated he did not. Nurse #5 revealed he no longer worked at the facility due to calling in sick too many times. Nurse #5 stated he was scheduled to work on 3/31/2024, but he was too sick to go to work, so he was fired.

Resident #6 was interviewed on 4/1/2024 at 5:11 PM. Resident #6 stated that the nurses in the facility only gave him the pain medication Oxycodone when he was allowed to have it. Resident #6 stated he was only allowed to have his Oxycodone every 4 hours and Nurse #5 never gave him his Oxycodone as frequently as every 2 hours or every 1 hour. He stated, "It never happened" referring to getting his pain medication more frequently than ordered. Resident #6 revealed the exact opposite was true because he had to beg Nurse #5 to give him his pain medication when it was time for it to be given.

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F 602	Continued From page 9 An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The facility pharmacist confirmed that if the medication Oxycodone was removed from the medication cart at the intervals documented by Nurse #5 on 3/26/2024 and 3/27/2024 for Resident #6, it would be a medication error. The facility pharmacist stated that if Resident #6 runs out of Oxycodone at an interval greater than expected both the pharmacy and the resident's physician would be alerted to a discrepancy because a new order for Oxycodone would need to be written. The facility Administrator was interviewed on 4/3/2024 at 12:55 PM. The Administrator stated had known Nurse #5 to be competent and well liked with no record of discipline at the facility. The Administrator stated Nurse #5 had worked in the facility for two years and he did not suspect drug diversion, or he would follow through with the facility protocol. The facility Medical Director was interviewed on 4/4/2024 at 2:30 PM. The Medical Director was informed of the 8 doses of Oxycodone removed from the medication cart by Nurse #5 for Resident #6 on 8/26/2024 and the 5 doses of Oxycodone removed from the medication cart by Nurse #5 for Resident #6 on 8/27/2024. The Medical Director stated it was "incredulous" and "didn't make any sense." The Medical Director stated she had been with the facility for 13 years and had never been apprised of any diversion of medication and that she did not know if Nurse #5 was diverting medication from Resident #6.	F 602		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689		5/10/24

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F 689	Continued From page 10 §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 observation, record review, and interviews with staff, Physician, Psychiatric Nurse Practitioner, and the facility's Pharmacy Consultant the facility failed to 1) analyze Resident #2's falls to determine causative factors and implement interventions to reduce the risk for further falls and 2) ensure a paraplegic resident (Resident # 1) did not roll out of bed during care. Resident # 2 was identified to have an impacted arm fracture (a fracture that generally occurs following a fall). This was for two of three sampled residents reviewed for accidents. The findings included: 1. Resident # 2 was admitted to the facility on 10/24/19. Resident # 2's diagnoses in part included vascular dementia, bipolar disorder, personality disorder, chronic kidney disease, and hypertension. Resident # 2's quarterly Minimum Dat Set assessment, dated 1/11/24, coded Resident # 2 as the following. The resident was severely cognitively impaired; dependent on staff for bathing and dressing; required substantial to maximum assistance for transfers and going from a sitting to standing position; required partial to moderate assistance with rolling in bed, going from a sitting to lying position, and going from a	F 689	1. A. For Resident #2 □ the staff that routinely work with this resident were inservice on ensuring that all falls are reported immediately to the nurse and the DON or ADON. The staff were also inserviced on ensuring that if Resident #2 complained of any pain that this was also immediately reported to the nurse and the DON or ADON. Unfortunately resident #2 was on hospice services and she passed away on 4-23-2024. B. For Resident #1 □ NA #1 was counseled and inserviced on good body mechanics and safety when delivering care to a resident in their bed. NA#1 also had a skills checklist performed on ensuring their abilities as an NA. 2. A. An audit will be performed to ensure that all residents have experienced a fall had the fall reported and documented in the electronic medical record. The audit will include monitoring residents for any new incidents or reports of pain. For reported falls they will be talked about in the daily morning stand up meeting and this will include interventions. When reviewing the fall details with the	

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lying to sitting position; had a history of one fall without injury since the last assessment, and required substantial to maximum assistance to walk 10 feet.

Resident # 2's care plan, dated 3/7/24, noted Resident # 2 had a history of falls related to poor balance and unsteady gait. One of the care plan interventions directed to determine and address causative factors of the resident's falls.

On 1/11/24 at 6:39 PM the wound care nurse, who was no longer employed at the facility, documented in a nursing note the following information. Resident # 2 had an unwitnessed fall in her room. The resident reported that "God had told her to walk." Resident # 2 was noted to have a nose bleed and no other injuries. The medical Nurse Practitioner was notified and instructed that Resident # 2 be monitored.

On the date of the 1/11/24 fall, a review of Resident # 2's vital signs log revealed the following: 1/11/24 at 10:25 PM pulse was 57; on 1/11/24 at 10:26 PM pulse was 59. Resident # 2's blood pressure registered 109/57 on 1/11/24 at 10:25 PM.
The day following the fall, Resident # 2's pulse was documented to be 59 at 12:11 AM on 1/12/24 and her blood pressure was 113/63 while lying down.

On 3/28/24 the DON (Director of Nursing) provided the facility's investigation documentation into the 1/11/24 fall. The notes were dated 1/12/24 and read, "Therapy evaluate. Wearing proper footwear at all time. Make sure bed to lowest position while in bed with call bell within reach but has cognitive changes. Up in chair

resident□s physician the medication for that resident will be reviewed to help determine if any of the medications that the resident is taken could have possibly contributed to the fall. This audit will be completed by the DON or their designee. This audit will be completed by 5-10-2024.

B. An audit will be performed to ensure that residents who receive care in their bed are having their care performed safely with good body mechanics. This audit will be performed by a member of the nursing management team by observing the staff delivering care to resident and checking off to ensure that care is being properly provided. This audit will be performed by the DON or their designee and will be completed by 5-10-2024.

3. A. All facility staff will be inserviced on ensuring that if they witness a resident fall or if they find a resident already on the floor that this is reported to that residents nurse immediately. The staff will also be inserviced on what happens after the fall including documentation, notifications, interventions, etc. This inservice will be performed by the Director of Nursing or their designee and will be completed by 5-10-2024.

B. The facility nursing staff will be inserviced on how to properly deliver care to a resident while they are in the bed. The inservice will also talk about proper body mechanics to ensure safety for the resident that is receiving the care. This

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during day to engage in activities. Nursing focal rounds."

The rehabilitation manager was interviewed on 3/27/24 at 2:40 PM and reported the following. There was no documentation Resident # 2 had been evaluated or screened by therapy staff since the date of 12/7/23. That was the date of the last documented screen. At that time, therapy was not indicated because the resident did not have the cognitive abilities to follow commands and participate.

A review of physician orders revealed that at the time of the 1/11/24 fall Resident # 2 was receiving Risperdal (an antipsychotic medication) 1.5 mg (milligrams) two times per day. This dosage had been prescribed since 12/15/23. Resident # 2 was also ordered to receive Minipress (a hypertension medication) 1 milligram daily. This dosage had been prescribed since 6/21/22.

On 1/15/24 the medical Nurse Practitioner (NP) noted she saw Resident # 2 for a fall and that nursing staff were reporting Resident # 2 had been deteriorating mentally for the last 6 months. The NP noted the resident's medications were reviewed and that her current medications would be continued.

On 1/17/24 Resident # 2's medical physician saw Resident # 2. At that time the physician noted the following. All meds were evaluated individually and felt to have a positive risk/benefit ratio. There were no side effects reported by nursing at this time. The nursing staff were to let her know if there were problems. At time of the assessment, the physician noted the resident's pulse was 54.

inservice will be performed by the Director of Nursing or their designee and will be completed by 5-10-2024.

4. A. An audit will be completed on all falls in the facility to ensure that the proper documentation has been completed and that interventions are being followed. The audit form will included that any contributing factors that may have contributed to the fall have been reviewed. These audits will begin the week of 5-13-2024. This audit will be completed weekly x 4 weeks and then monthly x 3 months. The audit will be performed by the Director of Nursing or their designee.

B. An audit will be completed to ensure that when care is being properly delivered to a resident in the bed and that proper body mechanics are being used to ensure resident safety. This audit will be performed by a member of the nursing management team by observing the staff delivering care to resident and checking off to ensure that care is being properly provided. The audits will begin the week of 5-13-2024. This audit will be completed weekly x 4 weeks and then monthly x 3 months.

5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that (1) all resident falls are being properly reported, documented on and that interventions are being followed and (2) that proper care is

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F 689	Continued From page 13 On 1/17/24 Resident # 2 was also seen by the Psychiatric Nurse Practitioner who noted staff reported Resident # 2's hallucinations had worsened. On 1/17/24 Resident # 2's Risperdal was increased to 2 mg two times per day. On 1/21/24 at 8:16 PM the wound care nurse documented in a nursing note the following information. Resident # 2 had been found on the floor and was bleeding from her head. She was transferred to the hospital ED (Emergency Department) for evaluation. Review of hospital ED records revealed Resident # 2 had lab work, CT (computed tomography) studies of her head/ spine, and an EKG (electrocardiogram) performed. According to the ED notes, the CT scans were negative. On 1/22/24 at 1:32 AM a facility nursing entry noted Resident # 2 returned at 11:50 PM on 1/21/24 with her head bandaged and her "x-rays" had been clear. On 3/28/24 the DON (Director of Nursing) provided the facility's investigation documentation into the 1/21/24 fall. The notes on the investigation were made on 1/22/24 and read, "Therapy evaluate. Make sure wearing proper footwear at all times. Make sure bed to lowest position while in bed with call bell within reach but has cognitive changes. Up in chair during day to engage in activities. Nursing focal rounds. Resident was sent to the hospital for evaluation. " On 1/22/24 Resident # 2 was seen by the medical NP again who noted the following. Resident # 2	F 689	being delivered to residents in their bed and that proper body mechanics are being used to ensure resident safety. The audit will be discussed during this meeting for 6 months.	

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had fallen over the weekend. The NP noted Resident # 2 was sent to the ED because she had hit her head, and all scans were negative. The resident could not tell the NP how she had fallen. The NP noted she had reviewed the medications, and they would be continued.

Two days after the 1/22/24 fall, on the date of 1/24/24 at 12:00 AM Resident # 2's pulse was documented to be 51. Her blood pressure was documented to be 106/67 at that time while lying down.

On 1/25/24 at 12:28 AM Resident # 2's pulse was documented to be 59 and her blood pressure was 128/73 while lying down.

On 1/26/24 at 8:38 AM Nurse # 2 documented in a nursing note the following information. The nurse had been exiting the room across the hallway when she saw Resident # 2 on the floor. The resident was not able to verbalize how she had gotten on the floor. She was assessed and found to have no injuries.

Nurse # 2 was interviewed on 3/27/24 at 11:05 PM via phone and reported the following. The staff had recently seen Resident # 2 prior to her being found on the floor. She (the nurse) was exiting the room across the hall when she looked into Resident # 2's room and saw that she was on the floor. She was assessed and not found to have any injuries.

On 3/28/24 the DON (Director of Nursing) provided the facility's investigation documentation into the 1/26/24 fall. The notes on the investigation were made on 1/26/24 and read, "Therapy evaluate. Make sure wearing proper

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footwear at all times. Make sure bed to lowest position while in bed with call bell within reach but has cognitive changes. Up in chair during day to engage in activities. Nursing focal rounding." There was no documentation Resident # 2's medications were evaluated in relation to her falls.

On 1/29/24 at 4:42 AM there was a note in the vital sign log that Resident # 2's pulse was 58 and irregular. Beside this documentation, there was a note which read, "new onset." At the time her blood pressure was 132/74 while lying down.

On 1/31/24 Resident # 2 was seen by the Psychiatric NP who noted staff reported no new concerns.

On 2/2/24 at 6:25 AM Nurse # 2 documented the following in a nursing note. She had been called to the room at 4:30 AM by a Nurse Aide. Resident # 2 had been found lying on the floor. Resident # 2 reported she had hit her head and her head hurt. A total physical assessment was performed and there were no contusions, bruising, or bleeding noted. The resident was able to move all her extremities. The on- call provider was contacted and ordered the resident to be evaluated at the hospital. The resident was transported to the ED at 5:50 AM.

Review of Resident # 2's hospital 2/5/24 discharge summary revealed following the fall on 2/2/24 she was hospitalized from 2/2/24 to 2/5/24. The hospital physician noted Resident # 2 had been admitted for "recurrent falls." It was identified that Resident # 2 had orthostatic hypotension and bradycardia. (Orthostatic hypotension occurs when an individual's blood

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pressure suddenly drops when they stand up from a sitting or lying position and can cause someone to feel dizzy or faint. Bradycardia is an abnormally low heart rate). On the discharge summary the physician further noted the following. Resident # 2's medications were reviewed and her Risperdal and prazosin (Minipress) were discontinued due to the side effect of orthostatic hypotension. Her EKG's (electrocardiogram) had shown she had bradycardia (a low heart rate). Cardiology was consulted and recommended a zio patch and to replete her electrolytes. She was to follow up with cardiology. The physician further noted, "repeat blood pressure check and monitoring at facility." (A zio patch is a patch which monitors an individual's heart activity.)

On 3/28/24 the DON (Director of Nursing) provided the facility's investigation documentation into the 2/2/24 fall. The notes were dated 2/2/24 and read, "Therapy continued. Make sure wearing proper footwear at all times. Make sure bed to lowest position while in bed with call bell within reach but had cognitive changes. Up in chair during day to engage in activities. Nursing focal rounding. Resident was sent to the hospital for further evaluation."

Upon Resident # 2's return to the facility on 2/7/24 her Minipress and Risperdal were not continued.

On 2/14/24 Resident # 2 was seen by the Psychiatric NP, who noted since Resident # 2's return to the facility she had been experiencing distressing hallucinations. The Psychiatric NP noted Resident # 2's Risperdal would be restarted at 2 mg twice per day.

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Review of physician orders revealed on 2/14/24 Resident # 2's Risperdal was restarted at 2 mg twice per day.

On 3/28/24 at 9 AM the Psychiatric NP was interviewed and reported the following. She was not aware the hospital thought that Resident # 2's medications were contributing to orthostatic hypotension and falls. She was not aware Resident # 2 had sustained four falls in less than a month's time period. The Psychiatric NP was interviewed regarding if there were other medications that might not cause the orthostatic hypotension and stated she could try other alternatives that might not.

The facility's Consultant Pharmacist was interviewed on 3/28/24 at 1:15 PM and reported the following. She was familiar with Resident # 2 and knew she had undergone multiple attempts at Risperdal drug reduction and failed. She had severe psychiatric problems. She was not aware of any other medications that would help with Resident # 2's psychiatric problems and not contribute to orthostatic hypotension, and she was not aware of any other good medication alternative to the Risperdal for Resident # 2. The consulting pharmacist thought the Minipress probably had contributed more to the Resident's orthostatic hypotension than Risperdal.

Between the dates of 2/5/24 and 3/4/24 there were no documented falls or accidents for Resident # 2 within her medical record.

On 3/4/24 at 1:58 PM the ADON (Assistant Director of Nursing) documented in a nursing entry that Resident # 2 complained of left arm

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pain with movement and the medical Nurse Practitioner had ordered an x-ray to be completed.

On 3/4/24 the medical Nurse Practitioner noted the following. Resident # 2 was complaining of left arm pain. The nursing staff were unaware of any recent falls or traumatic injury to her left arm. When attempts were made to gently rotate and lift Resident # 2's arm, the resident screamed in pain. There was no bruising, swelling, or abrasions noted. The medical NP noted she would order an x-ray of the resident's arm.

On 3/4/24 at 10:26 PM Nurse # 9 documented the following in a nursing note. Resident # 2's x-ray result had returned and showed she had an impacted fracture of the humerus (arm bone) and shoulder. She was transferred to the hospital for care.

Review of hospital records for the dates of 3/4/24 to 3/7/24 revealed the following. The hospital physician noted Resident # 2 had a mildly displaced, moderately impacted, mildly comminuted and minimally angulated left metaphyseal/humeral neck fracture. (A comminuted fracture is where the bone is fractured into more than one piece. An impacted fracture is where the ends of bones are driven into each other from the injury.) According to the hospital physician, the resident was seen by an orthopedic who recommended immobilizing Resident # 2's arm in a sling. Surgery was not recommended. While hospitalized, Resident # 2 was also found to have a pulmonary embolism for which she was treated. She was discharged on 3/7/24.

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On 3/7/24 the ADON noted at 2:57 PM in a nursing entry that Resident # 2 had returned with her left arm in a shoulder sling. Swelling and bruising were noted. She had no complaints at the time of the ADON's assessment.

NA # 3 and NA # 4 were interviewed on 3/27/24 at 4:15 PM together. These two NAs reported they had worked together to care for Resident # 2 on the 3:00 PM to 11:00 PM shift of 3/3/24. The Nurse Aides reported the following. Resident # 2 had been fine on their shift and had no complaints of pain nor did she fall. She hallucinated at times and believed that Jesus would tell her to get up and walk.

Nurse 7 was interviewed on 3/27/24 at 5:59 PM. Nurse # 7 had cared for Resident # 2 on the 3:00 to 11:00 PM shift on 3/3/24. Nurse # 7 reported the following. Resident # 2 was in bed on 3/3/24 and did not fall. She was okay during the shift. She had worked with Resident # 2 a few times. When she worked with her, Resident # 2 could not stand up and walk by herself. She did not recall speaking to the Director of Nursing or Administrator about how Resident # 2 could have injured herself after Resident # 2 was determined to have a fracture.

Nurse # 1 was interviewed on 3/28/24 at 8:09 AM and reported the following. She had cared for Resident # 2 on the night shift which began at 11:00 PM on 3/3/24 and extended to 7:00 PM on 3/4/24. Nothing had happened on that shift of which she was aware. She (Nurse # 1) generally worked at the facility about five times per month part time. When she had worked with Resident # 2, the resident had been fine since her 2/2/24 fall. She could walk some but was unsteady. At times

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Resident # 2 would come to her room's door and staff would have to redirect her. She (Nurse # 2) was not aware of what had occurred to cause Resident # 2's fracture. After Resident # 2's fracture was identified, none of the administrative staff had talked to her about the events of her night shift which began on 3/3/24.

NA # 5 was interviewed on 3/27/24 at 11:10 PM and reported the following. She had cared for Resident # 2 on the night shift which began at 11:00 PM on 3/3/24 and extended to 7:00 AM on 3/4/24. Resident # 2 had not fallen on her shift. With every round check, Resident # 2 had been in bed and had no complaints.

NA # 1 was interviewed on 3/27/24 at 12:25 PM and reported the following. He had cared for Resident # 2 on the 7:00 AM to 3:00 PM shift on 3/4/24. When he arrived Resident # 2 was in bed. He helped feed Resident # 2 breakfast. She did not have to move her arm at that time to eat, and she did not complain of anything. After breakfast he went into provide care. He began to remove her gown for care and had "barely" pulled on the gown to remove it. As he moved her arm, she began to scream. She complained her arm was hurting. He immediately stopped and got a nurse.

Medication Aide # 1 was interviewed on 3/27/24 at 12:15 PM and reported the following. She had been the Medication Aide on 3/4/24 on the shift which began at 7:00 AM. There had been nothing in the morning's nursing report about her arm hurting. NA # 1 had alerted her on 3/4/24 that Resident # 2 was having pain in her arm when he started to prepare to bathe her. She informed a nurse that the resident was having pain in her arm, and they obtained an order to x-ray her arm.

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MA # 1 further reported that before the fracture, Resident # 2 thought she could walk but she really could not do so. The staff had to keep an eye on her.

On 3/27/24 at 12:10 PM, Resident # 2 was observed in bed. She appeared confused. She was not able to say how her arm had been hurt.

The Director of Nursing was interviewed on 3/28/24 at 8:00 AM and reported the following. She had verbally talked to the staff who had cared for Resident # 2 on the shifts before Resident # 2 had a fracture. No one had said anything had happened to cause the fracture. She did not investigate further because she thought the fracture was due to the fall which had occurred on 2/2/24 and had not been identified at the time of the 2/2/24 fall.

During a follow up interview with the Director of Nursing on 3/28/24 at 10:30 AM the DON reported Resident # 2 would remove her heart monitor. Without the data, the cardiologist would not see her and therefore Resident # 2 had not had a follow up appointment with cardiology. The DON was interviewed about how the facility reviews falls and reported that every Friday all disciplines look at the past week's falls. They discuss such things as therapy screens, medications, proper footwear, and communication with the physician. She recalled that she had talked to Resident # 2's medical director about Resident # 2's fracture.

The resident's physician, who serves as the facility's medical director, was interviewed on 3/28/24 at 2:15 PM and reported the following. Generally, an impacted fall occurs when an

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individual puts out their arm to break a fall. The pressure on the bones to break the fall then breaks the bone. The physician reported in general if someone falls, then they would push with their arms and/or legs to get themselves up. She was unsure if Resident # 2 would have the physical capability to get herself off the floor if she had fallen. As medical director she did not recall anyone speaking to her about the events that transpired before the fracture occurred or discussed her medical opinion regarding the fracture. The physician noted that there was no indication in the record that the 2/2/24 fall had contributed to the fracture. The physician was also interviewed about the frequency of Resident # 2's falls since January 2024 and the resident's medications. The physician reported that at times the medical NP sees the resident in between the physician's visits, and she (the physician) had not realized the number of falls Resident # 2 had sustained until the discussion with the surveyor. She further reported that Resident # 2 had been on Risperdal for a long time, and she felt that Minipress had contributed more to her orthostatic hypotension than the Risperdal.

The facility's Administrator was interviewed on 4/5/24 at 8:53 AM and reported the following. The facility talked about falls every day. He could not recall specifics of their daily discussions.

2. Resident #1 had multiple diagnoses some of which included paraplegia, cerebral vascular accident with left sided weakness, aphasia, and post percutaneous gastrostomy tube placement.

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Documentation on the most recent quarterly Minimum Data Set assessment dated 2/20/2024 revealed Resident #1 had moderately impaired cognition and was dependent on staff for all activities of daily living. Resident #1 was also coded on the same assessment as having range of motion impairment on both sides of upper and lower extremities.

Documentation on a care plan dated 2/8/2024 for Resident #1 revealed a focus area for a high risk for falls relative to muscle weakness and cerebral vascular accident with left hemiparesis.

Documentation in an incident note dated 2/21/2024 at 12:49 PM revealed, "[Nursing Assistant #1] (NA #1) called this writer in the resident's room, on arrival, Resident (#1) is seen lying down on the floor with head up. Quick assessment done, noted resident to be bleeding from the right-side forehead. Code green activated, Vitals done [Blood Pressure] 115/70 [millimeters mercury] [pulse] 68 [beats per minute] [Temperature] 97.5 [Fahrenheit] [Respirations] 18 [Saturation of Peripheral Oxygen] 97 [Room Air]. Resident points to the head if asked if in pain. Dressing applied with cold pack. 911 called, [Medical Director] paged in the building came at bedside to assess [patient]. Wound Nurse, DON (Director of Nursing), ADON (Assistant Director of Nursing) at bedside relatives made aware 911 arrived and transferred resident to hospital."

Documentation in a hospital emergency department note dated 2/21/2024 revealed Resident #1 was treated for a superficial forehead laceration on the right side with tissue adhesive

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and returned to the facility.

An interview was conducted with NA #1 on 3/27/2024 at 12:44 PM. NA #1 explained that he had been giving Resident #1 a bath when he fell out of bed on 2/21/2024. NA #1 revealed the short upper side rails were up and Resident #1 was on his left side and grabbing onto the side rail with his right hand. NA #1 stated that it was usually not a problem to give Resident #1 a bath by himself but on this occasion the arm of Resident #1 must have "gave out and he rolled off the bed so fast I couldn't catch him."

An interview was conducted with the Rehabilitation Manager on 3/29/2024 at 1:46 PM. The Rehabilitation Manager revealed there had not been a recent rehabilitation screen for Resident #1, but Resident #1 did have a bed rail/ assist evaluation completed on 2/28/2024. The Rehabilitation Manager stated that after the fall from the bed the abilities of Resident #1 had not changed but Resident #1 had the upper side rails changed from a short rail to a half rail to aid in bed mobility and positioning. The Rehabilitation Manager revealed Resident #1 had no ability to move his entire left side and on his right side he had no lower or upper body strength but could grip with his right hand for a brief amount of time.

NA #1 was interviewed again on 3/27/2024 at 2:38 PM. NA #1 revealed he had pulled Resident #1 to the middle of the bed prior to him falling, but Resident #1 just couldn't hold himself using the rail and he rolled so quickly NA #1 was not able to catch him. NA #1 stated that Resident #1 did have a different side rail now after the fall.

An interview was conducted with the DON on

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F 689	Continued From page 25 3/27/2024 at 2:45 PM. The DON stated that Resident #1 would not have fallen from the bed had good body mechanics and positioning been used by NA #1. The DON stated that an in-service was conducted with all the nurse aides to include NA #1 on falls prevention with positioning during the provision of activities of daily living. The DON was interviewed again on 3/28/2024 at 10:38 AM. The DON explained that she verbally questions the staff as to what happened in each fall or injury a resident has but does not document these interviews. The DON explained that the facility interdisciplinary team meets every Friday to go over the falls in the facility and to discuss interventions. The DON explained the interventions usually included having a therapy screen, keeping the bed in the lowest position, frequent monitoring by staff, call bell in place, and appropriate footwear.	F 689		
F 693 SS=E	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 693		5/10/24

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F 693	Continued From page 26 §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and an emergency room physician interview the facility failed to provide care to a feeding tube site for one (Resident #1) of three sampled residents reviewed for feeding tube care. Findings included: Resident #1 was readmitted to the facility after a hospital admission from 2/8/2024 to 2/13/2024. Resident #1 had cumulative diagnoses, one of which included oropharyngeal dysphagia status post percutaneous gastrostomy tube placement. Documentation on a skin assessment dated 2/13/2024 by Nurse #10 did not reveal a description or any representation of what the gastrostomy tube site looked like upon the return of Resident #1 from the hospital. Nurse #10 no longer worked for the facility at the time of the investigation and contact information was not available for an interview. Resident #1 had an active February 2024 enteral feed order initiated on 9/9/2022 for, "every night shift clean tube site daily with normal saline, pat dry, and apply drain sponge if drainage noted." Documentation on the Medication Administration	F 693	1. Resident #1 had their gastrostomy tube site checked to ensure that the bandage had been changed per facility orders. 2. An audit will be performed on the current residents with a gastrostomy tube to ensure that their site is being care for as per facility orders. The audit form will check to make sure that any dressing/bandage is being changed per physician order. This audit will be performed by Director of Nursing or their designee and will be completed by 5-10-2024. 3. The facility nurses (RN□s and LPN□s) along with Medication Aides will be inserviced regarding ensuring that any residents with a gastrostomy tube are having their tubes care for according to facility orders. This inservice will be performed by Director of Nursing or their designee and will be completed by 5-10-2024. 4. An audit will be performed to ensure that residents with a gastrostomy tube are having their tubes care for according to	

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F 693	Continued From page 27 Record (MAR) for Resident #1 revealed the cleaning of the gastrostomy tube site had been performed on 2/13/2024 by Nurse #2. An interview was conducted with Nurse #2 on 3/28/2024 at 5:25 AM. Nurse #2 stated she did not recall if she changed the dressing on the gastrostomy tube site after Resident #1 returned to the facility on 2/13/2024 or what the bandage or site looked like. Documentation on the MAR for Resident #1 revealed the cleaning of the gastrostomy tube site had been performed on 2/14/2024 by Nurse #4. Nurse #4 no longer worked for the facility and contact information was not available for an interview. Documentation on the MAR for Resident #1 revealed the cleaning of the gastrostomy tube treatment was blank on 2/15/2024. Documentation on the MAR for Resident #1 revealed the cleaning of the gastrostomy tube site had been performed on 2/16/2024 and 2/18/2024 by Nurse #1. An interview was conducted with Nurse #1 on 3/27/2024 at 12:13 PM. Nurse #1 stated she was familiar with Resident #1, but she did not recall changing the dressing or what the dressing looked like for the gastrostomy tube site for Resident #1 after he returned from the hospital stay on 2/13/024. Documentation on the MAR for Resident #1 revealed the cleaning of the gastrostomy tube site had been performed on 2/17/2024 by Nurse #3.	F 693	facility orders. The audit form will check to make sure that any dressing/bandage is being changed per physician order. These audits will begin on the week of 5-13-2024. This audit will be performed weekly x 4 weeks and then monthly x 3 months and will be completed by the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that residents with a gastrostomy tube are having their tubes care for according to facility orders. The audit will be discussed during this meeting for 6 months.	

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An interview was conducted with Nurse #3 on 3/28/2024 at 1:30 PM. Nurse #3 stated she did not recall the gastrostomy tube site or the bandage over the site for Resident #1 going back to February. Nurse #3 stated it was too long ago for her to recall if she performed a task she checked off as completing on 2/17/2024.

Documentation on the MAR for Resident #1 revealed the cleaning of the gastrostomy tube site had been performed on 2/19/2024 by Med Aide #1.

There was no documentation in the electronic medical record of the appearance of the gastrostomy tube site for Resident #1 for the time period of his return from the hospital on 2/13/2024 to 2/20/2024, when he went to the emergency room.

Documentation in a nursing note dated 2/20/2024 at 6:55 AM written by Nurse #2 revealed, "[Medication] aide came and stated that something is wrong with resident's [gastrostomy] tube at 6:20 AM. Observed crack in main portal intake." The documentation additionally revealed the on-call physician was called and Resident #1 was sent to the emergency department for gastrostomy tube replacement via emergency medical services at 6:45 AM.
An interview was conducted with Med Aide #1 on 3/28/2024 at 10:48 AM. Med Aide #1 confirmed she notified Nurse #2 that the portal on the tube feeding was cracked. Med Aide #1 stated she would not have been the one to change the dressing on the tube feeding because this was the job of the nurse. Med Aide #1 insinuated that she was told by the nurse the dressing change

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was completed 2/19/2023 so she checked it off on the MAR as completed. Med Aide #1 did not recall what the bandage looked like because a nurse aide brought it to her attention the tubing was loose and fell out. Med Aide #1 stated she tried to put the tubing back in, but it was split and had a hole in it.

An interview was conducted with Nurse #2 on 3/28/2024 at 5:25 AM. Nurse #2 stated the Medication Aide (Med Aide #1) came to her and told her something was wrong with the gastrostomy tube site for Resident #1. Nurse #2 confirmed she did look at the gastrostomy tube and she observed a crack in the main portal intake, so she sent Resident #1 to the hospital to have the tube replaced. Nurse #2 stated she did not know what the gastrostomy tube site looked like prior to sending Resident #1 to the hospital on 2/20/2024. Nurse #2 further stated that her focus was on the hole in the split between the two ports on the gastrostomy tube.

Documentation in a hospital Emergency Department note dated 2/20/2024 written by MD #1, a hospital emergency room physician, revealed Resident #1 was sent to the emergency room due to a cracked adapter on the gastrostomy tube and then returned to the facility. The documentation in the note also revealed the physician commented that the dressing on the gastrostomy tube was very unclean and was dated 2/8/2024. Further physician comments revealed gastric contents were leaking from the site and the balloon had ruptured.

An interview was conducted with MD #1 on 3/28/2024 at 2:30 PM. MD #1 revealed the following information. MD #1 stated while he was

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in the emergency room on 2/20/2024, Resident #1 was brought in by the emergency medical services with a cracked adapter for his gastrostomy tube and it was malfunctioning. MD #1 noted that the bandage on the gastrostomy tube site was clearly labeled 2/8/2024 and had the appearance of being 12 days old. MD #1 removed the dressing and saw the skin was very red and irritated from the leakage of gastric contents around the site as well as being very malodorous. MD #1 stated that the ballon had less than 10 cc (cubic centimeter) of fluid and had to be replaced. (The end of the tube inside the stomach has a small balloon filled with water to keep the tube in place.) MD #1 stated he had a concern for poor hygiene care of the gastrostomy tube site.

An interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) was conducted on 3/28/2024 at 2:45 PM. The DON stated that the gastrostomy tube sites are cleaned, and the bandages changed on the 11:00 PM to 7:00 AM shift for the residents with gastrostomy tubes. The DON stated that if her staff checked off the cleaning of the gastrostomy tube site for Resident #1 was completed then she believed it was completed as ordered. The DON stated she did not believe MD #1's description of the gastrostomy tube feeding site for Resident #1 as he saw it and documented on 2/20/2024. The ADON stated the medication cart, wound cart, and in the top drawer of each gastrostomy tube feeding resident's room had supplies for dressing changes for the gastrostomy tube sites. The DON and the ADON stated the nurses provided good communication regarding the gastrostomy tube sites and any wound care that was needed.

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F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Medical Director/Physician interview, and Pharmacist interview the facility failed to remove narcotic pain	F 755	1. A. Nurse #5 is no longer employed by the facility. Nurse #5 employment was terminated on 4-8-2024. The nurses who	5/10/24

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medications from the medication cart within the parameters set by the physician's orders for narcotic medication; failed to follow procedures for disposal of wasted narcotic medication; and failed obtain an order for narcotic pain medication prior to removing narcotic pain medication from the medication cart. Additionally, the facility failed to have effective safeguards and systems in place to control for, account for, and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This was for three residents, (Resident #6, Resident #7, Resident #8) of three residents reviewed for pharmacy services for narcotic medication. Findings included:

1. Resident #6 was admitted to the facility on 9/13/2023 with multiple diagnoses some of which included benign neoplasm of the pituitary gland, history of cerebral infraction, and anxiety disorder.

Documentation on the current March 2024 orders revealed Resident #6 had a physician's order initiated on 10/27/2023 for Oxycodone with Acetaminophen 5-325 milligrams (mg) tablets to be administered as 1 tablet by mouth every 4 hours as needed for severe pain at the 8 to 10 level not to exceed 3250 milligrams per day. Additional documentation on the current March 2024 orders revealed Resident # 6 had a physician's order initiated on 9/13/2023 for observation of signs and symptoms of pain to be documented using chart codes.

Documentation of the pain level of Resident #6 on the Medication Administration Record (MAR) revealed a level of 0 on 3/21/2024 written at 10:57 PM by Nurse #5.

work on the medication cart for resident #6 will be inserviced on ensuring that controlled narcotics are given in the proper time parameters and that the proper controlled narcotics are given based on the pain level that the resident is reporting based on the scale provided by the doctor□s order. The inservice also went over ensuring that any controlled narcotic is properly signed out in the resident electronic medical record. This inservice will be completed by 5-10-2024 and will be delivered by the DON or their designee.

B. Nurse #5 is no longer employed by the facility. Nurse #5 employment was terminated on 4-8-2024. The nurses who work on the medication cart for resident #7 will be inserviced on ensuring that controlled narcotics are given in the proper time parameters based on the physicians order for that medication. The inservice will also review ensuring that any controlled narcotic is properly signed out in the resident electronic medical record. The inservice also included ensuring that the medication wasting form is filled out completely and signed by 2 nurses ensuring the proper wasting of any controlled narcotic. This inservice will be completed by 5-10-2024 and will be delivered by the DON or their designee.

C. Nurse #5 is no longer employed by the facility. Nurse #5 employment was terminated on 4-8-2024. The nurses who work the mediation cart for resident #8 will be inserviced on ensuring that there is a

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F 755	Continued From page 33 Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 4:00 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 6:00 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/21/2024 at 8:00 PM by Nurse #5. There was no documentation on the MAR on 3/21/2024 for the administration of Oxycodone with Acetaminophen 5-325 mg tablets for the 3:00 PM to 11:00 PM shift. Documentation of the pain level of Resident #6 in the MAR revealed a level of 5 on 3/26/2024 at 6:54 PM written by Nurse #5. Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 3:30 PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 5:20 PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 7:10 PM by Nurse #5. Fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 8:00 PM by Nurse #5. One hour and ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was	F 755	current doctors order before giving any controlled narcotic to a resident, that controlled narcotics are appropriately given based on the resident reported pain level and that controlled narcotics are being signed out in the resident electronic medical record. This inservice will be completed by 5-10-2024 and will be delivered by the DON or their designee. 2. A. An initial audit will be performed on those residents who are receiving controlled narcotics to ensure that they are receiving their controlled narcotics within the ordered time parameters and that the correct medication is being given based on the pain scale that is being reported by the resident. The initial audit will be completed by 5-10-2024. B. An initial audit will be performed to ensure that those residents who are receiving controlled narcotics have the medication is being signed in their electronic medical record when the medication is given. The initial audit will be completed by 5-10-2024. C. An initial audit will be performed to ensure that anytime that a controlled narcotic medication is documented as being wasted that there is the medication wasting form is completely filled out and signed by 2 nurses regarding the wasting of that medication. The initial audit will be completed by 5-10-2024. 3. A. The facility nurses (RN□s and LPN□a) and medication aides will be	

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removed for Resident #6 on 3/26/2024 at 9:10 PM by Nurse #5. Fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 10:00 PM by Nurse #5. One hour later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/26/2024 at 11:00 PM by Nurse #5.

There was no documentation on the MAR for the administration of Oxycodone with Acetaminophen 5-325 mg on 3/26/2024 from 3:00 PM to 11:00 PM.

Documentation of the pain level of Resident #6 in the MAR revealed a level of 6 on 3/27/2024 at 6:54 PM written by Nurse #5 for the evening shift.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #6 had the following information. One tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 3:15 PM by Nurse #5. One hour and fifty minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 5:10 PM by Nurse #5. One hour and ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 6:20 PM by Nurse #5. Two hours later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 8:20 PM by Nurse #5. Two hours and ten minutes later, one tablet of Oxycodone with Acetaminophen 5-325 mg was removed for Resident #6 on 3/27/2024 at 10:30 PM by Nurse #5.

There was no documentation on the MAR for the

inserviced on (1) ensuring that those residents who are receiving controlled narcotics are receiving those medications within the ordered time parameters and that the correct medication is being given based on the pain scale that is being reported by the resident, (2) ensuring that those residents who are receiving controlled narcotics have that medication signed out properly in their electronic medical record when the medication is given, and (3) ensuring that anytime a controlled narcotic medication is being wasted that the medication wasting form is completely filled out and signed by 2 nurses regarding the wasting of that medication. This inservice will be performed by the Director of Nursing and will be completed by 5-10-2024.

4. A. An audit will be performed to ensure that those residents who are receiving controlled narcotics are receiving those medications within the ordered time parameters and that the correct medication is being given based on the pain scale that is being reported by the resident. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or their designee.

B. An audit will be performed to ensure that those residents who are receiving controlled narcotics have the medication signed out properly in their electronic medical record when the medication is given. This audit will reviewed the controlled narcotic sign out sheet and

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F 755	Continued From page 35 administration of Oxycodone with Acetaminophen 5-325 mg on 3/27/2024 from 3:00 PM to 11:00 PM. The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON revealed Nurse #5 had been working at the facility for 2 years. The DON stated that despite being severely cognitively impaired, Resident #6 was very capable and knowledgeable of when his pain medication had been given to him. The DON stated Resident #6 had been administered all the doses of Oxycodone removed from the medication cart by Nurse #5 on 3/21/2024, 3/26/2024 and 3/27/2024. The DON did not think Resident #6 would suffer any ill effects of receiving Oxycodone with Acetaminophen outside the parameters stipulated by the physician. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made. Nurse #5 was interviewed on 4/1/2024 at 9:16	F 755	reconcile it with the resident electronic medical record to ensure that everything matches up correctly. The audit will also look at ensuring that a doctor order is present for any controlled medication that is begin signed out. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or their designee. C. An audit will be performed to ensure that that anytime a controlled narcotic medication is being wasted that the medication wasting form is completely filled out and signed by 2 nurses regarding the wasting of that medication. This audit will be performed weekly x 4 weeks and then monthly x 3 months. This audit will be performed by the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that (1) those residents who are receiving controlled narcotics are receiving those medications within the ordered time parameters and that the correct medication is being given based on the pain scale that is being reported by the resident, (2) those residents who are receiving controlled narcotics have the proper documentation in their electronic medical record when the medication is given, and (3) anytime a controlled narcotic medication is being wasted that there are the proper signatures along with the proper	

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F 755	Continued From page 36 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #6. Nurse #5 revealed Resident #6 was complaining on the 3:00 PM to 11:00 PM shift of terrible neck pain on 3/21/2024, 3/26/2024, and on 3/27/2024 so Nurse #5 gave him Oxycodone. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Oxycodone for Resident #6, Nurse #5 stated he did not. Nurse #5 stated that if residents were in pain, he gave them pain medication. An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide education for Nurse #5. The Pharmacist explained that Resident #6 needs to be asked what his pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist stated it had not been brought to her attention that there was any concern with the narcotic medications being administered outside of the orders. The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention.	F 755	documentation regarding the wasting of that medication. These audits will be discussed during this meeting for 6 months.	

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The Medical Director, who was also the physician for Resident #6, was interviewed on 4/4/2024 at 2:30 PM. The Medical Director stated that Resident #6 was on a very high dose of Oxycodone and nurses should be following the parameters of the physician's order for the Oxycodone unless there was authorization to do otherwise. The Medical Director stated narcotic pain medication cannot be arbitrarily given to the residents.

2. Resident #7 was admitted to the facility on 3/22/2024 with multiple diagnoses some of which included an ankle fracture, osteoarthritis, polyneuropathy, and fibromyalgia.

Documentation on admission physician orders revealed an order for Hydromorphone (Dilaudid) 2 milligram (mg) tablets to be administered as one tablet by mouth every 6 hours as needed for pain.

Documentation on the Controlled Drug Receipt/Record/Disposition Form for Resident #7 had the following information: Twenty pills of Hydromorphone (Dilaudid) 2 mg tablets were received by the facility on 3/22/2024. One tablet of Dilaudid 2 mg was signed out by Nurse #5 and "lost on the floor" on 3/22/2024 at 3:30 PM leaving 19 tablets remaining. The Diludid tablet that was "lost on the floor" did not have any corresponding nursing signature or initials from another nurse confirming the pill was "lost on the floor." One tablet of Dilaudid 2mg was signed out by Nurse #5 on 3/22/2024 at 3:30 PM leaving 18 tablets remaining. Four hours and thirty minutes later, one tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 8:00 PM leaving 17 tablets remaining. Two hours and forty minutes

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later, one tablet of Dilaudid 2 mg was signed out by Nurse #5 on 3/22/2024 at 10:40 PM leaving 16 tablets remaining.

There was no documentation on the Medication Administration Record for the administration of the medication Dilaudid to Resident #7 on 3/22/2024. There was no documentation written by Nurse #5 revealing what the pain level of Resident #7 was or if Resident #7 obtained relief from the three doses of Dilaudid removed from the medication cart on 3/22/2024.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #7. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Dilaudid for Resident #7, Nurse #5 stated he did not.

Documentation on a Basic Interview for Mental Status (BIMS) assessment dated 3/25/2024 revealed Resident #7 was assessed as cognitively intact with a score of 15 out of 15.

Resident #7 was interviewed on 4/1/2024 at 4:56 PM. Resident #7 said she did remember Nurse #5. Resident #7 acknowledged that she would not be able to specifically say on what date and time she received medications from Nurse #5. Resident #7 stated that on one previous occasion at another facility she was given a Dilaudid tablet of 3 mg, and she was so sleepy her family was concerned she would not wake up. Resident #7 stated she knew that she was not supposed to take more than 2 mg of Dilaudid every 6 hours,

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and she would not have taken that much Dilaudid in such a short time if it was offered to her.

The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made.

An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide education for Nurse #5. The Pharmacist explained that Resident #6 needs to be asked what his pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist confirmed that when a controlled medication was wasted, another signature or initial was needed by a nurse on the Controlled Drug Receipt/Record/Disposition form.

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The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention.

The Medical Director, who was also the Physician for Resident #7, was interviewed on 4/4/2024 at 2:30 PM. The Medical Director stated nurses should be following the parameters of the physician's order for the Dilaudid unless there was authorization to do otherwise. The Medical Director stated Nurse #5 should have known better than to administer that much Dilaudid within the time frame of approximately 7 hours. The Medical Director was unsure if Resident #7 could have handled that much of the medication Dilaudid.

3. Resident #8 was admitted on 8/12/2022 and had multiple diagnoses some of which included dementia, osteoarthritis, and breast cancer.

Documentation on the current November 2023 physician's orders revealed Resident #8 had a physician's order initiated on 4/5/2023 for Oxycodone HCL (Hydrocholoride) 5 milligrams (mg) to be administered by mouth in the form of one tablet every six hours for pain.

Documentation on a Controlled Drug Receipt/Record/Disposition form revealed 60 tablets of Oxycodone HCL 5 mg tablets were received for the use of Resident #8 on 11/10/2023.

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Resident #8 was discharged to the hospital on 11/13/2023 and was readmitted to the facility on 11/17/2023.

Documentation on physician orders for Resident #8 dated 11/17/2023 revealed an order for Hydrocodone-Acetaminophen oral tablets 5-325 mg to be administered by mouth every 6 hours as needed for pain for three days only until 11/20/2023.

There were no additional orders for narcotic pain medication Hydrocodone-Acetaminophen 5-325 mg in the electronic medical record for Resident #8 in the month of November 2023 or December 2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 0 on 11/21/2023 at 6:00 PM by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/21/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by Nurse #5 at 8:00 PM without an order to do so.

There was no documentation on the MAR (Medication Administration Record) of the administration of oxycodone 5 mg to Resident #8 on 11/21/2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 0 on 11/22/2023 at 5:34 PM.

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Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/22/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by Nurse #5 at 8:00 PM without an order to do so.

There was no documentation on the MAR of the administration of oxycodone 5 mg to Resident #8 on 11/22/2023.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 11/23/2023 one tablet of Oxycodone 5 mg was removed from the medication cart by Nurse #5 at 7:30 PM without an order to do so.

There was no documentation on the MAR of the administration of Oxycodone HCL 5 mg to Resident #8 on 11/23/2023.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 11/23/2023 at 9:59 PM.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 5 on 12/21/2023 at 4:12 PM.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed on 12/21/2023 one tablet of Oxycodone HCL 5 mg was removed from the medication cart by Nurse #5 at 7:50 PM with no order to do so.

There was no documentation on the MAR of the administration of Oxycodone HCL 5 mg to Resident #8 on 12/21/2023.

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Documentation on the current March 2024 Physician orders revealed an order for Resident #8 dated as initiated on 1/8/2024 for Oxycodone HCL 5 mg tablets to be administered as one tablet by mouth every 6 hours as needed for moderate to severe pain.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart by Nurse #5 on 3/22/2024 at 4:40 PM.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 3/22/2024 at 5:39 PM by Nurse #5.

Two hours and 30 minutes later, documentation on the Controlled Drug Receipt/Record/Disposition form revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart on 3/22/2024 at 7:10 PM.

Two hours and 40 minutes later, documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg tablet was removed from the medication cart by Nurse #5 on 3/22/2024 at 10:50 PM.

There was no documentation on the MAR of the administration of Oxycodone 5 mg tablets to Resident #8 by Nurse #5 on 3/22/2024.

Documentation on the nursing staffing schedule revealed Nurse #5 worked on the hallway

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Resident #8 resided on 3/23/2024 for the 3:00 PM to 11:00 PM shift.

Documentation on Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5mg was removed from the medication cart on 3/23/2024 at an undiscernible time by Nurse #5 leaving 6 doses remaining.

Documentation of the pain level of Resident #8 in the vital signs portion of the electronic record revealed a pain level of 4 on 3/23/2024 at 5:51 PM by Nurse #5.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5mg was removed from the medication cart by Nurse #5 on 3/23/2024 at 8:10 PM leaving 5 doses remaining.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 revealed one dose of Oxycodone HCL 5 mg was removed from the medication cart by Nurse #5 on 3/23/24 at 3:00 PM leaving 4 doses remaining.

There was no documentation on the MAR of the administration of Oxycodone 5 mg tablets to Resident #8 by Nurse #5 on 3/23/2024.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #8. When questioned if he called the physician to request permission for administration outside of the parameters of the order for Oxycodone 5 mg for Resident #7, Nurse #5

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stated he did not. Nurse #5 stated that if residents were in pain, he gave them pain medication.

The Director of Nursing (DON) and Assistant Director of Nursing (ADON) were interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident and the nurses should follow the physician orders and provide the medication within the parameters set by the physician. The DON indicated the nursing staff at the end of each shift make sure that the number of narcotic medications left on the medication card for each resident matched the number of narcotic medications signed out on the Controlled Drug Receipt/Record/Disposition form. The DON further explained that if after counting the number of narcotic medications for each resident and assuring the count matches the Controlled Drug Receipt/Record/Disposition form for each resident at the end of each shift then, speculation of a medication error or diversion was not made.

An interview was conducted with the facility pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated the facility needed to provide education for Nurse #5. The Pharmacist explained that Resident #8 needs to be asked what her pain level was, the pain medication signed out on the Controlled Drug Receipt/Record/Disposition form if appropriate for the pain level, administer the medication to the resident, and then sign the medication administration record that the medication was given. The Pharmacist confirmed that when a controlled medication was wasted, another signature or initial was needed by a nurse on the Controlled Drug Receipt/Record/Disposition form.

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F 755	Continued From page 46 The Pharmacist confirmed medication should only be given if there was a physician's order to do so. The Pharmacist stated when she comes to the facility, she made sure the number of narcotic medications in the cart for each resident matched the number of medications on the Controlled Drug Receipt/Record/Disposition forms for each resident. The Pharmacist stated she did not compare the MAR to each residents Controlled Drug Receipt/Record/Disposition form unless the facility brought a concern to her attention. An interview was conducted with the Medical Director, who was also the Physician for Resident #8, on 4/4/2024 at 2:30 PM. The Medical Director confirmed nurses should be following the parameters of the physician's order narcotic pain medication unless there was authorization to do otherwise. The Medical Director stated the facility needed to monitor the Controlled Drug Receipt/Record/Disposition form versus the MAR so that the pain medication orders were followed for Resident #8, because she really needed her pain medication.	F 755		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records.	F 842		5/10/24

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§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches

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F 842	Continued From page 48 legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and Pharmacist interview the facility failed to document the administration of narcotic medication in the medication administration record for 3 (Resident #6, Resident #7, and Resident #8) of 3 residents reviewed for accuracy of documentation of narcotic medication. Findings included: 1. Resident #6 had a current March 2024 physician's order for Oxycodone with Acetaminophen 5-325 milligram (mg) tablets to be administered by mouth every 4 hours as needed for severe pain at the 8 to 10 level. Documentation on the Controlled Drug Receipt/Record/Disposition form dated as initiated on 2/26/2024 recorded the removal of a dose of Oxycodone with Acetaminophen 5-325 mg tablet for Resident #6 on the following dates and times by Nurse #5: 3/1/2024 at 6:00 PM, 3/1/2024 at 10:10 PM, 3/4/2024 at 4:10 PM, and 3/4/2024 at 10:05 PM.	F 842	1. A. Nurse #5 is no longer employed by the facility. Nurse #5 employment was terminated on 4-8-2024. The facility nurses who work the medication carts for residents #6, #7 and #8 will be inserviced on ensuring that there is documentation in the resident electronic medical record showing that the controlled narcotic(s) were delivered to the resident. B. The other facility nurses will be inserviced on ensuring that all controlled narcotics that are given to the residents are signed out in the residents electronic medical record and on the controlled drug receipt/record/disposition form . 2. An initial audit will be completed on all the resident who are receiving controlled narcotics to check the documentation in the electronic medical record and the controlled narcotic sign out sheets to ensure that the documentation is correct.	

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F 842	Continued From page 49 There was no corresponding documentation on the Medication Administration Record (MAR) of Resident #6 for the administration of the doses of Oxycodone with Acetaminophen on 3/1/2024 and 3/4/2024 removed from the cart by Nurse #5. Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #6. Documentation on the Controlled Drug Receipt/Record/Disposition form dated as initiated on 3/1/2024 revealed the removal of a dose of Oxycodone with Acetaminophen 5-325 mg tablet for Resident #6 on 3/13/2024 at 6:00 AM by Nurse #9. There was no corresponding documentation on the MAR for the Administration of the Oxycodone with Acetaminophen on 3/13/2024 removed from the cart by Nurse #9. Nurse #9 was interviewed on 4/3/2024 at 11:23 AM. Nurse #9 stated she was certain she administered the dose of Oxycodone with Acetaminophen to Resident #6 on 3/13/2024 and had just forgot to document it on the MAR. Nurse #9 stated she was new to the facility, but she had learned that Resident #6 frequently requested pain medication multiple times a shift even when it was not due. Documentation on the Controlled Drug Receipt/Record/Disposition form dated as initiated on 3/1/2024 revealed the removal of a dose of Oxycodone with Acetaminophen 5-325	F 842	This initial audit will look at the last 14 days which will be 4-14-24 through 4-28-24. The audit will be performed by the Director of Nursing or their designee. This audit will be completed by 5-10-2024. 3. The facility nurses (RN□s and LPN□s) along with the medication aides will be inserviced on ensuring that all controlled narcotics are signed out in both the electronic medical record and the controlled narcotic count sheet. The inservice will be performed by the Director of Nursing or their designee. This inservice will be completed by 5-10-2024. 4. An audit will be performed to ensure that controlled narcotics are being signed out in both the electronic medical record and the controlled narcotic count sheets. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. The audit will be performed by the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure that controlled narcotics are being signed out in both the electronic medical record and the controlled narcotic count sheets. This audit will be discussed during this meeting for 6 months.	

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mg tablet for Resident #6 on 3/14/2024 at 10:00 AM and 3/18/2024 at 10:00 AM by Nurse #6.

There was no corresponding documentation on the March MAR for the administration of the Oxycodone with Acetaminophen to Resident #6 on 3/14/2024 and 3/18/2024 by Nurse #6.

Nurse #6 was interviewed on 4/1/2024 at 9:54 AM. Nurse #6 stated that it had to be an oversight on her part in not documenting the administration of the Oxycodone with Acetaminophen dose for Resident #6 on 3/14/2024 and 3/18/2024. Nurse #6 stated that Resident #6 asks so frequently for his pain medication that she had to remember to document on the MAR each time it is due that she gave it to him.

The Director of Nursing (DON) was interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident for accuracy of documentation.

2. Resident #7 had a physician's order initiated on 3/22/2024 for Hydromorphon 3 milligram (mg) tablets to be administered as one tablet every 6 hours as need for pain.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #7 dated as initiated on 3/22/2024 revealed the removal of one dose of Hydromorphon 3 mg for Resident #7 on 3/25/2024 at 12:30 PM, 3/252024 at 4:00 PM, and 3/27/2024 at 10:00 AM by Nurse #11.

Documentation on the March 2024 Medication

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Administration Record (MAR) for Resident #7 revealed there was no corresponding dose of Hydromorphon 3 mg administered on 3/25/2024 at 12:30 PM, 3/25/2024 at 4:00 PM, or 3/27/2024 at 10:00 AM by Nurse #11.

Documentation on the March 2024 MAR indicated Resident #7 received a dose of Hydromorphon 3 mg on 3/26/2024 at 3:34 PM by Nurse #11 with no corresponding documentation on the Controlled Drug Receipt/Record/Disposition form documenting the removal of the Hydromorphon from the medication cart.

Nurse #11 did not respond to requests for interviews.

The Director of Nursing (DON) was interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident for accuracy of documentation.

An interview was conducted with the facility Pharmacist on 4/2/2024 at 9:13 AM. The Pharmacist stated she knew Nurse #11 very well and suspected Nurse #11 was "pulled in two different directions" causing an error in not documenting correctly on the MAR and/or the Controlled Drug Receipt/Record/Disposition form.

3. Resident #8 had a physician's order initiated on 1/8/2024 for Oxycodone HCL (Hydrochloride) 5 milligrams (mg) to be administered by mouth every 6 hours as needed for moderate to severe pain.

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Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 dated as initiated on 11/10/2023 revealed the removal of a dose of Oxycodone HCL 5 mg on 1/17/2024 at 9:40 PM, 2/8/2024 at 9:00 PM, 2/10/2024 at 5:10 PM, 2/14/2024 at 5:20 PM, 2/14/2024 at 10:20 PM, 2/15/2024 at 5:15 PM, 2/15/2024 at 9:45 PM, 2/21/2024 at 9:10 PM, 3/5/2024 at 8:25 PM, 3/7/2024 at 5:00 PM, 3/9/2024 at 5:10 PM, and 3/14/2024 at 9:08 PM by Nurse #5.

There was no corresponding documentation on the January, February, and March MARs for Resident #8 for the administration of the Oxycodone HCL 5 mg doses on 1/17/2024, 2/10/2024, 2/14/2024, 2/15/2024, 2/21/2024, 3/5/2024, 3/7/2024, 3/9/2024, and 3/14/2024 by Nurse #5.

Nurse #5 was interviewed on 4/1/2024 at 9:16 AM. Nurse #5 stated he was very bad at documentation but, if he removed narcotics from the medication cart then he administered them to Resident #8.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 dated as initiated on 11/10/2023 revealed the removal of a dose of Oxycodone HCL 5 mg on 1/08/2024 at 12:17 PM and 2/29/2024 at 8:39 AM by Med Aide #3.

There was no corresponding documentation on the January 2024 and February 2024 MARs for Resident #8 for the administration of the Oxycodone HCL 5 mg doses on 1/8/2024 and 2/29/2024 administered by Med Aide #3.

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Medication Aide (Med Aide) #3 was interviewed on 4/1/2024 at 2:22 PM. Med Aide #3 revealed that if the documentation was not correct in the morning it was possibly because Resident #8 has a lot of behaviors in the morning. Med Aide #3 indicated it was sometimes difficult to get Resident #8 to take her medication before morning care was provided. Med Aide #3 stated "there must have been something going on" for her to not document on the MAR the provision of Oxycodone to Resident #8. Med Aide #3 stated she usually was very good at documenting on the MAR after she administered narcotics to Resident #8 but, she must have overlooked documenting the administration of the Oxycodone on the MAR on those days.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 dated as initiated on 11/10/2023 revealed the removal of a dose of Oxycodone HCL 5 mg on 2/24/2024 at 9:30 PM by Nurse #7.

There was no corresponding documentation on the February 2024 MAR for Resident #8 for the administration of the Oxycodone HCL 5 mg dose on 2/24/2024 administered by Nurse #7.

Nurse #7 was interviewed on 4/1/2024 at 10:15 AM. Nurse #7 stated it was an oversight on 2/24/2024 when she did not document the dose of Oxycodone administered to Resident #8 because she always administered narcotic medication to residents after she signed it out.

Documentation on the Controlled Drug Receipt/Record/Disposition form for Resident #8 dated as initiated on 11/10/2023 revealed the removal of a dose of Oxycodone HCL 5 mg on

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F 842	Continued From page 54 2/28/2024 at 3:23 PM by Nurse #8. There was no corresponding documentation on the February 2024 MAR for Resident #8 for the administration of the Oxycodone HCL 5 mg dose on 2/28/2204 administered by Nurse #8. Nurse #8 was interviewed on 4/1/2024 at 11:06 AM. Nurse #8 stated she was only at the facility on an as needed basis. Nurse #8 revealed she usually always wrote the narcotic medication that was administered on the MAR but, she indicated she must have made a human error on 2/28/2024. The Director of Nursing (DON) was interviewed on 3/28/2024 at 1:50 PM. The DON confirmed the Controlled Drug Receipt/Record/Disposition form should match the Medication Administration record for each resident for accuracy of documentation.	F 842		
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an	F 849		5/10/24

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LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements:
(i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.
(ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:
(A) The services the hospice will provide.
(B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter.
(C) The services the LTC facility will continue to provide based on each resident's plan of care.
(D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.
(E) A provision that the LTC facility immediately notifies the hospice about the following:
(1) A significant change in the resident's physical, mental, social, or emotional status.
(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services

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provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

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F 849	Continued From page 57 §483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F 849		

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F 849	Continued From page 58 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, hospice staff interview, and physician interview the facility failed to communicate and coordinate with hospice to identify a resident had sustained a dislocated finger. This was for one (Resident # 3) of two sampled hospice residents. The findings included: Resident # 3 was admitted to the facility on 9/3/09. The resident's diagnoses in part included a history of stroke, hemiplegia and hemiparesis, dysphagia, and advanced dementia. According to a hospital discharge summary,	F 849	1. The hospice company taking care of Resident #3 was contacted on 4-18-24 and instructed that they need to let the facility know of any changes to Resident #3. 2. An initial skin audit will be performed on all residents who are receiving hospice care to ensure that both the facility and the hospice company know any and all skin issues that are affecting the resident(s) that they are providing services for. This audit will be completed by the DON or their designee. This audit	

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F 849	Continued From page 59 dated 1/19/24, Resident # 3 had been hospitalized from 12/23/23 until 1/19/24. The hospital discharge summary also included the following information. The resident had pulled out his gastrostomy tube and nasogastric tube multiple times. A discussion was held with the family and he was to be made hospice with comfort care provided. According to the facility record, on 1/19/24 Resident # 3 was transferred to the facility as a hospice resident. On 1/25/24 a significant change Minimum Data Set assessment was completed. Resident # 3 was coded as severely cognitively impaired. Resident # 3's care plan, reviewed on 2/8/24, noted Resident # 3 had behavioral issues. On 2/27/24 Resident # 3's physician saw the resident and noted that he would be under hospice's care at the facility. Under the physician's assessment, there was no documentation of a joint deformity. Review of hospice documentation revealed Hospice Nurse # 2 obtained an order on 2/27/24 to clean Resident # 3's second digit on his left hand (the index finger) with saline and apply a 2 X 2 border dressing. The dressing was to be done two times per week and facility staff were to perform as needed. An order with a start date of 2/29/24 was entered into the facility electronic record to clean the second digit with saline, pat dry, and apply a 2 X 2 border dressing twice per week. The order was signed off by the facility physician who noted it	F 849	will be completed by 5-10-2024. 3. Each hospice company that the facility uses were informed that there will be binders placed at the appropriate nursing station for the resident that they are providing services for. This binder should include copies of their paperwork so that our facility staff can review whenever needed. Each binder will have the name of the hospice company on the outside of the folder so they know which binder to use for communications. Each hospice company was also informed that their staff need to make sure to inform the facility staff of any changes that are observed to their resident(s) when they are in the facility. The facility nursing staff will be inserviced on these hospice notebooks and where they are located at the nursing station and what type of information will be included within the notebooks. These meetings will take place by 5-10-2024. 4. An audit will be performed to ensure both the facility and hospice company are informed on any changes to resident skin conditions for those residents who are receiving hospice services. The audit will including a review of the hospice information and facility information regarding skin condition of hospice residents to ensure that both the hospice agency and facility are aware of any changes to skin condition. This audit will be performed on a weekly basis x 4 weeks and then monthly x 3 months. The audits will begin the week of 5-13-2024.	

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F 849	Continued From page 60 was "per hospice." According to an interview with the Director of Nursing (DON) on 3/27/24 at 1:45 PM the Hospice nurses changed Resident # 3's dressing to his index finger when they visited twice per week. On 3/28/24 at 10:00 AM Resident # 3 was observed as Hospice Nurse # 1, who reported she routinely visited Resident # 3 twice per week, cared for Resident # 3's left index finger. The following observation was made. When the dressing and gauze wrap were removed, the knuckle area had a pink open wound. At the middle joint of the index finger, there appeared to be a deformity and the finger deviated at an abnormal angle at the joint. This was an obvious contrast to the other three left fingers which were kept in a closed, curled up position at rest. The contrast was apparent upon removal of the dressing but not before the removal. The DON was interviewed on 3/28/24 at 10:30 AM and asked if she was aware there was a deformity of the joint. The DON reported the following. There had been no documentation by a facility nurse or Nurse Aide, and therefore the DON said, "How could we know?" Further interview with Hospice Nurse # 1 on 3/28/24 at 11 AM revealed she had routinely cared for Resident # 3 since his facility admission under hospice. She had been off work from 2/21/24 until 3/1/24 and Hospice Nurse # 2 had seen the resident during that time. When she (Hospice Nurse # 1) returned on 3/5/24 for the first time since being off work, there were orders in place to treat a sore to his left index knuckle.	F 849	The audit will be performed by the Director of Nursing or their designee. 5. The results of these audits will be brought to the monthly facility Quality Assessment and Assurance committee meetings to ensure both the facility and hospice company are informed on any changes to resident skin conditions for those residents who are receiving hospice services. This audit will be discussed during this meeting for 6 months.	

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His index finger also looked different at the joint when she first dressed it. She did not mention the joint deformity to the facility's Director of Nursing when she first noted it.

Hospice Nurse # 2 was interviewed on 4/4/24 at 8:50 AM and reported the following. Orders had been initiated on 2/27/24 to care for an open area to Resident # 3's left index knuckle. She was able to gently do range of motion on the finger. The finger could be flexed and extended. There was no deformity of the finger when she had cared for Resident # 3.

On 3/28/24 at 2:15 PM Resident # 3's physician, who serves as the facility's medical director, was interviewed. The physician did not know about a deformity of Resident # 3's finger and stated she would look at it when she was at the facility on 4/3/24.

Interview with the facility physician on 4/4/24 at 9:23 AM revealed she had seen Resident # 3 the previous day and also saw a x-ray had been done. She was not sure at the time of the interview when the x-ray had been done, but stated it showed Resident # 3's finger was dislocated. She thought it had occurred from him chewing on his finger. She reported at times Resident # 3 would pull his fingers to his mouth. From this action he would obtain sores which would heal, scar, and reopen. When she first saw the x-ray report she wondered if more follow-up needed to be done related to possible infection in the joint, but there had since been a discussion with hospice, and it was decided no further treatment was indicated.

Hospice Nurse # 1 was interviewed again via

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F 849	Continued From page 62 phone on 4/4/24 at 1:15 PM and reported the following. The x-ray had been done on 3/30/24. The report had shown the left index finger was dislocated but was not fractured. There was small bone erosion on either side. It also showed that the resident might have septic arthritis of the joint. She had talked to the hospice physician who felt since the visible wound on the finger had no outward sign of infection that nothing further would be done. They would continue their dressing changes. On 4/4/24 at 3:00 PM the facility provided a copy of the x-ray report. The x-ray had been completed on 3/30/24. The report showed on the second finger, there was a dislocation at the proximal interphalangeal joint with suspicion of small bone erosions of either side. It noted that septic arthritis could be possible. The Administrator was interviewed on 4/5/24 at 8:53 AM and reported the following. He did not know that Resident # 3's finger had been dislocated until the x-ray had been done on 3/30/24. His staff were there 24 hours a day, and hospice staff should communicate with his staff about changes they see when caring for a resident.	F 849		
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	F 867		5/3/24

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following:

§483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

§483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

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

§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

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improvements are realized and sustained.

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

§483.75(e) Program activities.

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

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F 867	Continued From page 65 available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, hospice staff interview, physician interview, pharmacy consultant interview, and psychiatric nurse practitioner interview the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the recertification and complaint investigation of 4/13/2021, the recertification and complaint survey of 6/30/2022, the recertification and complaint investigation of 11/2/2023, and the complaint investigation of 2/27/2024. This was for	F 867	A. Upon review it was determined that the facility needed to analyze falls to determine causative factors and implement interventions to reduce the risk of further falls, to ensure that a paraplegic resident did not roll out of bed during care. B. Upon review it was determined that the facility failed to remove narcotic pain medications from the medication cart within the parameters set by the physician□s orders for narcotic medication; failed to follow procedures for	

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F 867	Continued From page 66 3 repeat deficiencies in the areas of supervision to prevent accidents, hospice services, and pharmacy services. The continued failure of the facility during four federal surveys showed a pattern of the facility's inability to sustain an effective Quality Assessment and Assurance Program. The findings included: This citation is cross referenced to: F689: Based on observation, record review, and interviews with staff, Physician, Psychiatric Nurse Practitioner, and the facility's Pharmacy Consultant the facility failed to 1) analyze Resident #2's falls to determine causative factors and implement interventions to reduce the risk for further falls and 2) ensure a paraplegic resident (Resident # 1) did not roll out of bed during care. Resident # 2 was identified to have an impacted arm fracture (a fracture that generally occurs following a fall). This was for two of three sampled residents reviewed for accidents. During a recertification and complaint investigation survey of 4/13/2021 the facility failed to repair a loose siderail which resulted in a fall with injuries for 1 of 4 residents reviewed for accidents. During a recertification and complaint investigation survey of 6/30/2022 the facility failed to ensure a fall mat was in place according to the care planned fall safety interventions for 1 of 3 residents reviewed for supervision to prevent accidents. During a recertification and complaint investigation survey of 11/2/2023 the facility failed to provide supervision to a resident who was	F 867	disposal of wasted narcotic medications; failed to obtain an order for narcotic pain medication prior to removing narcotic pain medication form the medication cart; failed to have effective safeguards and systems in place to control for, account for and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. C. Upon review it was determined that the facility failed to communicate and coordinate with hospice to identify a resident had sustained a dislocated finger. To correct all of the above issues, the facility has put into place the following audits: A. The Director of Nursing or their designee will complete an audit weekly to ensure the facility analyzes falls to determine causative factors and implements interventions to reduce the risk of further falls and also to ensure that a paraplegic residents does not roll out of bed during care. This audit tool will be turned into the Administrator who will perform a double check to ensure the facility analyzes falls to determine causative factors and implements interventions to reduce the risk of further falls and also to ensure that a paraplegic residents does not roll out of bed during care. These audits will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to	

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F 867	Continued From page 67 assessed as a supervised smoker, while a resident was smoking in a designated smoking area, secure a resident's smoking materials and complete quarterly smoking assessments for a resident, who was assessed as no requiring supervision when smoking for 2 of 2 reviewed for accidents. F755: Based on record review, staff interview, Medical Director/Physician interview, and Pharmacist interview the facility failed to remove narcotic pain medications from the medication cart within the parameters set by the physician's orders for narcotic medication; failed to follow procedures for disposal of wasted narcotic medication; and failed obtain an order for narcotic pain medication prior to removing narcotic pain medication from the medication cart. Additionally, the facility failed to have effective safeguards and systems in place to control for, account for, and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This was for three residents, (Resident #6, Resident #7, Resident #8) of three residents reviewed for pharmacy services for narcotic medication. During a complaint investigation of 2/27/2024 the facility failed to provide pharmacy services within the time frame for a scheduled dose of medication for one of four residents observed during a medication pass observation. F849: Based on observation, record review, staff interview, hospice staff interview, and physician interview the facility failed to communicate and coordinate with hospice to identify a resident had sustained a dislocated finger. This was for one (Resident # 3) of two sampled hospice residents.	F 867	ensure that this process is being monitored. B. The Director of Nursing or their designee will complete an audit weekly to ensure the facility narcotic pain medications are removed form the medication cart within the parameters set by the physician□s orders for narcotic medication; that procedures are followed for the disposal of wasted narcotic medications; that an order is obtained for narcotic pain medication prior to removing narcotic pain medication from the medication cart and that there are effective safeguards and systems in place to control for, account for and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. This audit tool will be turned into the Administrator who will perform a double check to ensure the the facility narcotic pain medications are removed form the medication cart within the parameters set by the physician□s orders for narcotic medication; that procedures are followed for the disposal of wasted narcotic medications; that an order is obtained for narcotic pain medication prior to removing narcotic pain medication from the medication cart and that there are effective safeguards and systems in place to control for, account for and periodically reconcile controlled medications to protect the residents right to be free from potential drug diversion. These audits will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST CAROLINA REHAB AND WELLNESS	2575 W 5TH STREET GREENVILLE, NC 27834

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 68 During a recertification and complaint investigation of 6/30/2022 the facility failed to obtain a Physician's order for hospice services for 2 of 4 residents reviewed for hospice. The facility Administrator was interviewed on 4/3/2024 at 12:55 PM. The Administrator explained that the facility interdisciplinary team met every Friday to discuss falls and accidents so that interventions could be put in place to prevent reoccurrence. The Administrator indicated he did not feel further monitoring was warranted. The Administrator stated that the facility was monitoring the issue the facility was previously cited regarding having enough of liquid medication available for the residents and monitoring the medication pass. The Administrator further explained that the facility interdisciplinary team also discussed every Friday the results of the medication pass monitoring they had just started and had not identified any other issues with pharmacy services. The Administrator was interviewed again on 4/5/24 at 8:53 AM. The Administrator indicated the facility was monitoring hospice services but the hospice nursing staff needed to communicate with the facility if there was an issue going on so it could be addressed.	F 867	committee monthly for 90 days to ensure that this process is being monitored. C. The Director of Nursing or their designee will complete an audit weekly to ensure that there is communication and coordination with hospice to identify if any residents had sustained any injuries. This audit will be turned into the Administrator who will perform a double check to ensure that there is communication and coordination with hospice to identify if any residents had sustained any injuries. These audit will be reviewed weekly during a facility IDT meeting and then reviewed and discussed with the QAPI committee monthly for 90 days to ensure that this process is being monitored.	