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	345420	A. BUILDING _____ B. WING _____	C 04/23/2024

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E 000	Initial Comments An unannounced complaint investigation and recertification survey were conducted on 4/1/24 through 4/4/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # OLYW11. On 4/17/24 a surveyor returned to the facility to conduct a complaint investigation and exited the facility on 4/18/24. Additional information was obtained through 4/23/24 and therefore the exit date was changed to 4/23/24.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey were conducted from 4/1/24 through 4/4/24. Event ID # OLYW11. The following Intakes were investigated NC00212006, NC00214246, NC00212054, NC00213425, NC00215835, NC00215260, NC00215766, and NC00215923. On 4/17/24 a surveyor returned to the facility to conduct a complaint investigation and exited the facility on 4/18/24. Additional information was obtained through 4/23/24 and therefore the exit date was changed to 4/23/24. One of twelve complaint allegations resulted in a deficiency.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		5/7/24

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

Electronically Signed | 05/12/2024

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F 578	Continued From page 1 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records review, and staff interviews, the facility failed to have Advance Directives (code status) in the residents' record for 1 of 1	F 578	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility	

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F 578	Continued From page 2 resident reviewed for Advance Directives (Resident #44). Findings included: Resident #44 was readmitted to the facility on 3/14/24. The quarterly Minimum Data Set (MDS) dated 3/26/24 revealed Resident #44 was assessed as cognitively intact. Resident #44' s care plan dated 3/25/24 indicated the resident was care planned as having an advance directive of "Full Code". At the time of physician's orders review on 4/2/24, there was no active order for code status in Resident #44's Electronic Health Record (EHR). No Hard copy (paper charts) used in the facility. An interview was conducted with Nurse #2 on 4/3/24 at 10:15 AM. Nurse #2 stated the code status was usually displayed in EHR, next to the resident's picture, or in the physician's orders. Nurse #2 confirmed that there was no documentation to indicate the code status for Resident #44. During an interview on 4/3/24 at 10:32 AM, the Social Worker stated Resident #44 was readmitted to the facility on 3/14/24. She indicated the Advance Directives were discussed with the resident during the jump start meeting (baseline care plan) at readmission. The resident was a Full Code and there was no change in resident's code status. The Social Worker stated she does not notify nursing if there was no change in resident's code status. The nurses	F 578	has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F578 1. Resident #44 Code status was verified with the resident and entered in the resident□s medical record on 4/3/2024. 2. The current residents code status was verified with the resident, or the residents representative party and the orders were verified to ensure they were correct. Completed by the Director of Nursing and Director of Discharge Planner on 4/8/2024. 3. The Director of Nursing educated the unit managers on ensuring the code status order is entered in the residents' medical record upon admission and verified. Completed 4/8/2024. The Director of Nursing and designee educated the licensed nurses to enter the code status into the residents' medical record upon admission and if the code status is changed during the stay. Completed 4/16/2024. The Director of Nursing educated the Discharge Planners on if the residents code status changes they are to notify the unit managers and the licensed nurses to have the order changed in the medical record. Completed 4/8/2024. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing and designee	

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F 578	Continued From page 3 were notified when there was a change in resident's code status. During an interview on 4/3/24 at 12:40 PM, the Registered Nurse (RN) supervisor stated the residents Advance Directives were entered by the Nursing staff in the EHR. The RN supervisor further stated Nurses looked for a resident's code status under the resident profile, displayed next to the resident's picture in the EHR. In addition, the staff could look up the code status in the physician orders. The RN supervisor reviewed Resident #44's EHR and confirmed that there was no information regarding the resident's code status. The RN supervisor stated during any new admission or readmission, the admitting nurse would review the discharge orders and code status of the resident with the Provider. The Provider would review them and sign off or give verbal orders to be entered into the EHR. The RN supervisor indicated the admission nurse had missed the code status, resulting in no physician orders related to Resident #44's code status after her readmission to the facility. The RN supervisor stated the Social Worker (SW) and /or Social Worker Assistant would ensure the resident's code status was reviewed with the resident and /or resident's representative and if changes were made then the Nurse were notified for appropriate action. During an interview on 4/3/24 at 11:15 PM, Nurse Practitioner #1 stated that the admitting nurse would review the discharge medication and code status at the time of the admission / readmission from the discharge summary for any resident admitted to the facility. The admission nurse would then notify the Nurse Practitioner. The Nurse Practitioner stated the order was signed,	F 578	will verify the code status in the residents' medical record 3 times a week for 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. 5. Date of compliance: 5/7/2024	

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F 578	Continued From page 4 and/or verbal approval given. The admission staff would then enter the information in the resident's EHR. She was unsure about the code status for Resident #44. During an interview on 4/4/24 at 3:50 PM, the Director of Nursing (DON) stated the resident's code status should be entered in the resident's electronic medical record at admission and/or readmission by the admitting nurse. The DON further stated Resident #44 should have a physician's order regarding the code status entered in their medical records. Resident #44' s code status may have been missed during the readmission by the admission nurse as it was not changed during the recent hospitalization.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review and interviews with the staff, family member, physician, and nurse practitioners the facility failed to ensure effective communication occurred amongst staff and providers when a resident, who had chronic diarrhea, also began to have multiple episodes of nausea and vomiting in addition to the diarrhea. This was for one (Resident # 1) of one sampled	F 684	F684 1. Resident #1 no longer resides in the facility. 2. Current residents' progress notes and alerts were reviewed for clinical abnormalities for the following dates 4/14/2024 - 4/27/2024. Any clinical abnormalities were reported to the	5/7/24

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F 684	Continued From page 5 resident reviewed for acute medical changes. The findings included: Record review revealed Resident # 1 was originally admitted to the facility on 5/29/23 and resided there until 3/18/24. Resident #1 had the following diagnoses which in part included a sacral pressure sore with chronic osteomyelitis (an infection of the bone which does not respond to treatment), history of both ovarian and breast cancer, history of ileus, chronic diarrhea, complete heart block with history of a pacemaker placement, congestive heart failure, coronary artery disease with history of coronary artery bypass surgery times two, chronic pain, atrial fibrillation, diabetes, peripheral vascular disease with a history of bilateral below knee amputations, chronic kidney disease, gastroesophageal reflux disease, hypomagnesemia, history of ischemic colitis, history of colitis (diagnosed during a hospitalization of 10/31/23 to 11/3/23), history of multiple intestinal infections originating from bacteria. Resident # 1's facility electronic record included information on the Medication Administration Record (MAR) that the resident had multiple drug allergies. One of the listed allergies was "carbapenems." (Carbapenems are a group of antibiotics). The MAR did not include any specific reaction Resident # 1 had to carbapenems. On 6/16/23 Resident #1 had a palliative care consult. Notations on the consult indicated Resident # 1 would continue palliative care while at the facility.	F 684	medical provider. Completed 4/27/2024 by the Director of Nursing. 3. The Director of Nursing educated the current certified nursing assistants on ensuring when a resident has clinical abnormalities, they are to communicate this to the charge nurse even if this activity is chronic. The Director of Nursing educated the current charge nurses on ensuring when a resident has clinical abnormalities, they are to communicate this to the medical provider even if this activity is chronic. The communication is to be documented into the resident's medical record. Completed 4/29/2024. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing and designee will review the residents' progress notes to ensure any clinical abnormalities are reported to the charge nurses and medical providers weekly (Monday through Friday) for 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. 5. Date of compliance: 5/7/2024	

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Resident # 1's significant change Minimum Data Set assessment, completed on 1/25/24, coded the resident as cognitively intact. She was assessed to need substantial to moderate assistance with her activities of daily living. She was also assessed to be incontinent of urine and stool, and as having a pressure sore.

Resident # 1's care plan, dated 1/25/24, noted Resident # 1 was at risk for gastrointestinal problems secondary to a history of colitis, gastroesophageal reflux disease, and a history of gastrointestinal bleeding. Staff were directed on the care plan to administer medications as ordered and to obtain labs as ordered. The care plan also noted the facility had identified Resident # 1 was at risk for dehydration. Staff were directed to observe the resident for fluid imbalances.

Although not all inclusive, some of Resident # 1's medications on her facility order summary included the following.
Two Creon Oral capsules delayed release 36000-114000 with meals as a digestive aid. This was a current med as of the time of Resident # 1's final discharge. (Creon is a pancreatic enzyme replacement medication which assists with digestion).

Loperamide 2 mg (milligrams) as needed for diarrhea four times per day. This order originated on 11/3/23 and was a current medication as of Resident #1's discharge.

Magnesium oxide 400 mg orally every day. This order originated on 11/3/23 and was a current order at the time of the resident's final discharge.

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(Magnesium oxide treats hypomagnesemia and can cause diarrhea as a side effect.)

Doxycycline 100 mg twice daily. This antibiotic had been ordered from 1/15/24 to 3/13/24 for the treatment of Resident # 1's chronic osteomyelitis.

Additionally Resident # 1 was receiving Acidophilus Lactobacillus capsule once a day for intestinal health. This had been ordered on 11/3/23 and continued until the resident's final discharge. (This is a probiotic supplement.)

According to the record, Resident # 1 had both a chemistry (a type of blood test) and complete blood count completed on 1/30/24. Although not all inclusive some of the results showed the following:

BUN (blood urea nitrogen) 56.3 (Normal range was listed as 6-20)
BUN/Creatinine ratio 54.7 (Normal range was listed as 6-25)
Creatinine 1.03 (.5 to 1.20)
EGFT Cr PR-56 (This is an estimated glomerular filtration rate and helps determine kidney function and stages of kidney disease. The lab report noted Resident # 1's value of 56 equated to Stage 3 chronic kidney disease).

Review of Resident # 1's bowel log sheet revealed between the date of 3/1/24 to 3/18/24 there were 35 entries made by Nurse Aides (NAs). Of the 35 entries, 29 noted Resident # 1's bowel movements were "loose/diarrhea," 4 noted Resident # 1's bowel movements were "normal/formed," one noted Resident # 1's bowel movements were "putty like," and one noted "not applicable."

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On 3/11/24 NP # 1 noted in a progress note that Resident # 1 was seen, was in no acute distress, and had no concerns at the time of the visit.

On 3/12/24 Resident # 1 was seen by NP#1. NP # 1 noted in a progress note the resident had no acute concerns.

On 3/13/24 Resident # 1 was seen by an infectious disease physician for an outside consultation regarding her chronic osteomyelitis. According to the consult report, the infectious disease physician recommended Resident # 1 to receive two new antibiotics. The first was Daptomycin 540 mg (milligrams) intravenously once a day for osteomyelitis of the sacrum and vertebrae for two weeks. The second antibiotic was Ertapenem 1 gram intramuscularly once every day for two weeks. (Ertapenem is an antibiotic which falls in the classification of carbapenem antibiotics.) Resident # 1's allergy to carbapenem was noted on the infectious disease consultation with a notation that the resident's reaction was unknown.

On 3/13/24 at 3:41 PM Resident # 1's Unit Manager made a nursing entry documenting she called for a placement of a midline catheter for Resident # 1, and the company, which placed midlines, would be out on 3/14/24 to place the midline. (A midline catheter is a type of intravenous access which allows the intravenous catheter to stay in for longer periods of time for intravenous fluids and/or antibiotics to be administered).

On 3/13/24 at 4:55 PM Resident #'1 s Unit Manger signed off on a note in the record that the

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system had identified a possible drug allergy for Ertapenem.

On 3/13/24 at 5:29 PM there was a nursing notation that Resident # 1's facility physician had approved the infectious disease doctor's orders.

The Unit Manager was interviewed on 4/18/24 at 9:20 AM and reported Resident # 1's physician had been present in the facility on 3/13/24 and had reviewed the infectious disease physician's recommendations and given his approval.

The physician was interviewed on 4/18/24 at 4:00 PM and reported the following. In regards to the resident receiving Ertapenem while also having a flagged drug allergy to Carbapenems, the physician felt that the infectious disease physicians would have been diligent in reviewing the resident's history and saw that the medication had been tolerated in the past. If the resident had a true allergy to Ertapenem, then this would manifest itself within hours of the first administration of the medication. The physician reported at times, residents can report an allergy which in reality is more of a side effect to a medication.

During an interview with the consultant pharmacist on 4/19/24 at 12:30 PM the pharmacist reported individuals can say they have a reaction but not recall what the reaction was and then the drug becomes part of an allergy list. If the infectious disease physician felt the benefit of Ertapenem was more advisable than the risk, then the pharmacist did not think the medication should have been avoided. If the resident was to have a reaction, then it would be expected to manifest soon after the initial

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administration. It would be hard to rule out whether medical changes that happened a few days after the initial dose were related to the antibiotic.

Review of the Ertapenem's drug prescribing information located on the Federal Drug Administration's website revealed two of the most common adverse reactions were diarrhea and nausea.

According to Resident # 1's March 2024 medication administration record both the Daptomycin and the Ertapenem antibiotics were begun on 3/14/24 and given daily from 3/14/24 through 3/18/24. Also, according to the March 2024 Medication Administration Record, no PRN Loperamide doses were given in the month of March and the resident continued to receive her daily scheduled doses of Magnesium Oxide from 3/1/24 to 3/18/24.

On 3/15/24 NP # 1 noted in a progress note she saw Resident # 1 and the resident was noted to be in no acute distress and had no concerns.

On 3/16/24 (Saturday) at 4:20 AM Nurse # 4 documented in a nursing entry that Resident # 1 was on antibiotics without any signs of adverse reactions. Nurse # 4 also documented Resident # 1 remained afebrile with a temperature reading of 97.8.

On 3/16/24 (Saturday) at 2:58 PM Nurse # 2 documented a nursing entry noting Resident # 1 remained on antibiotics and had no adverse reactions. The resident's temperature was 97.5.

Nurse # 2 was interviewed on 4/17/24 at 2:50 PM

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and 3:20 PM and reported the following. She had cared for Resident # 1 between the hours of 7 AM and 7 PM on 3/16/24 (Saturday). She did not recall that Resident # 1 had any problems on that day during her care.

On 3/16/24 at 8 PM Nurse # 1 documented on Resident # 1's MAR that she administered Ondansetron 4 mg per the oral route. This was per an order that had originated on 11/3/23 for PRN (as needed) use for nausea.

On 3/16/24 at 9:16 PM Nurse # 1 documented a nursing entry noting the following information. Resident # 1 was actively vomiting. She had administered oral PRN nausea medication and it had been ineffective. The NP was notified and ordered Resident # 1 receive Ondansetron by the IM (intramuscular) route and to follow up if not effective.

On 3/16/24 Nurse # 1 documented on Resident # 1's March 2024 MAR that she administered Ondansetron 4 mg intramuscularly per a one-time order at 9:19 PM.

Nurse # 1 was interviewed on 4/18/24 at 11:12 PM and reported the following information. She had cared for Resident # 1 on 3/16/24 beginning at 7 PM until 7 AM on 3/17/24. Her vital signs had been stable. She did not recall any problems in the nursing report about the resident having problems during the prior shift. At the beginning of the shift Resident # 1 had been nauseated and vomited. The oral medication was not helping and therefore she called the on- call provider who gave an order that the Ondansetron could be administered by an IM injection. She administered it by the IM route and that helped.

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The resident's vomiting ceased after that. Nurse # 1 was further interviewed about Resident # 1's bowel movements and reported the resident was alert and oriented. The resident had not said anything about bowel problems or diarrhea.

Nurse Aide (NA) # 5 had cared for Resident # 1 on 3/16/24 (Saturday) and 3/17/24 (Sunday) from 7 PM to 7 AM. NA # 5 was interviewed on 4/17/24 at 3:40 PM and reported the following information. She recalled that either on Saturday or Sunday night, (but not both) the resident had been very nauseated. It "kept coming up" and she was vomiting noodles she had eaten. During the first two times she vomited there was a lot of emesis but then it grew smaller in the amount as she continued to vomit. She (NA # 5) knew the nurse called and talked to the NP and gave Resident # 1 some medication. In the morning hours the vomiting stopped. NA # 5 was further interviewed about Resident # 1's bowel movements and reported Resident # 1's stools were runny all the time. That was her normal bowel pattern. While changing her, the stool would keep coming at times. This was not unusual for the resident. This pattern had been the same both nights she cared for Resident # 1 on 3/16/24 and 3/17/24. The NA reported Resident # 1 could have stools five to six times per shift.

On 3/17/24 at 9:30 AM Nurse # 2 documented the following information in a nursing entry. Resident # 1 was nauseated and vomited undigested food one time. She administered Ondansetron at 9:12 AM. According to Resident # 1's March 2024, the Ondansetron was administered at 9:12 AM by Nurse # 2.

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A review of Resident # 1's vital sign logs revealed the following values for 3/17/24. Blood pressure 109/60; pulse 96; and temperature 98.1.

Nurse # 2 was interviewed on 4/17/24 at 2:50 PM and 3:20 PM and reported the following information. On 3/17/24 (Sunday) she cared for Resident # 1 from 7 AM to 7 PM. She (Nurse # 2) could tell Resident # 1 "did not feel her best" but she was alert and talking. The night shift staff had reported Resident # 1 had vomited on their shift. Resident # 1 was able to take her morning medications. Breakfast arrived and she ate but then vomited undigested food. She (Nurse # 2) administered the Ondansetron orally and she also called to let the on-call NP know Resident # 1 had vomited on her shift after having vomited on the previous shift also. She (Nurse # 2) asked the NP if it could be the antibiotics, but the NP did not think so. She (Nurse # 2) obtained an order for some IM promethazine (another medication used to treat nausea and vomiting) as needed if the nausea continued. The resident did not throw up again after breakfast and she did not have to administer the promethazine. Nurse # 2 was interviewed about Resident # 2's bowel movements and reported she had one loose stool of which she was aware that day. The Nurse Aide had been at lunch, and she had provided incontinent care herself to Resident # 1. The NAs had not reported any further bowel movements and she did not think Resident # 1 was having diarrhea.

Nurse Aide # 6 had cared for Resident # 1 from 7 AM to 7 PM on 3/16/24 (Saturday) and 3/17/24 (Sunday). NA # 6 was interviewed on 4/17/24 at 4:40 PM and reported the following information. She did not recall anything about the resident

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vomiting. She had routinely cared for the resident since the previous year. The resident routinely had loose stools. That was her normal pattern. She would often check on her because she knew the resident's stools were loose. She had "a lot" of watery stools on a regular basis. When turning Resident # 1 at times she had to jump back because the stool would start coming.

According to Resident # 1's bowel log sheet, NA # 7 had also documented an entry on 3/17/24. NA # 7's entry noted on 3/17/24 Resident # 1 had a normal/formed stool. NA # 7 was interviewed on 4/23/24 at 2:57 PM and reported the following information. Although she was not assigned to Resident # 1 on 3/17/24 she at times helped NA # 6 turn Resident # 1 and provide incontinent care as they worked as a team. At times Resident # 1 could have a formed stool in the morning hours and as time went on throughout the day, it would become loose and watery. The resident had required frequent changing and at times the stool was so loose it would run out of her brief.

NP # 2 was interviewed on 4/23/24 at 2:20 PM and reported the following information. She had taken the call when Nurse # 2 had called on 3/17/24. She was not the routine NP at the facility, but she was able to access the digital record if needed. During the interview, NP# 2 reviewed 3/17/24 on call notes which she could access from the call. The notes indicated the conversation had included that the Ondansetron had not been effective and promethazine was ordered. NP # 2 stated if the nurse had asked her if she thought the antibiotics were causing the nausea and vomiting, then she would have replied that she did not know rather than just saying that they were not. NP # 2 was interviewed

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regarding whether she recalled if she was told Resident # 1 was having diarrhea in addition to the nausea and vomiting, and NP # 2 replied she did not recall that being shared. The NP reported if this had been told to her, then she would have "dug a little deeper" into what was going on to see if an IV needed to be started to avoid dehydration. The NP was interviewed regarding whether it had been brought to her attention during the on- call phone call that one of Resident # 1's antibiotics which had been recently started also had a possible allergy alert. NP # 2 did not recall that being shared with her.

On 3/18/24 at 4:27 AM Nurse # 4 documented the following information in a nursing entry. The resident had experienced two episodes of nausea and vomiting. The resident was given IM promethazine and it had been effective. There had been no continuation of her vomiting at the time of the nursing entry made at 4:27 AM. The resident continued on her antibiotics for osteomyelitis. Resident # 1's family member had visited and requested that labs be drawn for the resident. The nurse had called the on- call provider and obtained orders for a CBC (complete blood count) and a CMP (complete metabolic count) to be done.

Nurse # 4 had cared for the resident beginning at 7 PM on 3/17/24 (Sunday) until 7 AM on 3/18/24 (Monday). Nurse # 4 was interviewed on 4/17/24 at 4:20 PM and reported the following information. At the first of the shift during report, the previous nurse had reported the resident had some vomiting. She had been told the Ondansetron had not been effective and therefore the previous nurse had called and gotten an order for the promethazine. During her

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(Nurse # 4's) shift, Resident # 1 vomited twice during one episode back- to -back. The first time it was a "significant" amount. The second time she vomited a few minutes later and it was clear emesis. Both amounts were less than an emesis basin. She administered promethazine and the resident had no further vomiting that shift. She knew the resident had a "general GI diagnosis" and she frequently had stool. They were not runny bowel movements, but they frequently came. The resident's family member visited and asked about lab work on Sunday (3/17/24) evening. She (Nurse # 4) looked and saw that no labs had been done since January. She called the provider and consulted about possible labs. She obtained orders for labs.

Resident # 1's family member was interviewed on 4/17/24 at 11:51 AM and reported the following information. She visited Resident # 1 on the evening of 3/17/24. The resident had been vomiting and experiencing diarrhea. The family member stated she was aware dehydration could affect kidney function, and she was concerned about the resident's kidney function with the fluids she was losing in her stool and emesis. She talked to the nurse who said she would talk to the practitioner.

NP # 3 was interviewed on 4/23/24 at 1:05 PM and reported the following information. She had taken the call on the evening of 3/17/24. She did not routinely provide services for the facility and did not have access to the resident records. Therefore, she relied on whatever the staff told her as she was making decisions. According to notes she could access from the 3/17/24 call, the facility had called and asked about getting lab work for Resident # 1 on 3/17/24. She did not

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recall specific details of the on-call conversation.

Review of labs revealed a CBC and CMP were drawn on 3/18/24 at 8:10 AM. The reported time of the CBC results was at 4:23 PM. The reported time of the chemistry lab results was 8:58 PM. Although not all inclusive some of the results were.
WBC 27.8 (Normal noted as 4.1-10.9.) (An elevated amount at times indicates possible infection.
Creatinine-2.67 (Normal range .5 to 1.20)
K- 4.2 (Normal range 3.3-5.1)
BUN-64.5 (Normal range 6.0-20.0)
eGFR Cr Pro-18 (Indicates Stage 4 chronic kidney disease)

On 3/18/24 at 10:10 AM Nurse # 3 noted in a nursing entry that Resident # 1 was abnormal and weak. She had spoken to the NP (NP # 1) and asked for an assessment. Orders had been given to start an IV of Normal Saline at 100 ml (milliliters)/hour.

Review of orders revealed an order for the normal saline at 100 ml/hour for 500 ml. According to the MAR, this began on 3/18/24 at 12:31 PM.

Nurse # 3 was interviewed on 4/18/24 at 8:52 AM and reported the following information. The resident was alert but weak on 3/18/24. She did not have any vomiting. She was able to take her medications. As the day went along, she seemed to get weaker. She normally did not eat breakfast. She ate a few bites for lunch, and she did drink a little bit. She (Nurse # 3) did not see any signs of outward dehydration. She did not know about her bowel movements. The resident did not have a specific complaint. She (Nurse # 3) asked NP # 1

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to look at the resident, and NP # 1 ordered the IV fluids which were started.

On 3/18/24 at 7:07 PM the Unit Manger noted Resident # 1 was flushed. Her vitals registered temperature 97.8, pulse 91 (normal range 60-100), respirations 22 (normal range 10 to 20), and blood pressure 105/46 (previous day's reading on 3/17/24 registered 109/60). She had cyanosis (bluish discoloration of the skin originating from a less oxygenated blood flow) to her oral mucosa (the lining of the mouth) and her speech was garbled. She appeared confused. The NP was contacted about the change and CBC results that had been returned. The NP ordered the resident be sent to the ER.

The Unit Manger interviewed on 4/17/24 at 4:45 PM and reported the following information. On Monday, 3/18/24, the resident was alert and would say she "felt alright" when asked. The UM stated the resident looked weak, and the NP had seen her that AM (3/18/24). Later in the day on 3/18/24 Nurse # 3 had noticed a change in the resident. Her vital signs were stable, but her color had changed. They felt she was just "not herself." She was talking but not in complete sentences. They called and got an order to send Resident # 1 to the hospital for evaluation.

NP # 1 was interviewed on 4/18/24 at 10:00 AM and on 4/23/24 at 1:40 PM and reported the following. As NPs they are taught to intervene to try to stabilize residents until a resident can be seen in person. If a resident is vomiting and having diarrhea, then they can lose fluids rapidly and become dehydrated quickly. Antibiotics in general can cause diarrhea. She did see Resident # 1 on 3/18/24. At that time, the resident

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appeared to be a little dehydrated and was not herself but was not critically ill. The facility tried to keep residents in the facility when they could and provide care. She ordered fluids for the resident via IV route on 3/18/24. Labs were also pending. In regard to her chronic diarrhea, the resident had been on Xifaxan at one time and it would have helped slow down some of her loose stools because at times it is given to help irritable bowel syndrome. She had discontinued the Xifaxan because the resident had refused to take it. Regarding the resident's daily Magnesium Oxide, she had not considered that it might be contributing to the resident's loose stools. In assessing diarrhea, the NP thought it beneficial to clarify exactly how stool appeared. The NP reported at times residents can have stools that are not truly formed but not considered to be diarrhea because of chronic gastrointestinal problems and it is important to validate the consistency of stools. The NP stated in some clinical settings, there are classification scales used to classify the consistency so treatment can be better determined.

Review of hospital ED (Emergency Department) notes, dated 3/18/24 revealed Resident # 1 vomited in the ED and had copious amounts of nonbloody yellow loose stool. She was alert to voice but would quickly fall asleep. IV fluids and diagnostic tests were done in the ED. The ED physician further noted, "Her condition appears significantly improved after receiving IV fluids. Suspect a significant amount of dehydration but also underlying concern for acute intra-abdominal infection, sepsis, possible pneumonia. Bowel obstruction etc. are all strongly considered." One of the diagnostic tests was a CT (computerized topography) of the abdomen which showed a

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"distal small bowel obstruction with single point transition within the right lower quadrant. adjacent to an ileocecal anastomotic staple line suggesting an underlying adhesion in this location." (Adhesions are bands of scar tissue in the abdomen that form between structures that are not typically together). According to the hospital record, supportive care was provided by giving IV fluids and antiemetics (medications for nausea) for the obstruction. No further intervention was needed for the obstruction. Further review of hospital records revealed the resident was found to have had a new stroke also. An infectious disease consult was also initiated regarding the resident's antibiotics due to osteomyelitis and suspected sepsis. The resident was hospitalized from 3/18/24 until her discharge on 4/4/24. According to the 4/4/24 hospital discharge summary her primary problem had been severe sepsis with lactic acidosis. (A condition in which lactic acid builds up in an individual's bloodstream due to a lack of oxygenated blood to an individual's tissues or an individual's inability to metabolize the lactate). According to the discharge summary it was not clear whether the resident's sepsis was due to her sacral osteomyelitis or an intra-abdominal infection. She was discharged to another care facility under palliative care.

During the interview with the consultant pharmacist on 4/19/24 at 12:30 PM the pharmacist reported the following. Magnesium can potentially contribute to diarrhea. Magnesium oxide is usually better tolerated than magnesium citrate, and there were no recommendations to routinely check magnesium levels for residents receiving supplementation. Resident # 1's dosage was an appropriate dosage.

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F 684	Continued From page 21 The physician was interviewed on 4/18/24 at 4:00 PM and reported the following. The resident had become septic regardless of multiple antibiotics and this led to her hospitalization on 4/18/24. He felt the resident had multiple medical problems and the facility had done everything they could for her in a skilled nursing facility setting prior to her transfer to the hospital. The physician further reported that a large contributing factor to kidney problems are high potassium levels, and in both the January and March 2024 lab values Resident # 1's potassium levels were within normal range. Regarding the resident's diarrhea, the physician reported that given the resident's history of stercoral colitis, then constipation would need to be avoided as well while trying to manage her gastrointestinal problems.	F 684		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an	F 690		5/7/24

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F 690	Continued From page 22 indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #129) reviewed with urinary catheters. The findings included: Resident #129 was admitted to the facility on 10/13/23. Her cumulative diagnoses included Stage 4 pressure ulcers of the right buttock and right thigh, and a history of urinary tract infections (UTIs). The resident's current care plan included an area of focus which indicated the resident required a urinary catheter related to wounds (Created on 10/15/23; Revised on 12/27/23).	F 690	F690 1. Resident #129 Bed was adjusted to ensure the foley was not on the floor. Residents were educated on keeping the bed at a height to ensure the foley does not touch the floor. 2. Current residents with Foleys were observed to ensure Foley□s were not on the floor. Completed 4/8/2024. Residents with a Brief Interview for Mental Status (BIMS) score of 12- 15 were educated on the importance of keeping the foley off the floor and the complications that can potentially happen. Residents with a Brief Interview for Mental Status (BIMS) score of 0-11 were observed to ensure foley remained off the floor. Completed 4/16/2024. 3. The Director of Nursing educated the current staff if they are to observe a	

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F 690	Continued From page 23 Resident #129 had a history of repeated UTIs requiring treatment with antibiotics on 11/29/23 to 12/6/23, 12/29/23 to 1/5/24, 1/29/24 to 2/5/24, and 2/14/24 to 2/21/24. A review of Resident #129's most recent Minimum Data Set (MDS) was a significant change MDS assessment dated 3/25/24. The MDS reported Resident #129 was cognitively intact. She was independent for eating, required supervision or touching assistance for personal hygiene, and substantial / maximum assistance for dressing her lower body. The resident was dependent on staff for all her remaining Activities of Daily Living (ADLs). The MDS assessment indicated Resident #129 had an indwelling urinary catheter. Multiple observations were conducted of Resident #129's urinary catheter bag either touching or partially lying on the floor of the resident's room. The urinary catheter bag did not have a detachable cover. These observations were as follows: --On 4/1/24 at 1:20 PM, an observation was made of Resident #129 as she was lying in bed. Her urinary catheter bag was touching the floor as it hung from the bed frame. --On 4/1/24 at 3:50 PM, the resident's urinary catheter bag was observed with approximately one inch of the bag lying on the floor of the resident's room as she was lying in her bed. --On 4/2/24 at 10:47 PM, the resident's urinary catheter bag was again observed to be touching the floor of the resident's room as she was lying in her bed. --On 4/2/24 at 12:41 PM, an observation was made of Resident #129 as she was lying in her bed. Approximately 1/4 of her urinary catheter	F 690	residents foley on the floor they are to notify the unit manager, licensed nurse, or the certified nursing assistant. The Director of Nursing educated the unit manager, licensed nurse, and the certified nursing assistant on ensuring the foley is off the floor and the complications if the foley was to be on the floor. Completed 4/16/2024. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing and designee will observe current residents with a foley to ensure they are off the floor daily on random shifts x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. 5. Date of compliance: 5/7/2024	

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F 690	Continued From page 24	F 690		

bag was observed to be lying on the floor.

Accompanied by Nurse #5, an observation was made on 4/2/24 at 12:44 of the resident's urinary catheter bag partially lying on the floor beside her bed. Nurse #5 was the hall nurse assigned to care for Resident #129. Upon viewing the catheter bag, the nurse was asked to share her thoughts about the placement of his catheter bag. The nurse reported the catheter bag should not be on the floor. She stated that sometimes the resident lowered the bed, resulting in the urinary catheter bag touching the floor. Resident #129 had an electric bed with a control pad, which enabled her to raise and lower the bed independently.

An interview was conducted on 4/3/24 at 1:00 PM with Resident #129. At the time of the interview, the resident's urinary catheter bag was appropriately positioned below the level of the resident's bladder and off the floor. When the resident was asked about the placement of her urinary catheter bag, the resident reported she had not been previously aware that her catheter bag was lying on the floor if she lowered her bed to the lowest level. The resident stated now that she was aware of the concern, she did not lower the bed down to its lowest position.

An interview was conducted on 4/4/24 at 1:53 PM with the facility's Registered Nurse (RN) Supervisor. During the interview, the RN Supervisor was asked what education was typically provided to nursing staff about the positioning of a urinary catheter bag. She reported staff were educated to ensure a urinary catheter bag was not on the floor and if the bag was hung on the bed frame, the bed should be

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F 690	Continued From page 25 raised to a level where the bag was off the floor.	F 690		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to: 1) Store medications in accordance with the manufacturer's storage instructions on 2 of 4 med carts (Teal South Med Cart and Mauve 2 South Med Cart); 2) Dispose of loose, unidentified tablets observed in the drawer of 1 of 4	F 761	F761 1. The Five loose, unidentified tablets that were observed to be lying on the bottom of a medication cart drawer were discarded on 4/1/2024. The medication neomycin, polymyxin B, and 0.1% dexamethasone ophthalmic suspension	5/7/24

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F 761	Continued From page 26 medication carts (Teal South Med Cart); 3) Label a medication stored in 2 of 4 med carts with the minimum information required, including the resident's name (Teal South Med Cart and Mauve 2 South Med Cart); 4) Discard expired medication stored on 1 of 4 medication (med) carts (Teal South Med Cart); and 5) Date a vial of injectable medication as to when it was opened to allow for the determination of its shortened expiration date in 1 of 2 medication storage rooms observed (Teal Med Room). The findings included: 1. An observation was conducted on 4/1/24 at 3:15 PM of the Teal South Medication (Med) Cart in the presence of Nurse #6. The observation revealed the following medications were stored on the med cart: a. The manufacturer's storage instructions for neomycin, polymyxin B, and 0.1% dexamethasone ophthalmic suspension (a combination antibiotic and steroid eye drop medication) indicated the eye drop bottle should be stored in an upright position. An unopened bottle of neomycin, polymyxin B, and 0.1% dexamethasone ophthalmic suspension eye drops dispensed from the pharmacy for Resident #25 on 2/12/24 was stored lying on its side in the medication cart. The manufacturer's storage instructions were observed to be printed on the label of the eye drops. An interview was conducted with Nurse #6 on 4/1/24 at 3:20 PM. When asked about the storage of the ophthalmic suspension eye	F 761	and the two 1% prednisone acetate ophthalmic suspension was stored in an upright position on 4/1/2024. One of the two opened manufacturer bottles of 145 micrograms (mcg) Linzess capsules were discarded on 4/1/2024 due to expiration date and the second bottle was labeled with the minimum required information on 4/1/2024. The vial of 0.5 milligrams (mg) / 3 mg per 3 milliliters (ml) of ipratropium bromide / albuterol inhalation solution and the multi-dose vial of Tuberculin PPD injectable medication was discarded on 4/1/2024. 2. The Director of Nursing and unit managers reviewed the medication carts and the medication rooms to ensure medications were label appropriately, if any medication were found to be expired or not label the medication was discarded, and suspension medication stored correctly. Completed on 4/9/2024. 3. The Director of Nursing and designee educated the license nurses and medication aides on when a medication such as a multi-dose vial, insulin pens, breathing treatments are to be dated according to the manufacturer's instructions and suspension medication to be stored upright. Completed 4/16/2024. Education will continue in orientation with new hire. In-person and/or via phone. 4. The Director of Nursing, unit managers, and designee will review the medication rooms 3 times weekly and 1 medication cart daily (Monday through Friday) for 8 weeks to ensure medications are dated according to the manufacturer's instructions. Results of these audits will	

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F 761	Continued From page 27	F 761		

medication, Nurse #6 reported she was not aware that these eye drops should be stored in an upright position.

b. Five (5) loose, unidentified tablets were observed to be lying on the bottom of a medication cart drawer.

An interview was conducted with Nurse #6 on 4/1/24 at 3:20 PM. At that time, Nurse #6 reported the loose, unidentified tablets needed to be discarded.

An interview was conducted with the facility's Registered Nurse (RN) Supervisor on 4/3/24 at 2:44 PM. During the interview, the Nurse Supervisor reported the manufacturer's storage instructions for the suspension eye drops were probably new to the facility's staff. She indicated the nursing staff would need to be educated on these instructions. When asked, the RN Supervisor also reported the medication carts should be cleaned after each shift and any loose tablets or capsules discarded.

2. Accompanied by Nurse #7, a second observation was conducted of the Teal South Med Cart on 4/2/24 at 10:32 AM. The observation revealed two opened manufacturer bottles of 145 micrograms (mcg) Linzess capsules (a prescription gastrointestinal agent used to treat constipation and irritable bowel syndrome) were stored in the top drawer of the med cart along with the facility's over-the-counter stock medication bottles. Neither of the medication bottles were labeled with the minimum required information, including the name of the resident the medication was dispensed for. The first bottle contained 6 capsules and had a

be reviewed at Quarterly Quality Assurance Meeting X 3 for further problem resolution if needed. The Director of Nursing will review the results of weekly audits to ensure any issues identified are corrected.
5. Date of compliance: 5/7/2024

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manufacturer expiration date of December 2023 (indicative of an expired medication). The second bottle of Linzess capsules (observed to be almost full) was not expired.

An interview was conducted with Nurse #7 on 4/2/24 at 10:40 AM. When asked, the nurse confirmed one bottle of Linzess capsules was expired and needed to be removed from the med cart. During a follow-up interview conducted on 4/2/24 at 12:37 PM with Nurse #7, the nurse reported she had removed the expired bottle of Linzess. However, the second opened bottle of Linzess capsules remained on the medication cart. Nurse #7 stated both bottles of Linzess were likely dispensed from the pharmacy in a labeled, plastic bag that had been inadvertently discarded. The nurse reported she understood the medication bottle needed to be labeled with the minimum required information (including the resident's name) and that she would share this concern with a supervisor.

An interview was conducted with the facility's Registered Nurse (RN) Supervisor on 4/3/24 at 2:44 PM. During the interview, the Nurse Supervisor reported, "We always tell them [nurses] to ensure the meds are labeled with the correct resident's name."

3. An observation was conducted on 4/2/24 at 11:06 AM of the Mauve 2 South Medication (Med) Cart in the presence of Nurse #2. The observation revealed the following medications were stored on the med cart:

a. The manufacturer's storage instructions for 1% prednisone acetate ophthalmic suspension (a steroid eye drop medication) indicated the eye

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drop bottle should be stored in an upright position.

Two bottles of 1% prednisone acetate ophthalmic suspension eye drops dispensed for Resident #106 were observed to be stored lying on their side in a drawer of the medication cart.

An interview was conducted with Nurse #2 on 4/2/24 at 11:10 AM. During the interview, the nurse reported she was not previously aware of the need to store suspension eye drops in an upright position. Nurse #2 stated she could place the eye drop bottle in a disposable cup to hold it upright.

b. One vial of 0.5 milligrams (mg) / 3 mg per 3 milliliters (ml) of ipratropium bromide / albuterol inhalation solution (a prescription medication administered via nebulization for the treatment of asthma or chronic obstructive pulmonary disease) was stored in an individual foil package on the med cart. The vial was not labeled with the minimum information required, including the name of the resident the medication had been dispensed for.

An interview was conducted with Nurse #2 on 4/2/24 at 11:10 AM. When asked who the vial of ipratropium bromide / albuterol inhalation solution belonged to, Nurse #2 stated, "I have no idea."

An interview was conducted with the facility's Registered Nurse (RN) Supervisor on 4/3/24 at 2:44 PM. During the interview, the Nurse Supervisor reported the manufacturer's storage instructions for the suspension eye drops were probably new to the facility's staff. She indicated the nursing staff would need to be educated on

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F 761	Continued From page 30 these instructions. When asked, the RN Supervisor also stated, "We always tell them [nurses] to ensure the meds are labeled with the correct resident's name." 4. The manufacturer's storage instructions for a multi-dose vial of Tuberculin PPD injectable medication indicated that once opened the product should be discarded after 30 days. An observation was conducted on 4/1/24 at 3:23 PM of the Teal Med Room in the presence of the Unit Manager for the Teal halls. The observation revealed one opened multi-dose vial of Tuberculin PPD injectable medication (used for skin testing in the diagnosis of tuberculosis) was stored in the med room refrigerator. Neither the vial nor the manufacturer box it was stored in were labeled as to when the vial had been opened. The labeling on the manufacturer's box indicated a vial of PPD solution in use for more than 30 days should be discarded. Upon request, the Unit Manager examined the vial and manufacturer box. She confirmed no date was written on the vial or box to indicate when it had been opened. The Unit Manager reported the vial should have been dated when opened, noting it was not supposed to be kept more than 30 days after opening. She reported she would discard this vial. An interview was conducted with the facility's Registered Nurse (RN) Supervisor on 4/3/24 at 2:44 PM. During the interview, the Nurse Supervisor reported the vial of Tuberculin PPD injectable medication should have been dated when opened.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii)	F 867		5/7/24

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F 867	Continued From page 31 §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §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.	F 867		

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F 867	Continued From page 32 §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, 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	F 867		

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F 867	Continued From page 33 facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility's quality assurance (QA) process failed to implement, monitor, and revise as needed the action plan developed for the recertification/complaint	F 867	F867 1. The Quality Assurance Committee met and reviewed the purpose and function of the Quality Assurance	

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investigation surveys dated 11/2/23 and 5/27/21; and for the complaint investigation surveys dated 7/6/23, 1/17/23, 3/31/22, and 12/13/21 in order to achieve and sustain compliance. These were for recited deficiencies on a recertification and compliant survey on 4/23/24. The deficiencies were in the following areas: Quality of Care, Bowel/Bladder Incontinence, Catheter, UTI, and label/ store drugs and biologicals. The continued failure during federal surveys of record showed a pattern of the facility's inability to sustain an effective quality assurance program.

The findings included:

This tag is cross-referenced to:

1. F684: Based on record review and interviews with the staff, family member, physician, and nurse practitioners the facility failed to ensure effective communication occurred amongst staff and providers when a resident, who had chronic diarrhea, also began to have multiple episodes of nausea and vomiting in addition to the diarrhea. This was for one (Resident # 1) of one sampled resident reviewed for acute medical changes.

During a previous recertification and complaint investigation on 11/2/23, the facility failed to determine or assess the need to continue daily bedside blood sugar monitoring for an insulin dependent resident with numerous comorbidities for 1 of 3 residents reviewed for diabetic blood glucose monitoring.

During a previous complaint investigation on 7/6/23, the facility failed to coordinate care for a resident with a seizure disorder. The resident's valproic acid medication dosage was decreased

Performance Improvement (QAPI) Committee and reviewed the ongoing compliance issues regarding 4/10/2024.
2. Current residents are potentially affected by this deficiency.
3. The Regional Director of Clinical Services educated the Administrator and Director of Nursing on the appropriate functioning of the QAPI Committee and the purpose of the Committee to include identify issues and correct repeat deficiencies related to Quality of Care, Bowel/Bladder Incontinence, Catheter, UTI, and label/ store drugs and biologicals on 4/10/2024.
4. On 4/10/2024, the Administrator educated the QAPI committee members consisting of, the Medical Director, Administrator, Director of Nursing, Unit Nurse Managers, Medical Records, Business Office Manager, Minimum Data Set (MDS) Nurse, Wound Nurse, Activities Director, Director of Rehabilitation, Dietary Manager, Staff Development Coordinator, and Pharmacy consultant at (minimum quarterly), on a weekly QA review of audit findings for compliance and/or revision needed. In addition to weekly QA meetings, the QAPI committee will continue to meet monthly. Quality Assurance. The QAPI committee will continue to meet monthly to identify issues related to quality assessment and assurance activities as needed and will develop and implement appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to repeat deficiencies. The monitoring procedure to

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F 867	Continued From page 35 by a Psychiatric Nurse Practitioner who believed it only to be used for mood stabilization and who was unaware the medication was being using for seizure control. There was no communication with the medical provider before the change. The resident seized, was hospitalized, and intubated following the dosage decrease. Prior to transport to the hospital, the resident's seizure was documented to not respond to intramuscular Ativan medication and lasted approximately 28 minutes before emergency medical services arrived for care and transport. This was for one of three sampled residents reviewed for seizure medications. During a previous complaint investigation on 1/17/23, the facility failed to identify the seriousness of 3rd degree facial burns when staff did not provide continuous monitoring of Resident #1's vital signs or assess the resident to determine the need for nursing or medical interventions until EMS arrived. The resident sustained second- and third-degree flame burns to both sides of his face, both ears, left chest, left upper arm, left forearm, and back of left hand. Additionally, the low outdoor temperature on 01/07/23 was recorded as 29-degrees Fahrenheit, and the resident was only wearing thin pajama pants and a short sleeve shirt while outside. The resident was described by EMS records as being "slouched/slumped over in his wheelchair" when they arrived, and he was pulseless and not breathing. EMS personnel immediately began cardiopulmonary resuscitation (CPR) once inside the ambulance. The resident went into cardiac arrest twice, required intubation, and became comatose due to his injuries. The resident expired on 01/12/23. This deficient practice occurred for 1 of 3 residents reviewed for	F 867	ensure the plan of correction is effective and specific cited deficiencies remains corrected and/or in compliance with the regulatory requirements is oversight by corporate staff. Corporate oversight will validate the facility□s progress, review corrective actions and dates of completion. The Administrator will be responsible for ensuring QAPI committee concerns are addressed through further training or other interventions. 5. Date of compliance: 5/7/2024	

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supervision to prevent accidents.

During a previous complaint investigation on 3/31/22, the facility failed to complete full body skin assessments, including resident's genitalia, back and lower legs for 1 of 8 sampled residents. On 3/13/22, the resident was sent to the emergency department (ED) for evaluation and the ED records indicated the Resident had significant swelling of his scrotum and groin, multiple excoriations to his foreskin with active bleeding, two sacral pressure ulcers and multiple skin discolorations over the body. In addition, an identification band (ID) band was imbedded in his back and a toenail partially lifted when they removed his compression hose.

During a previous complaint investigation on 12/13/21, the facility failed to change treatment orders after a podiatry visit, consistently provide wound care, and provide consistent wound care assessments for one of one resident reviewed for a non-pressure wound.

2. F690: Based on observations, resident and staff interviews, and record review, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 1 of 3 residents (Resident #129) reviewed with urinary catheters.

During a previous complaint investigation on 3/31/22, the facility failed to manage the care for a condom catheter; the facility had knowledge the resident was applying a condom catheter independently without a physician's order and wrapping medical tape around the condom catheter; the facility failed to consider alternative interventions for the resident's urinary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345420	A. BUILDING _____ B. WING _____	C 04/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALAMANCE HEALTH CARE CENTER	1987 HILTON ROAD BURLINGTON, NC 27217

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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incontinence for 1 of 2 residents reviewed for urinary catheters. On 3/13/22 the resident arrived at the Emergency Department (ED) with significant swelling of his scrotum and groin and his condom catheter was extensively taped with medical tape. The condom catheter was removed immediately on arrival due to concerns for compromised circulation to the penis and scrotal area. Blood was observed coming from his penis when the catheter was removed. The skin assessment in ED described multiple excoriated lesions to his foreskin with active bleeding. Resident #7 was admitted due to suspected septic shock.

During a previous complaint investigation on 12/13/21 the facility failed to obtain a physician's order and a diagnosis for the use of an indwelling urinary catheter for one of one resident reviewed for catheter use.

2. F761 : Based on observations, staff interviews, and record reviews, the facility failed to: 1) Store medications in accordance with the manufacturer's storage instructions on 2 of 4 med carts (Teal South Med Cart and Mauve 2 South Med Cart); 2) Dispose of loose, unidentified tablets observed in the drawer of 1 of 4 medication carts (Teal South Med Cart); 3) Label a medication stored in 2 of 4 med carts with the minimum information required, including the resident's name (Teal South Med Cart and Mauve 2 South Med Cart); 4) Discard expired medication stored on 1 of 4 medication (med) carts (Teal South Med Cart); and 5) Date a vial of injectable medication as to when it was opened to allow for the determination of its shortened expiration date in 1 of 2 medication storage rooms observed (Teal Med Room).

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	345420	A. BUILDING _____ B. WING _____	C 04/23/2024

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During a previous recertification and complaint investigation on 11/2/23 the facility failed to: 1) Accurately label medications (meds) to determine their shortened expiration date in accordance with the manufacturer's instructions on 3 of 4 med carts (Teal Middle Med Cart, Mauve 1 South Med Cart, and Mauve 2 North Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 2) Discard expired medications and/or meds without a legible expiration date on 1 of 4 medication carts (Teal Middle Med Cart) and 1 of 2 medication store rooms (Mauve 1 Med Room) observed; 3) Label medications with the minimum information required, including the name of the resident, on 1 of 4 medication carts (Mauve 2 North Med Cart) observed; 4) Store medications in accordance with the manufacturer's storage instructions on 1 of 4 medication carts (Mauve 1 South Med Cart) observed.

During a previous recertification and complaint investigation on 5/27/21, the facility failed to provide the date medications were opened stored in 3 of 6 medication administration carts; failed to remove expired medications stored in 2 of 3 medication storage rooms (Mauve1, Teal North and Teal South halls).

During an interview on 4/4/24 at 4:03 PM, the Administrator stated the Quality Assurance (QA) committee 1) identifies areas of concern, 2) does a root cause analysis, 3) develops a plan, audits, and monitors that plan and 4) discusses the outcome. System changes and additional tasks would be put in place as needed to resolve the issue. Regarding the repeated deficiencies, the Administrator stated depending on the areas of the concerns the facility will determine the team

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members and a team lead. The Administrator would be part of the team. The Administrator stated the old plan of correction would be revisited and analyzed to see where the failures and breakdowns happened. This would help analyze the cause of repeat deficiency. The team leader will interview staff and residents (if applicable) to determine what changes need to be made. He indicated once the facility identified the changes that need to be made then a plan of correction was written. The policies and procedures would be reviewed. The plan would involve identifying staff or residents that may have been affected. The Administrator indicated once the plan was put in place, education, audits, and the monitoring phase would be completed. The plan of corrections, audit and monitoring tools would be discussed in QA meeting and the QA committee would see how the approach can be changed if needed. This could be education and training of staff or revision of the approach or new approach if needed.

The Administrator was interviewed again on 4/23/24 at 3:50 PM. The Administrator stated their Quality Assurance program, looked at outliers, tracks, and trends regarding resident care. They then develop a plan of action. If their Quality Assurance program had missed something in the care for Resident # 1, then they could "revisit" her care and look at what they had missed doing for the resident.